



# Shropshire, Telford & Wrekin STP



## Sustainability and Transformation Plan



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

**Region:**  
Shropshire and Telford & Wrekin



STP Directors Monthly Report  
April 2018 *<Final>*  
*Next Update June 2018*



### Integrated System Working, the transition from STP to ICS

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

### Integrated Care Systems

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

### Further Information:

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



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

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

### 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.



Our ambition is simple:

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

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

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

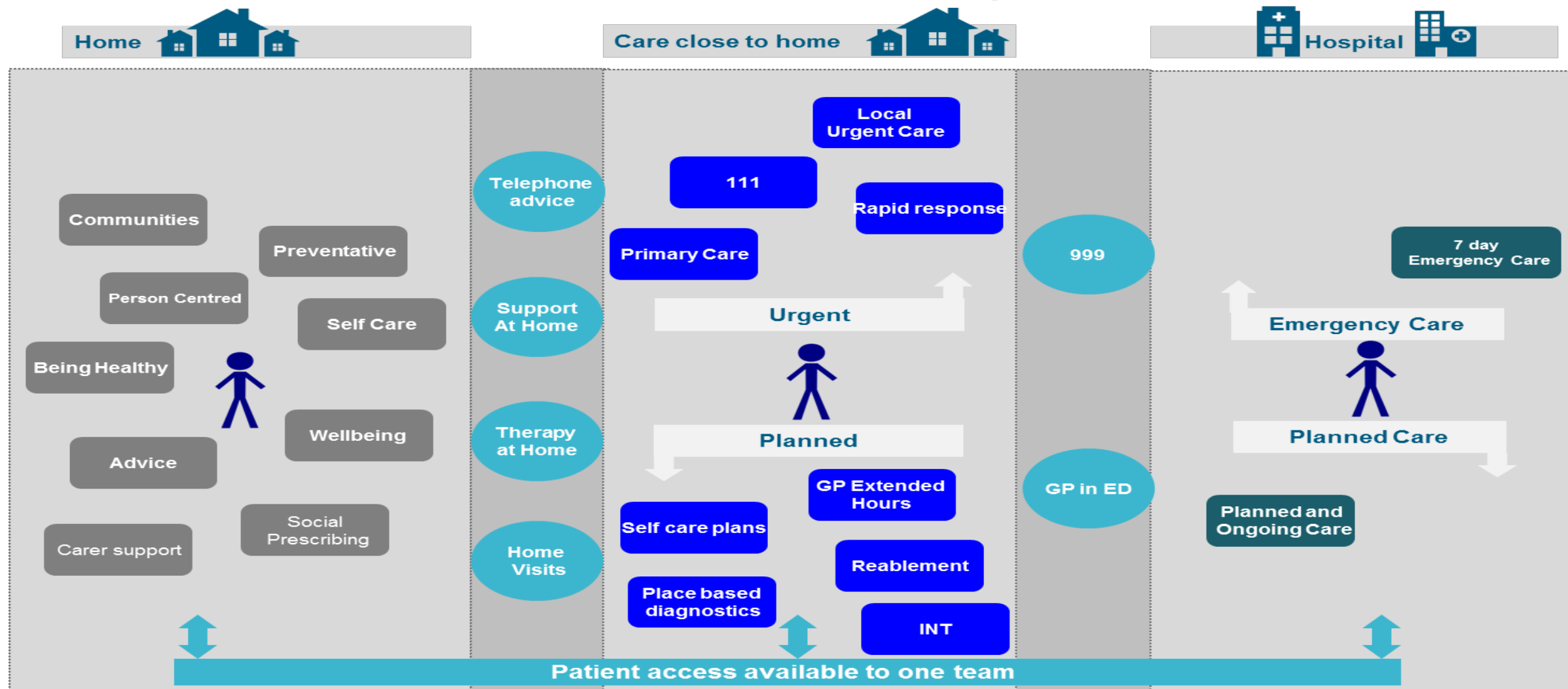
We want care to flow seamlessly from one service to the next so that people don't have to tell their story twice to the different people caring for them, with everyone working on a shared plan for individual care.

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



Its all about integration

## Planned, Preventative and Urgent Care





## Stop Press – Further details in Next Report – June 2018

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- STP System Leaders Group – The Kings Fund OD Phase 1 now concluded
- STP Clinical Strategy Group – relaunch – 1<sup>st</sup> meeting in May
  - Supporting STP Clinical Priority areas
  - Underpinning a clinically driven system
  - Increased engagement across all STP Partners including patient voice
- STP Transformation Delivery Group – The Kings Fund OD Phase 2 to commence in May / June
- Future Fit Public Consultation commences in May



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# Commissioner Led System Improvements Plan on a page



## Programme needs to:

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

## System Partners / Enablers need to:

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

## The progress:

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

## Key Interventions / Milestones

Primary Care Development including risk profiling, case management, enhanced service delivery

Development of a Hospital at Home service to support admission avoidance

Development of a Rapid Response and Resolution team to manage patients prior to and during crisis

Development of DAART and Community Bed Provision

Enhancement of the Frailty Front Door/Community Pull Team

## Risks to delivery

### Risks

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

## Data

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





## Programme needs to:

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

## System Partners / Enablers need to:

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

## The progress:

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

## Key Interventions / Milestones

Encouraging healthy lifestyles

Promoting community resilience

Direct care in the community

Speciality review

## Risks to delivery

### Risks

#### Actions:

Develop enablers as detailed below

Community Information Portal which holds information on services and groups in the area

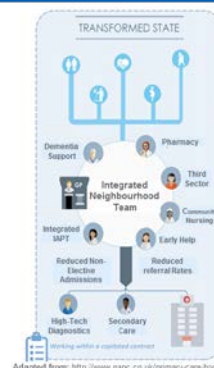
Robust and practical communication and engagement plan

Strong, well represented working groups to progress development

Strong leadership within the organisations involved

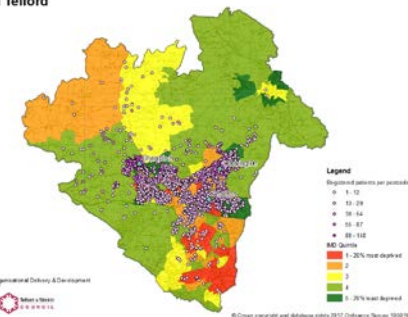
Proactive working relationships between stakeholder

## What next – using data to drive change



Adapted from: <http://www.nps.co.uk/primary-care-home>

Central Telford



Produced by Operational Delivery & Development  
Telford & Wrekin  
2018

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### Programme needs to:

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

### System Partners / Enablers need to:

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

### The progress:

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

### Key Interventions / Milestones

Develop health economy wide cancer strategy based on National Cancer Taskforce priorities in the national strategy

Use of Digital Health solution to develop new whole population models of care

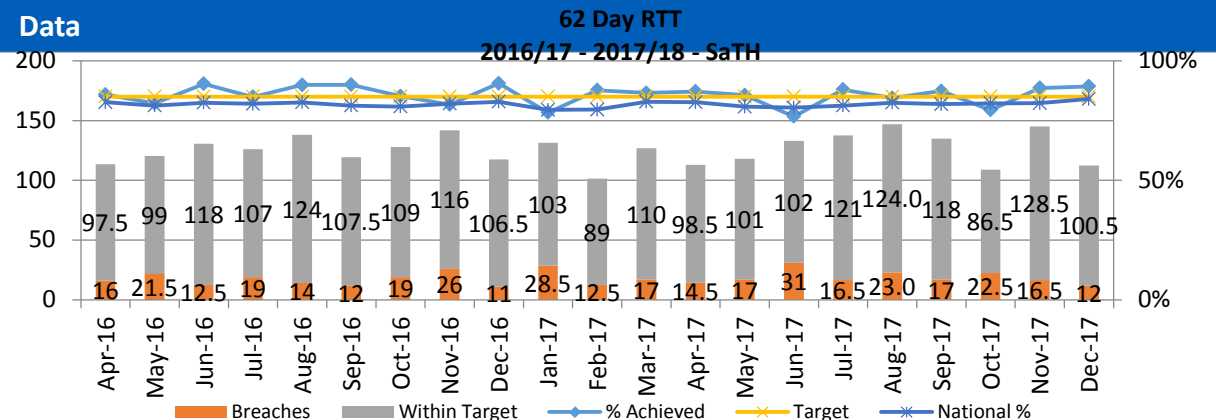
Investment from NHSE to support tertiary centres to improve performance against cancer waiting times

Plan capacity needs to implement GP direct to test aspects of NG12 guidance

Development of a whole health economy cancer strategy and action plan linked to STP priorities

### Risks to delivery

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



**Programme needs to:**

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

**System Partners / Enablers need to:**

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

**The progress:**

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

**Key Interventions / Milestones**

Facilitate effective personalised care planning and planning ahead and support those important to the dying person

Ensure equal access to palliative and end of life care. Develop systems to identify when a person is in the last year if life

Establish concept of 'living well' supporting advanced and anticipatory planning and access to services

Ensure skilled and compassionate workforce. Identify education needs across the county

Work in partnership to ensure that care is co-ordinated between systems.

**Risks to delivery****Risks**

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

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

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

**Data****Data is required to quantify this for example:**

Those attending AE and the nature of emergency admissions and interventions  
 The types and numbers of high cost LTC interventions where the patient dies within a certain time limit when other care and treatment options could have been used.

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



## Programme needs to:

The GPFV programme has five main elements:

### New models of care

- Developing an approach to “working at scale” among practices
- Linking practices working at scale to wider new models of care – i.e. the Out of Hospital Model (SCCG) and Neighbourhood Working (TWCCG)

### Extended Access

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

### Workforce

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

### Resilience/Workload

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

### Estates and Technology Transformation Fund

- Delivering against key physical and digital projects, funded through the ETTF

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

## System Partners / Enablers need to:

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

### Workforce

- The CCGs need to work with other health stakeholders to increase and improve the integration of workforce across different providers.
- The OOH and neighbourhood working models, and the Future Fit strategy, need to be aligned to primary care strategic planning when considering workforce mobilisation

### 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 to develop at-scale working
- Primary Care is inputting into the development of both the Out of Hospital Model (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 has been agreed
- Funding for 2018/19 projects (Skype and Telehealth) has been agreed
- Good progress has been made on a number of estates projects to address growing population GMS needs and to link with hospital service transformation

## Interventions and process change milestones

Increased levels of working at scale between practices

100% of the population having access to GP appointments 8am to 8pm Mon-Fri and at weekends/bank holidays subject to local need

Targets for workforce recruitment and retention across primary care met

Successful implementation of the GPFV 10 High Impact Actions

Successful implementation of ETTF funded IT and estates projects

## Risks to delivery

### Risks

1. Lack of alignment between the at-scale primary care plans and the Out of Hospital plans
2. Continued uncertainty around continuation of funding for extended access pilots and the post-October 1st scheme(s)
3. Insufficient interest from GP practices in providing the extended access service
4. Inability of CCGs/GP practices to attract new GP and non-doctor clinicians to the local area
5. Pressure on revenue budgets from ETTF-funded capital estates projects
6. A change in historical culture is required to enable transformation and collaborative change in Primary Care which will take time to embed
7. 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

### Workforce

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

### Resilience/Workload

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

### Estates and Technology Transformation Fund

- VOiP Telephony Project – 2 sites now live for VOiP and Wi-Fi



## Programme needs to:

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

## System Partners / Enablers need to:

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

## The progress:

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

## Key Interventions / Milestones

Contractual talks pencilled for March 18 with aim to increase IAPT access

Implementation of Community Mental Health Hubs joining the Main Provider and Third Sector Organisations almost complete

Implementation of Community Mental Health Hubs joining the Main Provider and Third Sector Organisations almost complete

Development and delivery of new models of integrated care for MH and LD services

Benchmark and scope likelihood of having local PICU beds to reduce OOA placements

## Risks to delivery

### Risks

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

## Data

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



## Programme needs to:

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

## System Partners / Enablers need to:

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

## The progress:

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

## Key Interventions / Milestones

Timely direct access to MSK therapies operating under a single specification (April 2018) and central booking (Sept 2018)

Shropshire Patients have access to services compliant with NICE OA Quality Standards, in Primary Care from September 2018

SOOS established as Countywide community based specialist MSK assessment and treatment service from March 2018 & providing MSK triage by April 2018

All routine MSK direct access to be coordinated through SOOS, the specialist access route April 2018

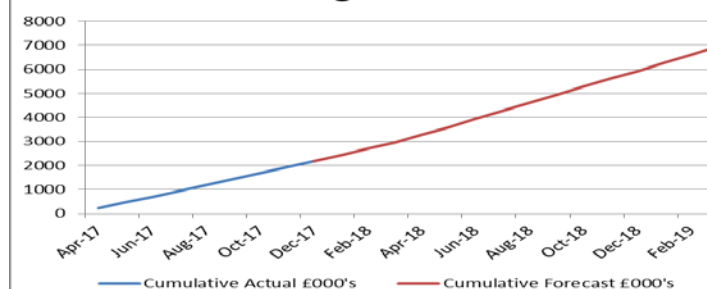
Aligned incentives contract in place with RJA from 1<sup>st</sup> April 2018

## Risks to delivery

- Risks**
1. Lack of GP/provider engagement and support for the agreed pathways and associated compliance issues
  2. Availability of conservative management
  3. Patient expectation /acceptance of non surgical interventions
- Actions:**
1. Communication and engagement plan and targeted practice visits
  2. Mapping of demand and capacity . Action plan to maximise utilisation and MSK business case to increase capacity
  3. Patient and public involvement. Active engagement with and support from Health Watch and Shropshire Patient Group. Implementation of Shared decision making and partnership working with PHE .

## Data

**Expenditure Reduction - Trajectory to National Average Intervention Rates**







## Programme needs to:

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

## System Partners / Enablers need to:

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

## The progress:

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

## Key Interventions / Milestones

Approval to proceed to formal consultation by NHSE (date tbc)

Consultation exercise completed and results analysed and report available to inform DMBC (date tbc)

IIA Mitigation Plan and Ambulance Impact Modelling completed prior to the end of the consultation period in order to inform DMBC

All key actions arising from external reviews of the programme completed

Development of DMBC (date tbc)

## Risks to delivery

### Risks

Lack of resource to effectively deliver a public consultation, including programme management, patient and public involvement and communications, impacting on ability to receive QA from external assessor  
Insufficient non-pay budget to deliver a public consultation of this scale  
Significant political and campaign opposition to the proposals, impacting on programme reputation in the media  
Uncommissioned activity, including travel and transport analysis, therefore impacting on planning public involvement in the process  
Continuing delay in progressing to formal consultation risks damaging the reputation of the programme and the increasing workforce challenges in SATH with recruitment and retention of ED clinicians risks decision to close PRH A&E overnight to maintain safe services has to be taken which could be viewed as predetermination ahead of completion of the consultation exercise

### Actions:

## Data



Programme needs to:

- Awaiting details of this plan on a page – further update to follow

System Partners / Enablers need to:

The progress:

Key Interventions / Milestones

Risks to delivery

Risks

Data





# Urgent & Emergency Care

System Improvements

Plan on a Page

Mixed format of Plan on a page and updates to reduce duplication

**SATH needs to:**

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

**System needs to:**

1. Implement the following schemes:-
2. **F1**: Shropcom to work with SATH to explore the potential for Shrewsbury DAART to function as the frailty assessment area
3. **F3** Reduce admissions/re-admission from Care Homes by a) focus on high admitters; b) Care Home team (T&W)
4. **F4** Reduce admissions/re-admission from Care Homes by a) focus on high admitters;) b Trusted Assessors (Shrops) to reduce Los
5. Reduce occupied bed days by impact of **F1&2** and **F3 & 4**

**The progress: 5.4.18**

- Frailty MDT in RSH piloted since Sept – scheme continuing post end of non-recurrent NHSE funding at the end of March 2018.
- Evaluation report drafted and out with stakeholder partners for comment. Final report will be submitted to A&E Group 17.4.18.
- Mapping of existing services and pathways underway to inform the PRH model.
- Meeting being scheduled with SATH/Shropcom to explore the potential of DAART as the frailty assessment area
- £333K invested in new Care Home Team (T&W). 4 Trusted Assessors appointed to work with Shropshire Care Homes – start in post w/c 9.4.18
- Both CCGs to work with SPIC to focus on high admitting homes. Shropshire have commenced a deep dive to identify homes to target.
- System focus on 3 areas:-Prevention, Admission Avoidance and End of Life.
- CHAS being reviewed as part of 'Out of Hospital' service design
- Care Home Pharmacists appointed in both SC and T&W
- Practices using Frailty Index to identify/risk stratify patients – next steps will be ensuring all Care Home residents have advanced care plans/CHAS; and then all >75s

**Interventions**

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

F2 Replicate model at PRH with Community Matron/Rapid Response

Resolve payment for Frailty Teams from 1.4.18

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

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

**Risks to delivery**

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

**Data**

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

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

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

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



## SATH needs to:

1. Develop Chris Green's basic model to accurately reflect SaTHs demand and capacity
2. Agree final version of acute model and resulting actions agree project approach and action plan /timescales
3. Task and Finish Group to be set up to implement findings from acute model
4. Work with commissioners to define the acute support required to review and strengthen Discharge to assess in line with the findings of the out of hospital work

## System Partners / Enablers need to:

1. System lead to visit Wye Valley to discuss implementation of SOP with Powys.
2. Gain input from Powys to the process by mid April
3. Draft report on out of hospital demand & capacity to be complete end of April
4. Workshop to receive out of hospital report early May, agree the findings, including chance to redefine and strengthen D2A
5. Agree project approach and action plan /timescales
6. Final plans to A&E Delivery Board in May

## The progress:

1. Acute modelling meeting with SaTH was held 27th March
2. Review of PW1for Shropshire, Telford and Wrekin completed by end of March 2018.
3. Community Hospital capacity review completed
4. Not secured input from Powys to review
5. Draft ToR went to A&E board
6. SaTH COO has met with Powys team
7. Powys SOP being developed by SaTH COO

## Interventions and process changes

Complete LOS reviews on all bedded environments by the end of February 2018

Complete review of percentages of simple and complex discharges by 7<sup>th</sup> March 2018 and compare with national average

Review findings of the Appropriateness Evaluation tool to add intelligence

Complete Length of Stay review in the acute Trust- end March 2018

Dennis Holmes to complete interviews with identified system leaders and staff – end March 18

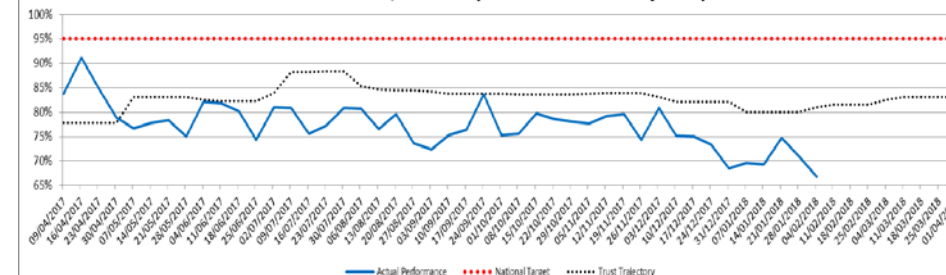
## Risks to delivery

### Risk

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

## Data

SaTH A&E 17/18 Weekly Performance Vs. Trajectory





### 3A. Project -Reduction in the Stranded Patient Metric

Project Overview				Overall Project Status
Project Title:	Stranded Patients	Deadline:		<div style="background-color: orange; width: 100px; height: 100px; display: flex; align-items: center; justify-content: center;"> <b>AMBER</b> </div>
Exec Lead:	Edwin Borman	Project Lead:	Gemma McIver	
Clinical Lead:		Project Group:	Improving patient flow	
Date of Report:	18th April 2018	% improvement in admitted performance target 4%		

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

#### Key Items completed this week/since the last report

- SOP completed for check chase challenge
- Rota extended to end of July
- Planning for Peer review commenced
- Made Event planning on going
- Collation of patient stories around stranded for each group to use as an example
- Targeted support on ward 22
- Therapists attending CCC
- FFA immediate plan and long term solution scoped
- Referral to LA's for most complex flagged up in the check chase challenge - Richard worked this through at PRH

#### Key Issues/Risks

- Need senior clinical challenge, support and capacity to support sustainability of the improvements
- Forward look for PW2 beds and 3 Telford

#### Key Items for next week

- HRG top reasons for admission and stranded patients – bench marking on going
- PSAG use into CCC
- MADE
- Focused approach for CCC – more than one person extra MDT push for prep to bank holiday weekend?

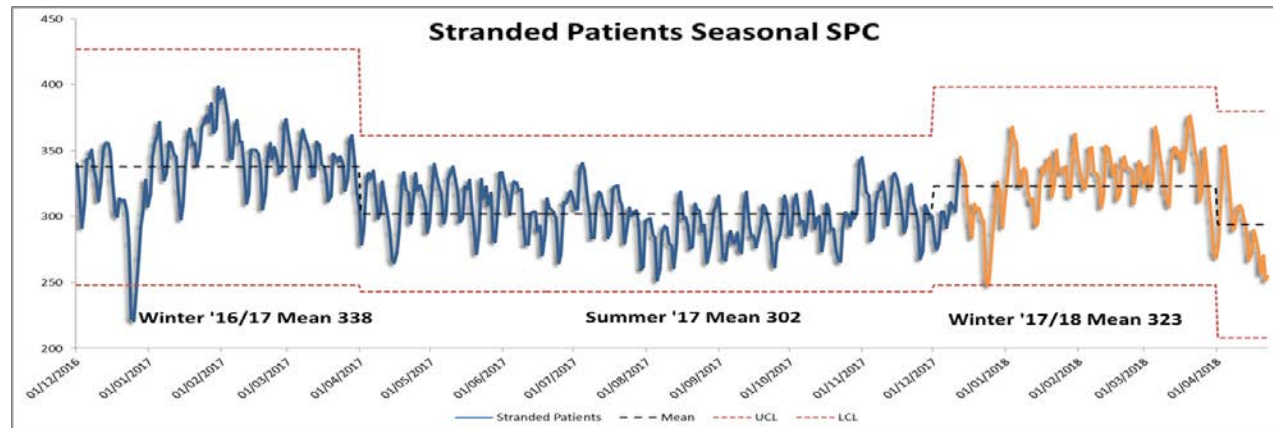


Performance

	Base Position as at March 18	02/04/2018	09/04/2018	16/04/2018	23/04/2018	30/04/2018	07/05/2018	14/05/2018	21/05/2018	28/05/2018	04/06/2018	11/06/2018	18/06/2018	25/06/2018	02/07/2018
Hospital															
RSH	185	180	175	170	165	155	145	140	135	125	120	115	110	100	100
PRH	165	145	140	135	130	125	120	110	105	100	95	90	85	85	80
Total	350	325	315	305	295	280	265	250	240	225	215	205	195	185	180
Planned Reduction		(25)	(35)	(45)	(55)	(70)	(85)	(100)	(110)	(125)	(135)	(145)	(155)	(165)	(170)

Actual Midnight  
Monday

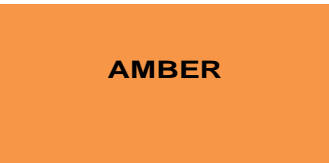
RSH	177	175	164	157
PRH	113	125	126	124
Total	290	303	290	281





# ED Systems and Processes

## Project Summary

Project Overview				Overall Project Status	
Project Title:	Improving ED Processes	Deadline:	06.04.18		AMBER
Exec Lead:	Nigel Lee	Project Lead:	Rebecca Houlston		
Clinical Lead:	Dr Kumaran Subramanian	Project Group:	Urgent Care improvement Programme		
Date of Report:	25th April 2018	% improvement in admitted performance target		TBC	

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

### Key Items completed this week/since the last report

- ED flow coordinators in post – rota template to reflect reduced crossover
- Professional standards and SOP for doctors circulated for review – MC confirmed amendments required. To be discussed at meeting on 26/04/18
- Action tracker produced in line with trajectory included in Trust Operational Plan (saved on central drive for information)
- ED workforce Exec level meetings have taken place 20/04/18 and 23/04/18 due to significant fragility of staffing both departments
- Daily escalation of staffing levels provided to Medical Director
- 1 Consultant locum failed to attend as planning on 23/04/18 – awaiting confirmation of new start date and another locum consultant booked from 7<sup>th</sup> May
- ED Consultant interviews take place on 30/04/18 – 1 shortlisted
- ED workforce and recruitment forecast plan completed
- Specialty performance report shared with NL and EB

### Key Issues/Risks

- ED workforce status – impact upon ability to deliver required process changes
- Operational Team capacity to deliver required process changes
- Senior nursing sickness levels – awaiting outcome of plan
- Constant changes to medical rota to cover key shifts resulting in gaps ‘within hours’ is resulting in significant delays tbs.
- Financial impact of highly escalated salaries for overseas doctors and locums
- Additional physio clinics following the ED clinics no longer being in place – funding source required
- CDU paper – funding for staffing not yet confirmed
  - Medical capacity to review clinical pathways for CDU/AEC is limited
  - Inappropriate use of CDU – daily monitoring



### Key items for next week

- Continue to embed CDU
- All patients to be managed against professional SOP's/ professional standards
- On-going recruitment drive and review of potential locums
- ED Nurse Coordinator meetings being arranged – professional standards to be included at session
- Continue to push internal ED actions to improve non admitted performance
- RPIW Specialty Review commencing 30/04/18

### Performance metrics

- April MTD non admitted performance is 86.89% against a target of 88%
- April MTD admitted performance is 37.79% against a target of 53.4%
- CDU at PRH average of 9 patients a day with an average of 2/10 already breached due to the unit not being open 24/7. Throughput is currently an issue due to delays in being seen



# Red2Green/SAFER

## 3A. Project Summary

Project Overview				Overall Project Status
Project Title:	Objective 7 - Red 2 Green/SAFER	Deadline:		<b>AMBER</b>
Exec Lead:	Deidre Fowler	Project Lead:	Rachael Brown	
Clinical Lead:	To be agreed for each site	Project Group:	Improving patient flow	
Date of Report:	25 <sup>th</sup> April 2018	% improvement in admitted performance target 4%		

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

### Key Items completed this week/since the last report

- Red2Green tracker form converted onto psag. In 'test' phase currently. To 'go live' beginning of May in line with EDD update. Comms and training required for staff
- Super - stranded patient reviews continue to take place on a weekly basis for both care groups across both sites. Weekly escalation meetings in place to discuss and highlight patients for further attention. Task and finish group establish to support this work.
- SAFER pin board monthly information available on people link boards. Evidence supports improvements to morning discharge numbers – ward 27 and ward 28 (from single monthly figures to double figures). Currently no ward is achieving 1 pre-lunchtime discharge daily. The impact has been less in SC wards, this could be due to the baseline from where the team were starting from, or as a result that the red2green support 4 areas and not 1 ward.
- Weekly information / feedback developed for all ward areas focusing on SAFER scoreboard, to commence April onwards.
- Theory of constraints focusing on ward 22 T&O and ward 22S&A – ongoing support for the work provided by Red2Green team
- Check, chase, challenge process in place across both sites, all care groups. Metrics agreed to uncover key delays / blocks in patient journeys. Task and finish group in place. Therapists now attending their ward areas daily.
- Red2Green team taking place in RPIW for FFA completion – 30 day period in place at PRH.
- RPIW completed for CLD, Red2Green supported. Patient journey facilitator continues to support ward for the next 30, 60, 90 day period. Discharge performance continues to improve in March / April, pre10 and pre 12., although still reliant on a consistent approach from the team to board round attendance and use of CLD.
- Launch of 70 day end pparalysis on both sites / both care groups.
- Snapshot feedback gained from areas supported by Red2Green regarding board rounds/ ward rounds, CLD and the 4 questions.





# Red2Green/SAFER

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## Key Issues/Risks

- FFA ownership of completion
- Discharge planning process and med fit category, changing of pathways, and ability to 'flag' complex patients earlier in the patient journey. Changed available on psag
- Internal blocks: doctor review / specialty referrals and FFA completion still highlighted as areas of concern
- Lack of red2green tracker form completion leading to insufficient and potentially misleading data on some wards. Weekend completion remains poor
- Workforce shortfalls, hinder consistency at board and ward rounds, and inhibit flow

## 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
- Continue to support RPIW for FFA completion on ward 10 and 11. Not in test period 30, 60, 90 days.
- Continue to support RPIW for CLD on ward 32 during test period 30, 60, 90days.
- Stranded patient reviews both care groups, with weekly metrics, and escalation.
- Check, chase, challenge approach and process and outcome from meeting.
- Planning underway for a MADE event in May.
- Continuing with 70 day end pparalysis challenge
- EDD changes to psag – training of staff



### Health and social care system needs to:

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

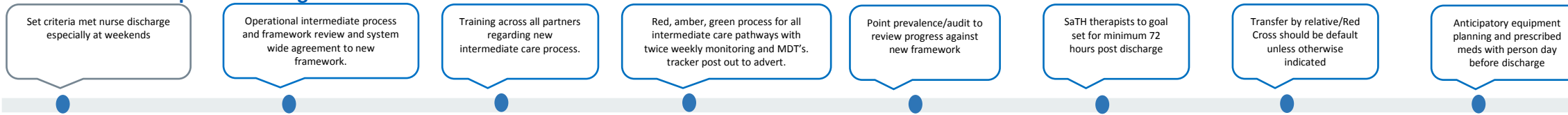
### System needs to:

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

### The progress:

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

### Interventions and process changes



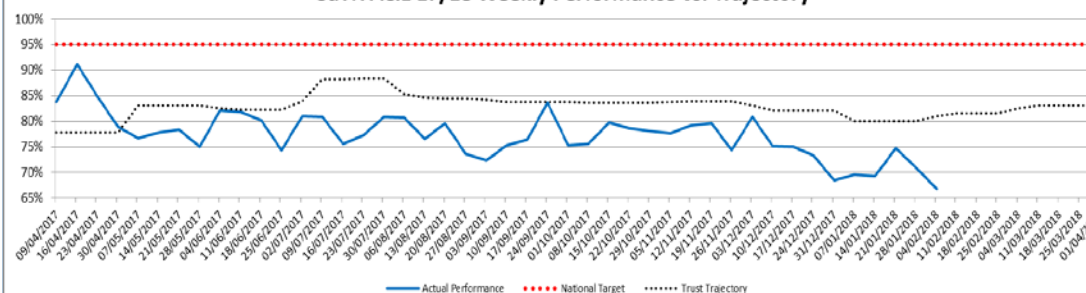
### Risks to delivery

#### Risk

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

### Data

SaTH A&E 17/18 Weekly Performance Vs. Trajectory





## Programme needs to:

- Awaiting details of this plan on a page – further update to follow

## System Partners / Enablers need to:

## The progress:

## Key Interventions / Milestones

## Risks to delivery

Risks

## Data



## Programme needs to:

- Awaiting details of this plan on a page – further update to follow

## System Partners / Enablers need to:

## The progress:

## Key Interventions / Milestones

## Risks to delivery

Risks

## Data



# Transformation Enablers

System Improvements

Plan on a Page



### Programme needs to:

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

### System Partners / Enablers need to:

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

### The progress:

- Universal Capabilities: target to significantly deliver by March-18 – successful. (9/10 see data below). New programme items to be decided in refreshed LDR.
- linking with Maternity to strengthen the link with Digital and structure the changes required. Workshop scheduled to clarify the digital items in the programme.
- Information Governance – ISG signed up to by all agencies, progress report requested
- Refined membership of the clinical group and programme board using questionnaire.
- Investigating programme management software for use across the LHE.
- LDR refresh plan accepted at DEG. Workshop to be scheduled.
- LDR update also requested by GP IT Forum to guide their programmes.

### Key Interventions / Milestones

Data Sharing Agreements on Electronic register across the LHE  
May 2018

LDR refreshed and new Digital Programme defined. GP IT Forum also follows lead of LDR.

Electronic Patient Record systems need to be procured for SaTH and RJAH to support shared access to Integrated care records.

Network - shared procurement in place. Access for all orgs at all sites

### Risks to delivery

#### Risks

Resources – (lack of funding, governance and leadership to progress strategic planning, and availability. commitment from senior management to release or increase resources)

Lack of Technology standardisation - Action :Identify interoperable platforms and recommending their use across the STP

Licencing costs are set to increase with a requirement to migrate to a supported set of office applications with revenue costs instead of capital.

Executive Strategic Direction

Lack of clear co-ordinated approval processes for schemes with a cross-organisation impact.

Complex governance arrangement (STP is not an executive group with delegated authority. )

Lack of consistent engagement from social care and mental health trust.

Uncertain leadership of the DEG. No consistent CCIO appointment process and no DEG CCIO position defined.

#### Actions:

Creation of 3 supporting groups

### Data

ID	Universal Capability	Significantly deployed	Pass
A	Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions.	Pharmacists using more than most	Y
B	Clinicians in urgent and emergency care settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in U&EC).	SaTH has it available, but not yet using process to access via spine	Y
C	Patients can access their GP record.	Available 98.2% - 0.12% registered to use	Y
D	GPs can refer electronically to secondary care.	GPS refer via e-referrals to RAS/TRAQS.	Y
E	GPs receive timely electronic discharge summaries from secondary care.	Stats on discharge summaries issued within 24 hours of discharge to be collated by provider.	Y
F	Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care.	Some improvement possible, but significantly deployed	Y
G	Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly.	CPIS on Spine SCR	Y
H	Professionals across care settings made aware of end-of-life preference information.	Not by Digital. Evaluation did not prove that Digital would help	N
I	GPs and community pharmacists can utilise electronic prescriptions.		Y
J	Patients can book appointments and order repeat prescriptions from their GP practice.	100% offer. 15.2% registered	Y



### Programme needs to:

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

### System Partners / Enablers need to:

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

### The progress:

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

### Key Interventions / Milestones

Circulate workshop outcomes , feedback through STP/Council/OPE partners/Local Councillors. Market Town specific Workshops to inform next steps

Run Telford & Wrekin Workshop, identify opportunities and then bring together all opportunities into one whole system approach

Overarching and adopted estate strategy aligning with the estate outcomes and key STP outcomes

Outline rationalisation plan, with better use of void space, shared/bookable space, joint utilisation, extended opening hours, energy efficient

Evidence using Geographical Intelligence Systems applied in layers ; to include Voluntary Sector services

### Risks to delivery

#### Risks

- Timelines for funding bids vary across different organisations; aligning for cross-organisational estate projects difficult to achieve.
- Aligning existing projects and agreement on potential future opportunities
- Engagement not fully embraced
- Rejection of future capital bids through omission of estate projects/concepts from STP Estates Strategy
- 

#### Actions:

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

### Data

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





### Programme needs to:

- Update the planning assumptions made in the 5 year STP financial plan and identifying a more robust view on the scale of savings in the following areas;  
**Corporate services** savings in the health economy, using recent benchmarking data,  
**Shared recruitment** processes (being developed by the Workforce Work stream  
**Procurement savings** through model hospital and PPIB data  
**Estate rationalisation** (developed by the STP Estates Work stream)
- Develop an over view that makes it clear what exists in plans already and whether the programme can stretch the thinking to gain more operational and financial value ( e.g. target set to drive costs to the national median).

### System Partners / Enablers need to:

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

### The progress:

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

### Key Interventions / Milestones

Initial exploration of the Model Hospital opportunities for Providers, including corporate services and ambition set – February 18

Initial discussion with Midlands and Lancashire CSU Value Add proposal to pump prime further review and option appraisal – March 18

Commence CSU diagnostic – April 18

Evaluate CSU diagnostic conclusions and agree programme of change – Summer 18

Implement change programme – Autumn 18 onwards

### Risks to delivery

#### Risks

The scale of opportunity will not be realised due to;

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

#### Actions:

A review of the effectiveness of the existing county wide Procurement Group

Using the CSU diagnostic and option appraisal process to increase pace, draw conclusions and propose a change programme which will require tangible agreement.

### Data

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





## Programme needs to:

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

## System Partners / Enablers need to:

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

## The progress:

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

## Key Interventions / Milestones

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

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

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

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

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

## Risks to delivery

### Risks:

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

### Actions:

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

## Data

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

### Individual areas of workforce:

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



## Programme needs to:

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

## System Partners / Enablers need to:

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

## The progress:

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

## Key Interventions / Milestones

Gain a clear understanding of the vision and values of the STP that have been signed up to by all partners

Map activity across workstreams to understand timing of potential service changes

Develop a comprehensive communications and engagement strategy

Develop and deliver channels for communication of STP priorities

Support service reconfiguration activity

## Risks to delivery

### Risks

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

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

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

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

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

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

## Data

Plan is to use Comms & Engagement data to inform

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



### The programme needs to:

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

### System Partners / Enablers need to:

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

### The progress:

#### STP

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

#### Telford & Wrekin – Healthy Telford

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

#### Shropshire – Healthy Lives

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

### Opportunities

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

### Key Interventions / Milestones

Improve access and use of population health and wellbeing data from across the system to support decision making

Develop and Deliver System CVD & Diabetes Strategy

Deliver the prevention expectations of cancer strategy

Develop system social prescribing infrastructure

Develop and Deliver System Obesity Strategy

Development of a system plan to reduce harm related to alcohol

Develop the system MECC Plus proactive approach, including training and delivery plan

### Risks to delivery

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



### Programme needs to:

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

### System Partners / Enablers need to:

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

### The progress:

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

### Key Interventions / Milestones

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

Work with the Integrated Care System and work streams to:

1. attain / retain identified financial and quality benefits
2. Identify additional opportunities to recover the reported control deficit

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

Develop and deliver channels for communication of STP priorities

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

### Risks to delivery

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

### Data

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

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



# STP PMO Resource

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## STP PMO Support

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

## Current Support Provided

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

## STP Governance

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



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

STP Programme Director  
STP Urgent Care Director  
STP Head of PMO  
STP Communication & Engagement Lead  
STP Senior Project Administrator  
STP Programme Manager  
STP Programme Manager  
STP Programme manager  
STP Programme Manager  
STP Programme Manager  
STP Programme Manager  
STP Programme Manager

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STP Programme Leadership  
System Urgent & Emergency Care  
PMO Transformation & Enablement  
System Communication & Engagement  
STP Diaries, Meetings, Events Requests,  
Future Fit, Transport, Telford Neighbourhoods  
Future Fit, Population Health, Prevention,  
Digital Enablement  
Strategic Workforce  
Estates, Back Office  
System Finances  
Urgent Care, MSK

Future Fit Programme Support  
Future Fit Senior Communication & Engagement  
Future Fit Communication & Engagement

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Future Fit Programme Project Support  
Future Fit Programme  
Future Fit Programme

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

If you have a programme of work not already identified in this slide pack that you would like to see developed across our system that has clear **SYSTEM** benefits:

Please contact [jo.harding1@nhs.net](mailto:jo.harding1@nhs.net)

Existing governance arrangements will still apply to all programmes of work in terms of approvals





# Shropshire, Telford and Wrekin Sustainability & Transformation Programme Governance Structure

