Title of the report:	STP Programme Update
Responsible Director:	Phil Evans, STP/Future Fit Director
Prepared by:	Joanne Harding, Head of STP PMO
Input from:	All input identified below

Purpose of the report:
The purpose of this paper is to provide an update with a high level RAG rated Programme Status Report against the STP Programme Structure, Governance and Delivery Plan.

Key issues or points to note:
The Dashboard below gives a sense check as to the individual components that make up our system wide STP and our progress towards system wide working

Criteria used to demonstrate progress towards system working	
Accountable care systems are place-based systems which have taken on the collective responsibility for managing performance, resources and the totality of population health. In return, they receive greater freedoms and flexibilities from NHS England and NHS Improvement. (Shropshire STP is still in discussion stage re ACS across system leadership, the criteria below is for information)	
Effective leadership and relationships	• Strong leadership team, with mature relationships across the NHS and local government • Effective collective decision-making that does not rely solely on consensus • Clinicians involved in the decision-making, including primary care • Evidence that leaders share a vision of what they're trying to achieve
Track record of delivery	• Evidence of tangible progress towards delivering Next Steps on the Five Year Forward View especially: redesign of UEC system, better access to primary care, improved mental health and cancer services • Leading the pack on delivery of constitutional standards, especially A&E and cancer 62 day • Ability to carry out decisions that are made, with the right capability to execute on priorities
Strong financial management	• Demonstrated ability to deliver financial balance across the system • Where financial balance is not immediately achievable, control totals are being achieved and there is a compelling system-wide plan for returning to balance and/or resolving historic debt • System will is ready to take on a shared control total and has effective ways of managing collective risk
Coherent and defined population	• A meaningful geographical footprint that respects patient flows of at least 0.5m • "Core" providers in the area provide ~70%+ of the care for their resident population • Is contiguous with STP or if not has clear division of labour with STP and is not simply a 'breakaway' area • Where possible, is contiguous with local government boundaries
Care redesign	• System has persuasive plans for integrating providers vertically (primary care, social care & hospitals) and collaborating horizontally (between hospitals), supported by a solid digital plan • Widespread involvement of primary care, with GP practices collaborating through incipient networks • Commitment to population health approaches, with new care models that draw on the best vanguard learning • Includes a vanguard with plans to scale or has demonstrated learning from the best new care • models

STP Director's Update to STP Partnership Board
Jan 2018

Phil Evans, STP/Future Fit Director

The purpose of this report is to provide the meeting audience and distribution list with a summary of progress in regard to delivery of the STP Programme Development & Delivery.

This report will be used at all Board Meetings from 2nd Weds of each month until the following 2nd weds of next month

RAG rating		Key Updates / Issues / risks Last Updated: 10/01/2018
1.0	Sharing a Patient Story – where available and approved for wider sharing	
2.0	**Overall STP Programme Governance**	
2.1	STP Programme Structure & Reporting STP PMO Contact Phil.Evans1@nhs.net Jo.Harding1@nhs.net	• STP Programme Structure, Leadership and agreed system priorities are being refreshed. • STP PMO Team is now established and are aligned to the programme Delivery Groups and Enabling Groups • STP Coordination and communication of programme activities will be facilitated by Office 365 and STP Partner organisations will have full sight and functionality to contribute to system plans via this platform in coming months. • Shropshire Council is working with STP Digital PMO Programme Manager to develop a "STP System wide website" to support overall communication and engagement of wider STP activities.

2.2	STP PMO Finances
	Last update 15/12/17 JH
	STP PMO Contact
	Jo.Harding1@nhs.net
		• The STP PMO is operating within the STP overall budget controls set by STP Partners
		• All partners have now been issued with 17/18 invoices
		• Outstanding payments due from
		  ○ SCCG
		  ○ TWCCG
		  ○ SSSFT
		• Payments received from
		  ○ SaTH
		  ○ RJAH
		  ○ SCom

3.0	**Programme Delivery – Out of Hospital Transformation**	
3.1	Telford Neighbourhood Last updated by Awaiting update Louise Mills (Workstream 1) Ruth Emery (Workstream 2 & 3) Updated 13/12/2017 STP PMO Contact Andrea.Webster5@nhs.net	**Workstream 1 - Community Resilience & Prevention** (Neighbourhood working) **Community Resilience** • 518 people have completed Making Every Contact Count training. Attendance has recently focussed on staff from Council Early Help & Support, social care providers and GP practices. • MECC/Active Signposting training has been developed for receptionists in consultation with Practice Mangers. 100 staff participated in the pilot. Further training scheduled for January. • Safe and Well Visits (Shropshire Fire and Rescue Service) - during the first 3 months of the project 33 referrals were made to My Choice.

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		• The Healthy Telford Blog is now established providing a mechanism to share local stories, news, ideas and best practice. The blog has an average of 1000 visitors each month https://healthytelford.wordpress.com • A network of 36 trained Community Health Champions across Telford and Wrekin, working with each other and their wider communities **Social Prescribing** Newport • Establishment of the Newport & District Community Patient Group to support co-production of the programme • A Weekly link worker clinic at Newport Cottage Care. Referrals are slow and more work is required on partner engagement and developing pathways. Clients are presenting with low level mental health issues, anxiety, depression, loneliness & isolation (including carers) Examples of recent social prescribing solutions: (1) Lady whose Partner had to go into care - was becoming increasingly isolated at her own admittance – Is considering becoming a Volunteer for Feed the Birds and also hoping to join the new Nordic Walking group in the New Year. Invited to attend Neighbourhood Meeting to help her to mix more with the community (2) Lady supporting Autistic son – put in touch with My Choices for access to request support review, informed of different options including shared lives, advocacy and employment and training support, Branches and local mental health drop in (3) Husband and wife (Husband Carer) - Referred to Carers Centre and Thursday CAB session for benefits support and Senior Gym for supervised physical activity and social sessions for wife (4) Local resident (attends cottage care) wanted advice and help to reduce her transport costs to her activities over the week – investigated and sourced local quotes and linked her up to a new service who provide a better service for her than taxis (5) Young Person attended with mum – signposted to BEAM drop in Hollinswood and other local community groups that can offer her support. Ongoing support of Parent Carer negotiating the education support system. Also funded some training to set up her own community group in Newport Community Development Initiatives in Newport linked to the social prescribing programme Linking with Newport Retirement Living Complexes (Wrekin Housing Trust) – engaging residents about projects and also using rooms for training • Collaborative working between Newport Rotary and Walking for Health to establish a 'Bench to Bench Project' to enable inactive residents to begin gentle graduated physical activity. Local volunteers are mapping benches and producing paper maps which will be around the community. It is envisaged that led walks will start in the New Year. • Nordic Walking group: local resident now qualified as Nordic Walk Leader and leading weekly walks • Feed the Birds - In Partnership with Shropshire Wildlife Trust and Community Participation Team. 3 Volunteers trained in Newport who will

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		be matched to isolated clients in their local areas • A Pilot programme is being developed with Wrekin Housing Trust Retirement living schemes in Wellington. More physically able residents are volunteering to work across schemes to support isolated residents on other local schemes. 3 Volunteers are being recruited across 2 pilot schemes in Wellington. When this is evaluated it is hoped to expand to the Newport schemes. Central East Telford • Citizen's Advice clinics running successfully within Donnington and Charlton Medical Practices • Music to movement sessions for the inactive at Donnington surgery. Patients are being signposted from Long Term Conditions reviews. 9-10 attendees. • Branches are now linked in • A local community focus group has been established – with support volunteers are mapping community assets • Meeting held with Shawbirch PPG – very supportive, GPs interested in developing some ideas & have requested meeting in the new year. **Healthy Lifestyles Service** • The Healthy Lifestyle Service includes a small number of Healthy Lifestyle Advisors. • There are just 2 GP surgeries who do not have a dedicated HLA but discussions are in place to address this. In addition to this some GP clinics have increased from 1 half-day session to 2 full days due to the clinics being 100% booked and the GP's being encouraged by the positive outcomes of patients resulting in more referrals. • Positive links with Speciality Consultants at Princess Royal Hospital have been developed – resulting in an increase in referrals of patients from their clinics Since April the service has delivered brief interventions to 19,911 people (2016/17 outturn position was 19,263); completed 2,082 Health Checks; worked with over 1000 adults to develop personalised healthy lifestyle plans and made 7,617 onward referrals to community based support. The team are now operating at full capacity. • 100 adults have participated in creative arts programmes as part of the Building Better Opportunities Programme. A large number of participants experienced poor mental health, issues with physical disability and pain management, substance misuse and rehabilitation, or socially isolated **Workstream 2 – Neighbourhood Teams** • Directly bookable slots for GPs to access Early Help and Support Workers has commenced in some GP practices, which is gradually being rolled out to all practices. • Estates workshop has taken place with GPs, SSSFT, ShropCom to scope estates provision across the locality and gain an understanding of services delivered and where from, and consider where estates could overlap between health and the local authority to support collaborative working. • Two MOUs have been drafted – one for the Neighbourhoods (i.e. how the

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		practices will work together as a neighbourhood), and the second for the operation of the Neighbourhood Teams • Service specification for Neighbourhood Teams currently underway, due for completion by the end of November. • The CCG is working with the Strategy Unit to develop an evaluation strategy to measure the impact of neighbourhood working, to ensure robust, real measurables are in place for the programme. • Work continues to progress with Social Prescribing, including 100 reception staff trained in Making Every Contact Count (MECC) and further training scheduled for January. • MDT meetings have commenced in Newport Neighbourhood (includes mental health, community nursing, social care, therapists etc.) to support patients at risk of admission to hospital, and identify ways that patients can be supported who have been identified by a risk stratification tool. • First draft of Alliance Agreement for integrated teams has been drafted and is currently being reviewed by stakeholders. **Workstream 3 – Systematic specialty review** **Diabetes** STP Area won £200k in funding over two years to increase Diabetes Structured Education and achievement of NICE Treatment Targets (TT) and we also developed locally a CCG GP Incentive scheme to improve TT achievement. The following work has been taking place to support patients to be managed more optimally: • Additional specialist support and advice via neighbourhood level MDT (support to primary care) with case reviews and consultant clinics • individualised practice support (e.g. visits to practices to discuss their results, share best practice and identify training/support needs) • incentive scheme to improve all 3 targets. • structured patient education (provided by ShropCom) Outcomes: The percentage of patients with diabetes who achieve all three targets (BP, Chol, HbA1c (blood glucose levels)) in Telford & Wrekin has increased. 546 more people have achieved all three target values and are now at reduced risk of diabetes related complications. • Ongoing work: Work continues to improve the overall level on this measure whilst also reducing inter-practice variation. • Work continues to encourage more patients to take up the structured education, and a press release has been developed to go out in the next two weeks intended to increase awareness of the education on offer • New Three Tiered Diabetes Model of Care has been developed, we are working with ShropCom to mobilise a pilot, or demonstrator site, in at least one of the four neighbourhoods, commencing 2nd April 2018.Workstream 1 - Community Resilience & Prevention
3.2	Shropshire Neighbourhood (Out of Hospital Programme) Last Updated by	**Workstream 1 - Community Resilience & Prevention** **Working across organisations to connect vulnerable or at risk communities with support to improve health and wellbeing outcomes.** • **Resilient communities** – developing and making best use of local assets in

RAG rating		Key Updates / Issues / risks Last Updated: 10/01/2018
	Lisa Wicks 13/11/17 STP PMO Contact Andrea.Webster5@nhs.net	communities; developing hyper local directories and community connectors – on going • **Social Prescribing** – demonstrator sight in operation (Oswestry), rolling out to Albrighton, Bishops Castle, and Brown Clee next (early 2018). Early discussions with Shrewsbury based practices for third phase. Awaiting news of national funding – Health and Wellbeing Fund • **Diabetes Prevention** – working to connect pilot models with the National Diabetes Prevention Programme – evaluation on tenders in Jan 2018 • **Fire Service Safe and Well** – rolled out across Shropshire and T&W – connecting people with lifestyle, loneliness, falls risk and warmth risk to support. • **Physical Activity** – developing community postural stability instructor programme – delivery to begin early 2018; developing MSK prevention training offer; Falls risk campaign, 'Let's Talk About the F Word'; improving access to physical activity options in communities; developing Everybody Active Every day. • **Housing** – working across health and care to develop a range of options for step up and step down facilities; linking to one public estate and STP estates • **Mental Health** – Delivering Health Checks for those with enduring MH conditions, developing sanctuary scheme for to prevent section 136 crisis, connecting low level MH to Social Prescribing and community support such as Shropshire Wild Teams • **Carers** - Delivering all age carers strategy; improving hospital discharge to support carers, improving access to information and advice, carers assessments and support for young carers; improving support for those with dementia and their carers through Dementia Companions – pilot in Oswestry and Ludlow from November 2017. **Workstream 2** Work has commenced within the localities to develop the out of hospital model of care (based on the 9 commissioning clusters). The design work will be overseen by a CCG's design authority as part of the programme governance. Admission avoidance modelling has been undertaken by practice to inform the out of hospital model. The model is based on the following: • Rapid Turnaround at the Front Door • Community beds and Crisis Resolution • Hospital at Home • Community Services • Non-core enhanced services Outcome based specifications will be developed by locality for each element of the model based on: • Maintenance of good health • Locally determined practice-level management of cohort conditions • Timely, efficient access to cluster-level core services • Health crisis prevention through cluster-level case-management • Admission avoidance through Integrated locality-level crisis resolution • Efficient and effective treatment and stabilisation of acute need A review of MIU, DAART and Community Hospitals has also been undertaken and a case for change developed. Pre-engagement is currently taking place and feedback will be considered by the Clinical Reference Group at the end of November.

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		A health needs assessment for Shropshire has also been commissioned to inform the out of hospital model of care.
3.3	Powys Neighbourhood Last updated by Andrew Evans STP PMO Contact Andrea.webster5@nhs.net	The Locality Model comprises of five key service components as follows: • Primary Care • Community Resource Team and Virtual Ward • Community Hospital: Health and Social Care Centre (Core Elements: Health & Wellbeing Advice Hub, Health and Wellbeing Day Centre, Intermediate Care Unit (Step up/Step Down), End Of Life Unit • Community Hospital: Diagnostic and Treatment Centre (Core Elements: Minor Injuries Unit, Diagnostic Unit, Assessment and Treatment Unit, Day Care Unit • Acute Hospital Care **Unscheduled Care Improvement Plan** The vision for unscheduled care in Wales is that people should be supported to remain as independent as possible, that it should be easy to get the right help when needed and that no one should have to wait unnecessarily for the care they need, or to go back to their home. We will achieve this by working with patients and carers as equal partners to provide prudent care. We will put quality and safety first, working with staff to improve the care we deliver by identifying and removing any waste from our work, and openly sharing our outcomes or learning **Planned Care Improvement Plan** The vision for planned care in Wales is to improve the flow of patients along their healthcare journey by ensuring that their experience of assessment, diagnosis and treatment is based on augmented, safe and reliable systems. In essence this means that we must ensure that people access care at the right level for their needs: right care; right time; right place; right people
4.0	**Programme Delivery – Acute & Specialist – in Hospital Transformation**	
4.1	Local Maternity Services Last update: Programme Lead – Fiona Ellis 10/01/2017	• Transformation Plan – NHS England have released guidance for identifying Baselines and trajectories and the LMS plan is being refined accordingly. Funding bids are being developed ready for submission to NHS England on 31st January 2018 for non-recurrent funding in 2018/19. The amount available has not been confirmed. Reporting against local measures will commence this month. • Maternity and Newborn Service Reconfiguration – Proposals to re-model Midwife Led Services have been endorsed by both Shropshire CCG and Telford and Wrekin Governing Bodies. A period of consultation is now being planned and is anticipated to commence early in 2018. Neonatal and Consultant let unit reviews have commenced. • Perinatal Mental Health – A funding bid is being finalised in preparation for the expected bidding opportunity during January 2018 for Perinatal Mental Health funding.

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4.2	Muscular Skeletal Services
	Updates to be provided by Sabrina Brown 15/12/2017
	
	STP PMO Contact
	maggie.durrant@nhs.net
		• Shropshire MSK Programme Board has been established and includes the following work streams:
		  ○ Physiotherapy
		  ○ SOOS
		  ○ Value based commissioning
		  ○ Rheumatology
		  ○ Communications
		  ○ Education, support & Prevention
		
		• A standard MSK community based physiotherapy service specification has been drafted and approved at the CCG's November Clinical Commissioning Committee meeting. The specification will facilitate consistency in service provision and reporting across the four providers. This is the first stage to a number of service improvement initiatives for physiotherapy. Work is currently underway to model up the enhancement and expansion of conservative management services as an evidence based alternative to surgical procedures.
		• Shropshire Orthopaedic Outreach Service is currently implementing a redesign and expansion of an existing community based specialist MSK service. Additional staff has been recruited and premises identified to serve as hubs in Shrewsbury and the South of the County. Plans are in place to go live during this financial year 17/18.
		• The nationally mandated elective care high impact MSK triage intervention for all orthopedic referrals will be completed via RAS/ SOOS via a phased approach to full implementation
		• MSK VBC: The Value Based Commissioning process is operating well at the Robert Jones & Agnes Hunt provider however a small number of issues are outstanding and are scheduled to be resolved shortly. The policy has been updated and is scheduled for approval at the January CCC meeting.

4.3	Urgent Emergency Care Updates to be provided by Claire Old	• UEC tracker submitted to NHSE, no questions raised or feedback received. • System Winter plan has been included in the submission • Confirmation that we have received the 197k from NHSE
4.4	Future Fit / Sustainable Services Programme Updates provided by Phil Evans Last update provided by Pam Schreier 15/12/17 STP PMO Contact pam.schreier1@nhs.net	• All information has been provided to NHSE and no further requests for additional information are expected. • Conversations continue between SaTH, NHSI and the Treasury regarding capital funding ahead of approval to proceed. • All public facing consultation documents and the PCBC has been signed off in draft and await NHSE approval. • Public facing consultation materials and the website continue to be developed and all necessary translations into Welsh being progressed. • The consultation plan and event planner are being developed with public facing, deliberative and third party events being added as information becomes available. Early drafts of this were shared for feedback with the Joint HOSC. • As part of the Consultation Institute QA process a further meeting is planned for the new year. • The FF Assurance Group and the Clinical Design Group met on 14 December 2017. •

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5.0	**Programme Delivery – Enablement of Transformation**	

5.1	Digital Enablement Group
	Last updated by
	Rob Gray
	12/12/17
	
	STP PMO Contact
	robgray@nhs.net
		• Office 365 pilot implementation for STP team has been priced up.
		  • Licence costs have been agreed.
		  • Implementation costs from the CSU are being reviewed.
		• Started to nominate owners (sponsors) for each programme and project.
		  • Those without owners will be cancelled from the programme
		• Design Authority:
		  • Piloting project process with End of Life module.
		  • Planning to fit in with overall integrated care record.
		  • Clinical workshop scheduled to define process requirement
		• Clinical Professional Reference
		  • Reinstated regular meetings.
		  • Primary aim to nominate clinical lead for every programme and project - agreed by group
		  • EoL process to set template.
		• Information Governance
		  • Agreed to nominate an IG lead for every project as advisory contact
		  • Agreed to send rep to other group meetings to get overview of all workstreams.
		  • Agreed to chase Owner for the scope for the data sharing gateway project.
		Key risks:
		  • lack of project managers offered by contributing organisations.
		• Lack of attendance at group meetings

5.2	Strategic Workforce Group
	Last updated by
	Heather Pitchford
	02/11/17
	
	STP PMO Contact
	Sara.edwards3@nhs.net
		Strategic Workforce Group
		• SaTH have agreed to employ the first cohort of apprentices to enable the Agile Workforce Programme to continue at pace. We are receiving some extra support from HEE with this to feed into the national programme
		• First iteration of Mental Health Plan submitted on time, meeting planned 9th Jan with stakeholders to agree strategy for March submission
		• Many requests for plans are coming through with Cancer Plans next on the horizon. Workforce Group discussing strategy for completing these requests on next agenda along with a plan to produce a system wide baseline by March 18
		• There is a need to revise TOR
		System Organisational Development workstream
		• **Transformational Change through System Leadership** application was successful. NHSE are supporting a Team to enhance our neighbourhood Programmes of work. Participants include STP PMO, ShropCom, SCCG, T&WCCG
		Programme will include out of hospital care for Adults
		• The Kings Fund are supporting **STP system wide OD**, this includes
		  ○ Facilitated STP Programme Delivery Refresh session on 22nd Nov, this has approx. 50 confirmed attendee's
		  ○ Facilitated System Leaders Session via 1:1 & group session Date 20th Dec 17
		  ○ Future co-designed workshops to support system transformation
		  ○ A full debrief from the 22nd Nov session will be available once write up is complete
		Training & Development Workstream
		• Funding bids have been received by HEE and all allocations made in draft prior to final sign off

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		• Final allocation is expected to be £522,600
5.3	Strategic Estates Group Last updated by Becky Jones 11/01/18 STP PMO Contact maggie.durrant@nhs.net	• Baseline data validation is ongoing to provide the baseline information for the Workbook and asset mapping. • SHAPE data validated, meeting DoFs on 11/01/18 to discuss STP Strategic Estates Workbook. Although information has been requested, information given as to why it's needed and support offered in gathering, the current position is that the Workbook details are not fully reflective of the current position. The Workbook is a living document and as such can be regularly updated. It will therefore be a standing item at the LEF and work will continue to ensure it is up-to-date. However, the submission in March will have to be a 'current position' rather than a complete position. • Close work continues with Shropshire County Council on the asset mapping work • Shropshire Community Needs Workshop being planned for 27 February • Telford & Wrekin Community Needs Workshop planned for 17 April • Data mapping progressing well and identifying ways to share data across health and Council to enable programme of mapping to continue and opportunities to be identified • Presentation to Voluntary Sector Assembly on 16 Jan to ensure stakeholder engagement • Shropshire CC hosting a mapping system to pull together all baseline data to use to plan opportunity projects based on health, housing or employment needs identified through the asset mapping process. Supported by Telford and Wrekin Council • New LEF Joint Chair identified as Amanda Alamanos (NHSE) and Tim Smith (Shropshire CC) to give whole system support and linkage • Presentation given to Telford CCG PCCC to discuss efficiency and transformation approach and received positive response • Strengthening links with other workstreams • Agreed that LEF will look at energy efficiencies, linking in with Back Office Group and individual nominated at LEF • One Public Estate (OPE) received some funding so hopeful of using some of it to progress the Whitchurch project forwards. Initial project meeting now taken place, really positive progression **Key risks** Finance and data support still required for Workstream
5.4	Strategic Back Office Updated provided by Ros Preen 15/12/17	A refocus is required for the new year, facilitated by; • The more substantive STP PMO support arrangements starting to have traction both directly for the group but also generally across the work streams, • The ability to review the refreshed health provider corporate service data which was submitted to NHS Improvement at the end of November and will enable further benchmarking to be undertaken, and • A quick conversation with Midlands and Lancs CSU to explore their support model which is up and running in 4 STP footprints (meeting being scheduled for January) The group acknowledges the contributing/associated work going on in other enabling work streams, principally; • Workforce in relation to their focus on looking at options to support collaborative bank and recruitment processes (still in early stages), and

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		• Integrating our 'public estate' through the Estates work stream. • It is anticipated that the Digital work stream could at some point bring into its remit a focus on the IM&T 'back office' which will require further support The Back Office working group will meet in January and will be looking for options in the rest of the 'back office' and to expand thinking around the Carter agenda/ model hospital etc taking into account all of the above.
5.5	Communication & Engagement Group Last updated by Pam Schreier 15/12/17 STP PMO Contact pam.schreier1@nhs.net	• The communications and engagement work stream met on 14 December 2017. • Leads aligned to each work stream provided feedback, where available, on work streams progress. In-depth feedback was provided on the Telford& Wrekin and Shropshire Neighbourhoods activity. • Winter communications was discussed in-depth including the draft winter communications and engagement plan, (for which the Programme Director is asked to confirm governance procedure for sign off; the plan for the additional funding secured from NHSE and the links to the A&E Delivery Group and a request for one coordinated message from all providers at times of escalation or adverse weather conditions. • PS provided an update on Future Fit activity and potential timescales for consultation. • PS reported that further work will be undertaken in the coming weeks to explore the proactive, positive activity in the A&E Delivery Group to identify potential good news stories and interviews for the media. • The SRO updated on the work progressing with the Kings Fund and the meeting due to take place on 20 December 2017. • AW attended from the STP PMO and presented the directors update and advised on the new members of the PMO and their responsibilities. • Communications around MLU, the Maternity Review and going forward the Women and Children's element of the Future Fit programme was discussed. DB will invite PS and AH to a meeting/conference call to discuss joined up messaging following SaTH's discussion with its retained agency on 15 December 2017. • Wider STP Communication & engagement strategy still needs to be developed and work has commenced on this and will be progressed in the new year.
5.6	STP "System" Finance Group STP PMO Contact Jo.harding1@nhs.net	• Review of governance documents to support work stream. • A methodology that tracks system finances needs to be developed and agreed. • Financial Modelling resource required to support system modelling of finances.
5.7	STP Clinical Design Group Last updated by Jharding 15/12/17 STP PMO Contact Jo.harding1@nhs.net	• Agreed to review TORs in light of STP focus rather than just FF • Agreed view from the group that the group needs to evolve to become and STP Clinical Design Group with wider representation from Clinical Leads with clear tasks to support delivery of system transformation. • Focus needs to be on system wide pathway development
6.0	**Cross Cutting Work Programmes of work**	
6.1	GP5YFV STP PMO Contact Sara.edwards3@nhs.net	• The Shropshire STP GP5YFV Workforce plan has now been reviewed by our DCO NHSE Assurance panel. The panel would like to feedback that the plan is FULLY ASSURED with a score of 63.69% (pass score is 50%).

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		The panel noted that the plan was well structured and clear but lacking in detail in some areas with scope to further develop strategically. Specifically the panel would like to see greater focus on the STP footprint rather than individual CCG's to demonstrate increased connectivity across the whole area; it felt that the plan could be more ambitious with further exploration and commitment to exploit national schemes and funding sources and also HEE funding for training. It is clear that work is still in progress and further transformation schemes will need to be included within the plan to diversify workforce and increase multi-disciplinary working. It is suggested that Shropshire, whilst not feeling the same heat as other STP's, could make the most of the headroom that exists locally to get ahead of the transformation curve as workforce pressures are expected to worsen. The plan will be challenging to deliver and there are material risks for delivery which will need to be checked and mitigated.
6.2	Mental Health Awaiting update Richard Kubilis Frances Sutherland STP PMO Contact Sara.edwards3@nhs.net Andrea.webster5@nhs.net	• Mental Health Workforce Planning submission is required fully worked up by end of March 18 • First meeting iof this group took place on 9th Jan where system wide representation attended to contribute to the development of this plan • Clinical lead identified as Cathy Riley from SSSFT
6.3	Transforming Care Programme Manager Di Beasley	• Update to be provided
6.4	Frailty Updates to be provided by Michael Bennet (1&2) Emma Pyrah (3&4) 01/12/17 Gemma McIver STP PMO Contact Andrea.webster5@nhs.net	5 Work streams within the Frailty Programme of work Frailty Programme Board reinstated – first meeting scheduled 21.12.17 (Programme Exec lead Fran Beck) **Workstream 1 - Prevention & Primary Care** • CSU developed Frailty tool to support electronic Frailty Index (eFI) completion and risk stratification of frail patients • Frailty risk stratification being piloted within identified neighbourhood to target support to high risk patients • *My Health Record* (Frailty card) being developed to capture baseline information of patients and support decision-making to appropriat4 clinical care. Plan to pilot in specific care homes when agreed **Workstream 2 - Crisis / admission avoidance** • Review of Intermediate Care Team (ICT) pathways and processes to support admission avoidance. ICT includes BRC and Carers Support Worker and addition capacity via iBCF monies • T&WCCG commissioned Care Home MDT to deliver training, skill development, clinical assessment and admission avoidance from care homes. Recruitment of staff to commence December / January. Rapid Response aligned to specific care homes to support and admission avoidance

RAG rating		Key Updates / Issues / risks Last Updated: 10/01/2018
		• ICT daily attendance in ED to support admission avoidance **Workstream 3 - Flow through acute hospital** • Phase 2 of the Frailty Front Door at RSH operational service relaunch on 13th November 2017 supported by the Acute Frailty Network. Phased increase from 10am-2pm to 9am-5pm Mon-Fri during November as workforce comes on stream. • Memorandum of Understanding agreed at A&E Delivery Board setting out all key stakeholder partners commitments and responsibilities in phase 2 of this project from November 17 – March 2018 and an additional pump priming funding. • Data recording and reporting schedule agreed and formal reporting to the project group to commence from 6.12.17. • PDSA programme and timeline to be agreed by 13.12.17. • Weekly frailty leads meeting refocused to concentrate on Frailty Front Door (project lead Emma Pyrah). Patient rep joined the group on 1.12.17. • **Workstream 4 – Discharge to Assess** • Fact Finding Assessment (FFA) and process refreshed and updated documentation implemented. • D2A reset session held with stakeholder partners in November 2017 to revisit the original D2A principles from 2015 and confirm they remain fit for purpose. Revised set of underpinning principles and processes to be signed off at the next meeting 29.12.17. • Shropshire Council have commissioned an additional 20 pathway 3 beds (interim placements for patients requiring complex assessments) which increases capacity for discharge and the ability to identify patient's potential for rehabilitation/enablement. • Shropcom are working with Shropshire LA to introduce from December a trusted assessor role for care homes, supported by SPIC. • Detailed action plan against the LGA 8 High Impact Changes in development. Concern expressed that the system does not have a formal reporting mechanism for progress on this when it is a mandated requirement which is reported on through NHSE and BCF formal routes. To be discussed at A&E Delivery Group. • D2A Task & Finish Group continues to meet monthly • **Workstream 5 End of Life** Below
6.5	End of Life Update provided by Cath Molineux 12/12/2017 STP PMO Contact Andrea.webster5@nhs.net	• National Workshop planned for 8th Feb 18 for our STP via NHSE The workshops will demonstrate how effective EoLC can deliver 'next steps' priorities, including urgent and emergency care, cancer, financial sustainability and personalisation and choice. The workshops will support development of local strategy and delivery plan across Shropshire • End of Life planning – project at discovery stage to prep for mandate creation. Workshop scheduled for Dec 13th (see notes below)

RAG rating		Key Updates / Issues / risks Last Updated: 10/01/2018
		'Ensuring our services provide high quality care that is affordable and sustainable' (Shropshire STP) The SCHT Palliative and EOL Strategy for adults 2017-2020 is not about trying harder and doing better for the last few days of life but by doing things differently further upstream. This approach needs to be taken across the whole system, in the pathways for people with long term conditions/co-morbidities/cancer and also integrated into the neighbourhood team approach. Systems and practitioners need to work upstream with all patients with any type of long term condition/co-morbidities, so treatment options and decisions have been previously discussed and mapped out. Actual care will be appropriate to preferred care options, already discussed and planned ahead for and reduce very significantly the number of inappropriate high cost interventions being delivered and the number attending A/E because treatment options will be managed proactively and less reactively. Upstream working is recognising as early as possible in any disease trajectory when a person is in at least in the last 12 months of life. This approach reduces the current position where there is a crisis in the last few days and weeks of life and that person will end up in hospital. The STP already sets out the demographics depicting the rise in our older population, those with Long Term conditions and increase in single households and the unsustainability of the current and future demand. **Data is required to quantify this; for example:** • Those attending AE and the nature of emergency admissions and interventions costed and used inappropriately; • The types and numbers of high cost LTC interventions where the patient dies within a certain time limit when other care and treatment options could have been used. • Those being admitted 3 times a year or more(particularly those patients with severe frailty). What are expected outcomes as result of implementing this approach: • Improved patient/family/carer/partner experience • Appropriate use of interventions for all LTC/Cancer/Co-morbidities-disease trajectories • Care and treatment options are planned ahead • Increase in number of people who have an advance care plan reflecting their wishes and preferences including where they want to die. • Reduce demand on the acute sector • Having upstream/planning ahead conversations as an intervention-seen as a positive, with symptom management and still get a quality of life What happens if we don't do upstream working? Paying for inappropriate care- wasting limited resources. When appropriate for treatments to continue or when to stop. Making most of restrictive resources. Demand on acute services continues to rise. **Current Situation** • Shropshire does have a system EoL Group but does not yet have an Eol Strategy for Shropshire. • The EoL group has been working on smaller issues that arise ie discharge meds for patients coming home from SaTH etc etc. • The Community Trust have a strategy and the hospice are just refreshing theirs, it is recognised that a wider system strategy joining together the priorities from each organisation is required. A small group met and developed a list of strategic objectives from the two existing strategies and the Ambitions for Palliative and end of life care (2015/20) to provide local direction for 3-5 years.

RAG rating		Key Updates / Issues / risks Last Updated: 10/01/2018

		These are:
		• To ensure equal access to palliative and end of life care.
		  ○ Systems to identify patients for referral
		  ○ Access Criteria
		  ○ Processes for referral
		  ○ Referral documents
		  ○ Frailty
		• Ensure access is based on need not condition.
		  ○ Establish a needs based model that identifies phase of illness and a system for prioritization
		  ○ Links with non-cancer specialists
		• Establish systems of prognostication to identifying patients in the last year of life.
		  ○ GSF register
		  ○ Frailty register
		  ○ Important conversations
		• Establish the concept of 'Living Well'
		  ○ Documentation supports / directs the professional to identify patients' preferences/goals for living
		  ○ Culture of care is enablement
		  ○ Programs for palliative rehabilitation are established
		• Further develop homecare models to support a preference to be cared for and die at home
		  ○ Hospice to continue to develop the H@H service
		  ○ H@H is placed on a sustainable financial footing
		  ○ Integration of H@H with the Hospice Outreach Service
		• Ensure a competent workforce
		  ○ Identify education needs across services
		  ○ Robust systems for appraisal and CPD across groups
		  ○ Establish education programs
		• Establish systems that support advanced and anticipatory care planning and timely access to services.
		  ○ Identify key worker
		  ○ Consider joint documentation (patent held?)
		• Work in partnership to ensure that care is coordinated between services.
		  ○ Commissioning
		  ○ Services compliment not replicate each other
		  ○ There is shared documentation where possible (RESPECT, EOL care plan, PPC)
		• Consider 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

Key (based on STP PMO system intelligence)

	Unknown	Need to engage and receive update from Programme Lead
	On track – no issues requiring escalation	
	Require Programme Delivery Executive Lead & or SRO input	Where this is required, this will be detailed in recommendations and noted for relevant SRO
	Require STP Partnership Board input	Where this is required, this will be escalated via STP Partnership Board by STP Programme Director