



Shropshire, Telford & Wrekin STP



Sustainability and Transformation Plan



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

Region:
Shropshire and Telford & Wrekin



STP Directors Update
Oct Draft 2018



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

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

Priorities

- Focusing on neighbourhoods to prevent ill health and promoting the support that local communities offer to help people lead healthier lives and encourage them to care for themselves where appropriate.
- Multi-disciplinary neighbourhood care teams working closer together supporting local people with long-term health conditions, and those who have had a hospital stay and return home needing further care.
- Ensuring all community services are safe, accessible and provide the most appropriate care.
- Redesigning urgent and emergency care, creating two vibrant 'centres of excellence' to meet the needs of local people, including integrated working and primary care models.
- Making the best use of technology to avoid people having to travel large distances where possible – especially important to people living in the most rural communities in Shropshire and Powys.
- Involving local people in shaping their health and care services for the future.
- Supporting those who deliver health and social care in Shropshire, Telford and Wrekin, developing the right workforce, in the right place with the right skills and providing them with local opportunities for the future.

STP Development Programme



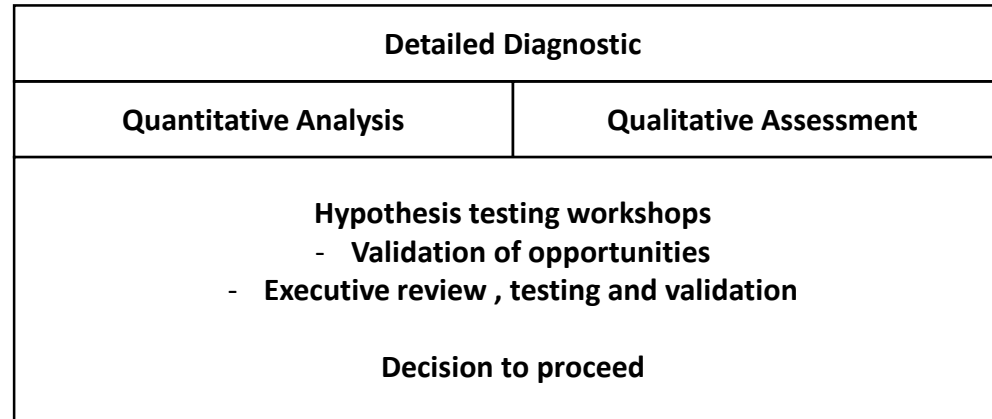


Facilitated offers delivered over a condensed time period:

- System Opportunity Diagnostic programme
 - Hypothesis testing, Validation and priority setting
 - Identification of transformation programmes and priorities
 - Qualitative self assessment
- System support (Facilitated learning events)
 - Leadership
 - Provider alliance
 - Structural architecture
- Development of ICS
 - ICS roadmap
 - Meeting the requirement of the ICS MOU



Launch Event & Mobilisation



Diagnosis and
design phase

(weeks)



Transformation Programmes

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

Delivery and Support

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



System Capacity Building

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

Transformation
delivery and
improvement
phase
(weeks)



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



- NHSE will co ordinate a qualitative self assessment exercise, the scope of which will be informed by the STP.
- Assessment will utilise the key concepts of the Integrated Care System (ICS) maturity index designed to provide a self assessment and anonymised baseline for the health system
- Approach:
 - Structured interviews around the core capabilities of: leadership and governance, readiness and commitment to operate as a single system, financial management, current performance, delivery and impact across the system.
 - Understanding the barriers to system development
- Output to shape the system **capacity support programme**



Diagnostic Review:

- Designed to support the system to identify opportunities available to the system
- Undertaken through both quantitative and qualitative analysis
- Quantitative data and information analysis output a report that seeks to quantify the identified opportunities.
- Qualitative diagnostic – self assessment to shape development programme

Facilitated Workshops – delivered over a number of sessions:

- To discuss data, information and evidence base
- Generate and test hypothesis
- Focused output on quantification of opportunities and next steps.
- Planning for delivery and system support
- Gateway signoff



Facilitated Programme Support / Action Learning Sets

- Support to executive leadership across the system
- Readiness and commitment to operate as a system across all partners
- Financial strategy and programme delivery
- Progressing the ICS – roadmap
- Meeting the requirements of the ICS MOU

Transformation priority programmes

- Intensive review and detailed shaping of selected priority programmes
- Gateway signoff



The offer:

- North Midland DCO have agreement with National Team to access:
 - External support and subject matter exercise
 - Length of high impact delivery 3-6 months
 - Expert facilitation of programme and workshops
- Transitional support to move to sustainable business as usual at approximately 3 months
- Delivery team shared across multiple high impact areas
- ICS programme facilitation (Jointly funded)



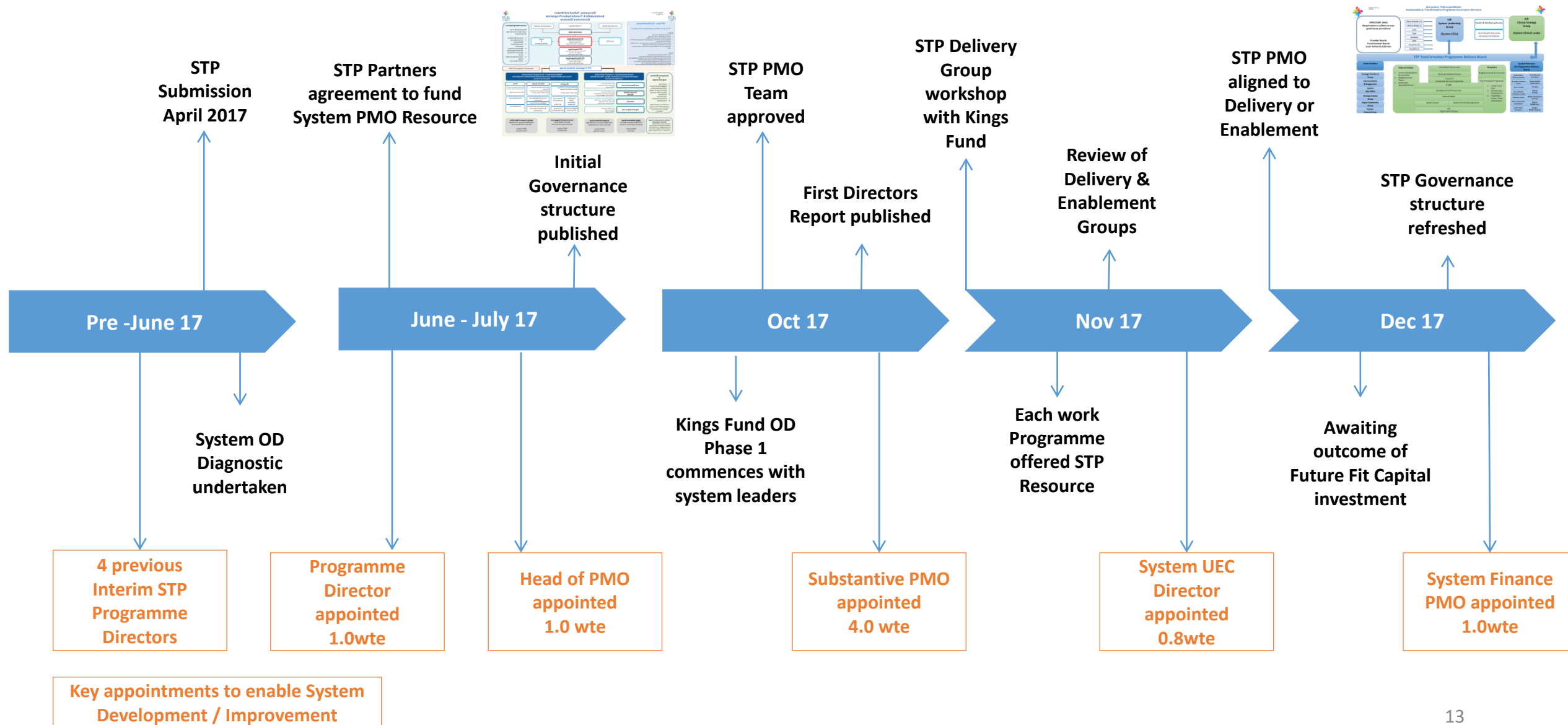
- NHSE/I project team to meet weekly
 - Facilitator/alliance
 - Project manager
 - Locality Director/leads
- Steering group to meet 2 weekly
 - STP leads
 - Alliance lead
 - Project manager
 - Expert advisors/regional support



- Work through the ICS 12 week Development Programme (start date to coincide with new STP Chair appointment)
- Develop Shropshire, Telford & Wrekin ICS Roadmap
 - Clear system Governance and programme management support
 - Aligned to system priorities
 - Further develop System Strategic Commissioning
 - Identify System Redesign Requirements
 - Clinically Led, building on the work of the STP Clinical Strategy Group
 - Understand **WHAT** enablement requirements are needed and **HOW** they will be delivered and by **WHEN**
 - Financial alignment
 - Estates
 - Digital
 - Workforce
 - Back Office functions
 - Be clear how as a system we will continually improve and sustain those improvements

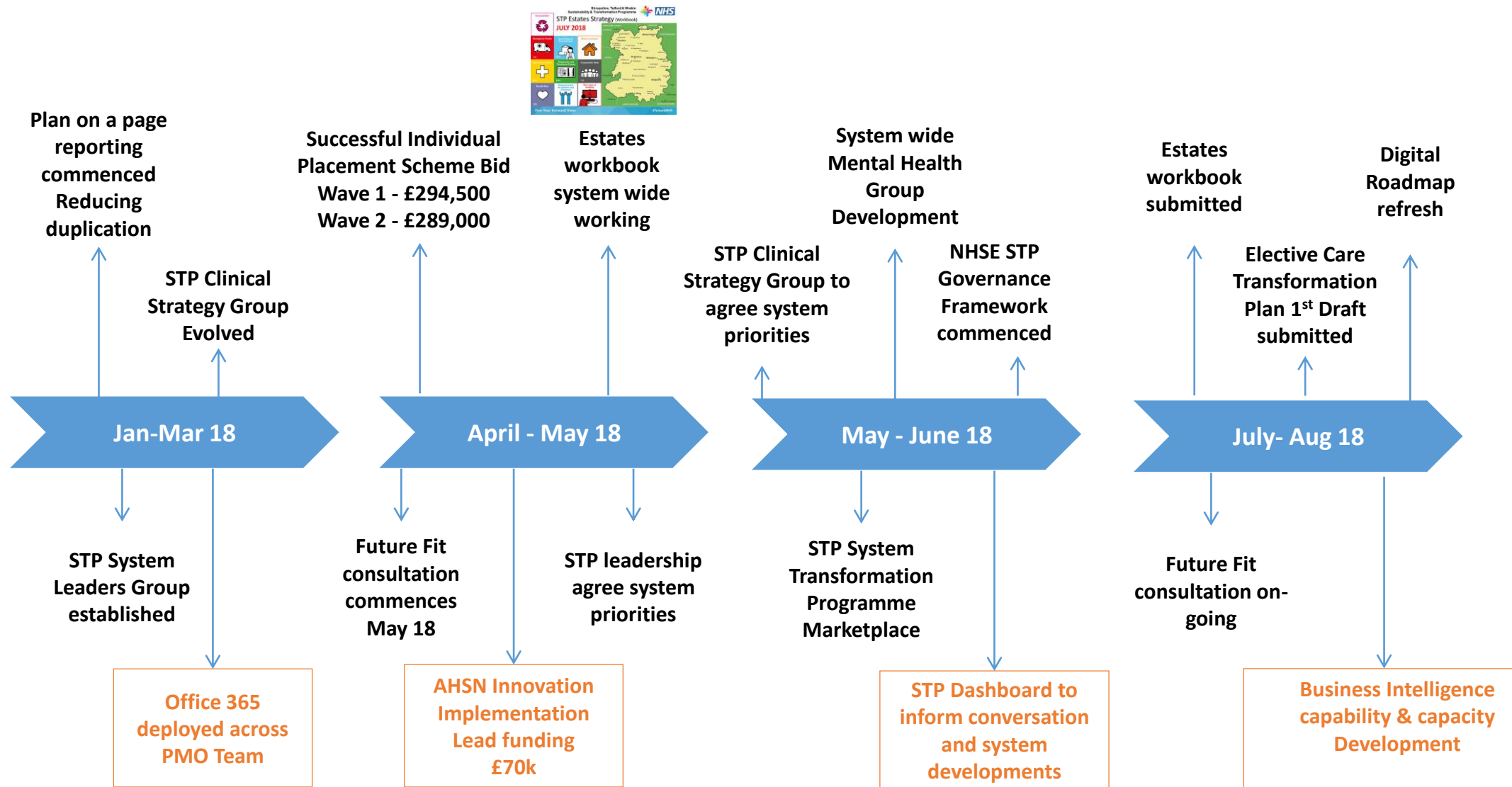


Timeline of key STP activities June 17 – Dec 17



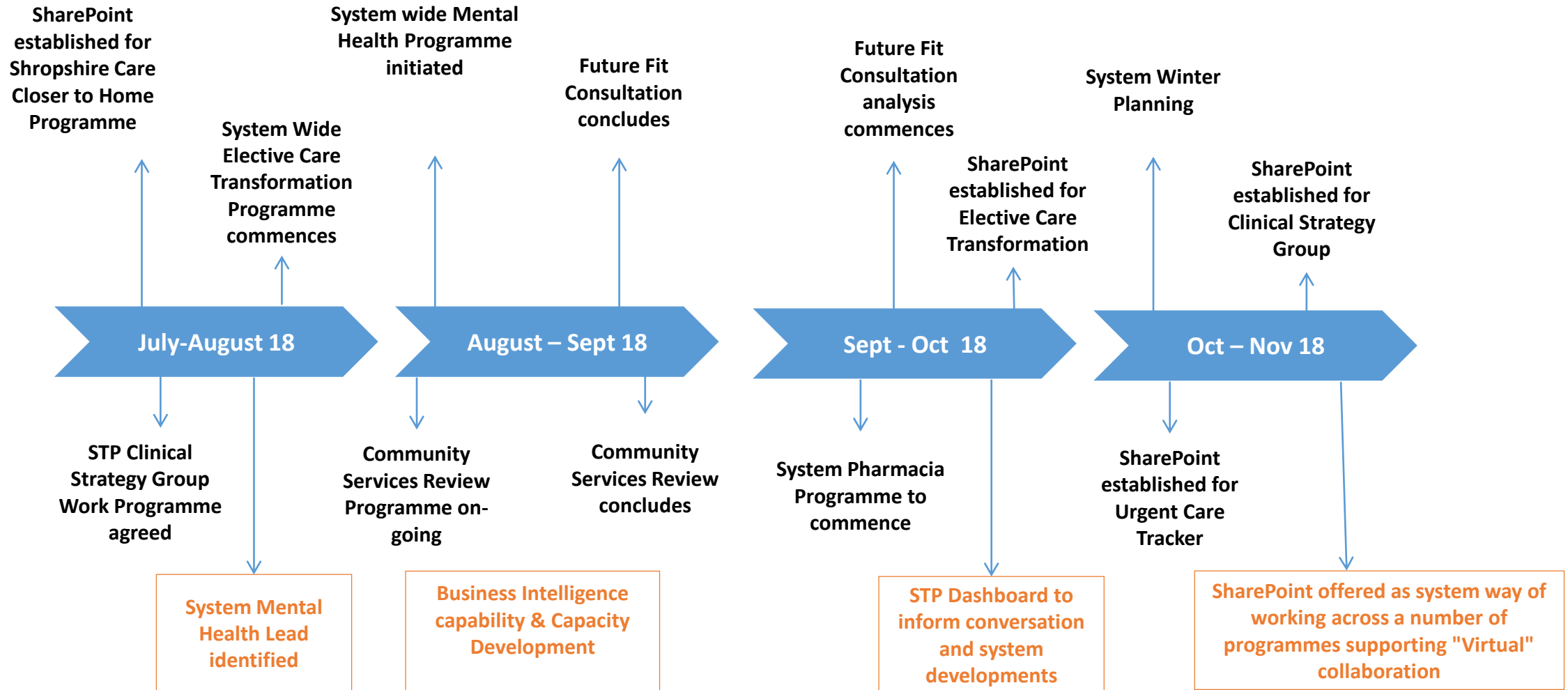


Timeline of key STP activities Jan 18 – Aug 18





Timeline of key STP activities July 18 – Aug 18





Shaping STP System Thinking

- STP Review meetings with NHSE & I
 - Last review meeting was 6th Sept, we continue to be “Level 3” – making progress
- System wide working gaining momentum – next slide shows system wide groups
 - STP Leadership Group – Integrated Care System / Partnership developments
 - Clinical Strategy Group – meeting bi-monthly and work programme developing around STP Priority areas
 - Mental Health Group – just being establish
 - Elective Care Transformation – established and work programme drafted
 - Digital Enablement – Roadmap and work programme being reviewed
 - Population Health & Prevention – being established, system leads identified
 - Urgent Care, Frailty, Winter Planning – established and work programme underway
 - System wide Estates – submission completed
 - System Wide Pharmacia – draft formed and work programme being developed
 - Strategic Workforce Partnership working for our system transformation
 - Strategic planning
 - Organisational development
 - Education & training
 - Secondary Care reconfiguration (Future Fit) – consultation ongoing
 - Shropshire Community Services Review – work programme with GE Finnemore / Neil McKay
 - Out of Hospital Programmes
 - Shropshire Care Closer to Home
 - Telford & Wrekin Neighbourhood working



System Wide Working

Strategic Development & Leadership

Recruitment of independent STP Chair
STP System Leaders Group
Local Workforce Action Board (LWAB)
STP Clinical Strategy Group
Health & Well-being Boards
Community Services review work programme
System Communication & Engagement
System wide consultation and feedback through existing mechanisms

Strategic Enablement

Strategic Estates Group
Strategic Back Office
Digital Enablement Group
Strategic Workforce Planning

Strategic System Finances

System population health & prevention

System Business Intelligence

Strategic Delivery of change

Hospital reconfiguration (Future Fit)

Urgent & Emergency Care

Winter Planning

High Impact Changes

Frailty

IUC / 111

Out of Hospital Care Delivery

Shropshire Care Closer to Home

Telford & Wrekin Neighbourhoods

Primary Care Transformation

Mental Health Transformation

Cancer & End of Life

Elective Care Transformation – 8 workstreams identified

1. Procedures of Limited Clin Value 2. MSK

3. Ophthalmology 4. Diabetes 5. MRI

6. Out-Patients 7. Neurology 8. Dermatology

Pharmacia Programme

Local Maternity Services



Performance & Transformation Reporting Requirements

- 132 Deliverables categorised as:
 - **47 Operational deliverables**
 - Established indicators
 - Automated Data Collection through Statutory reporting (previously UNIFY)
 - **85 Transformation deliverables**
 - Mix of quantitative and qualitative standards
 - Data sources not established for all quantitative standards
 - Non statutory/local reporting required for some
 - Being built into FYFV Dashboard as data sources are identified
 - **Monthly reporting on ALL 85**

Note:

These requests come through a variety of routes and land in different parts of the system, all with different deadlines and requirements using a mix of templates that are continually being revised



Shropshire, Telford & Wrekin STP

Performance and Transformation overview

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

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

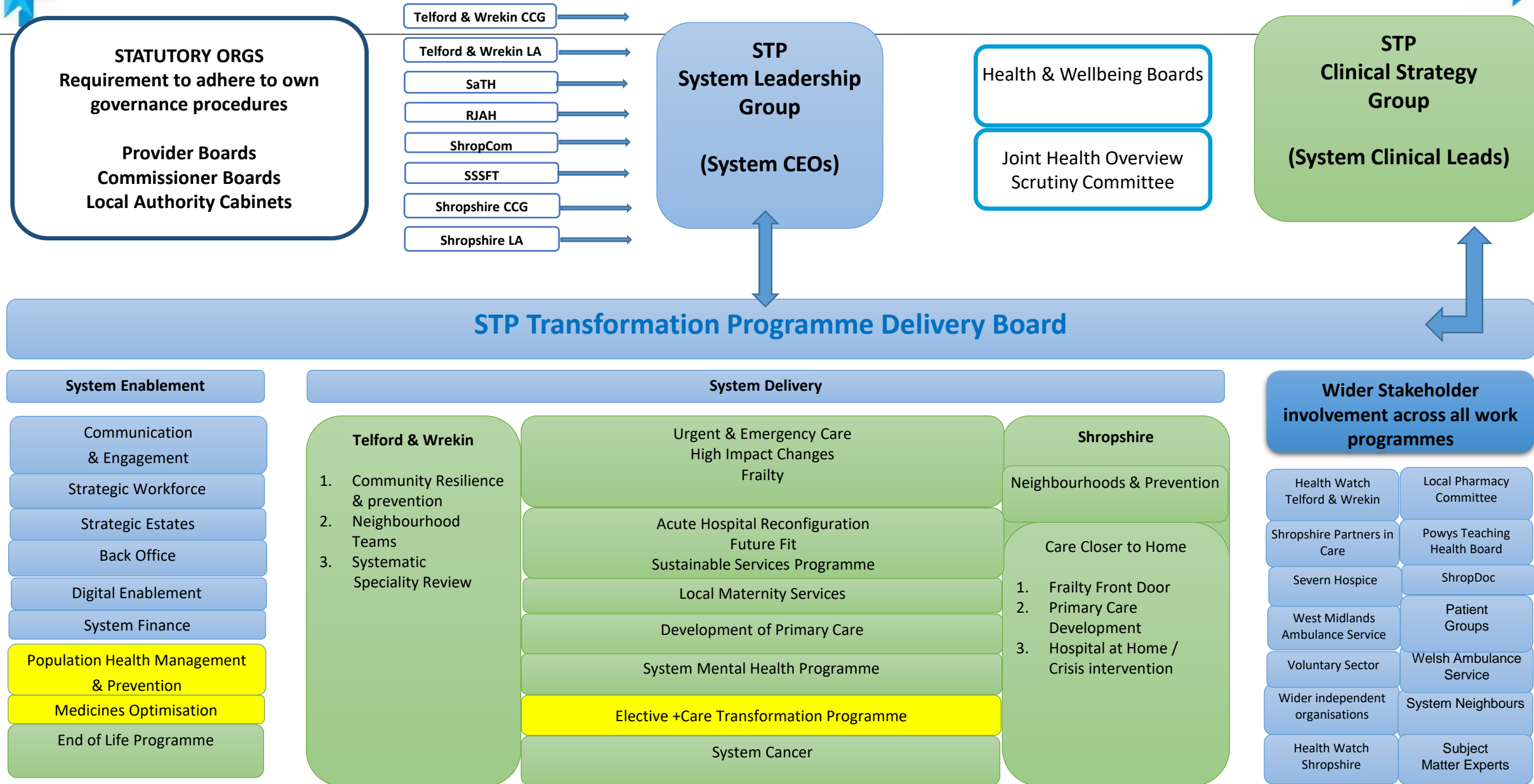
85 Assurance Statements 18/19	RAG
CHC x 3	Green
Maternity x 5	Green
Primary Care x 14	Green
7 day services x 1	Red
Transforming Care x 2	Green





Shropshire, Telford and Wrekin Sustainability & Transformation Programme Governance Structure

Draft – tba - changes





STP PMO Team

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



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



Delivery Programmes	SRO / Exec Lead Clinical Lead Programme Director (where applicable)	Programme Key People	Clinical Lead Where applicable	STP PMO Link to Programme Enablement
Comms & Engagement		Pam Schreier Sophie Powers	n/a	Maggie Durrant
Workforce	Jan Ditheridge Victoria Maher	Heather Pitchford Nichola Bradford		Sara Edwards
Estates	Clive Wright Tim Smith	Becky Jones	n/a	Maggie Durrant
Back Office	Dave Evans Ros Preen		n/a	Maggie Durrant
Digital	Mark Brandreth Gail Fortes-Myers Andrew Boxall	Andrew Crooks Simon Adams	Andrew Roberts	Rob Gray
Finance	Claire Skidmore		n/a	Paul Gilmore
Population Health management	Kevin Lewis Helen Onions	Emma Sandbach	Kevin Lewis	Penny Bason
Medicines Optimisation	Gail Fortes-Myers	Lynne Deavin Mani Hussain	Jacqui Seaton Liz Walker	Jo Harding
End of Life	Derek Willis	Heather Palin	Derek Willis	Jo Harding
Clinical Strategy Group	Julian Povey		STP - Julian Povey Rachel McKeown – AHP's	Jo Harding



System Submissions to NHSE Governance

STP PMO currently support the following submissions to NHSE

1. Urgent & Emergency Care Tracker

- System Coordination of response by Prog Director Claire Old & Maggie Durrant
- Oversight and Exec sign off by Julie Davies on behalf of both CCGs

2. Elective Care Transformation Tracker

- System Coordination of response by CCGs & STP PMO Jill Barker
- Oversight & Exec sign off by Julie Davies on behalf of both CCGs

3. Mental Health Transformation – Tracker not yet available / required

- System Coordination of system Plan by STP Mental Health Strategy Group (co-chaired by Tony Elliot & Steve Trenchard (on behalf of both CCGs
- Oversight & Exec Sign off by Fran Beck on behalf of both CCGs

4. Clinical Vulnerable Services Stocktake

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

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



Appendixes

Following slides provide additional level of detail

These slides are “Live” and are continually updated as work programmes progressed, they are published bi-monthly



Commissioner Led Transformation Programmes



Phase 1

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

Phase 2

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

Phase 3

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



Phase 1 - update

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

Phase 2 - update

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

Phase 3 - update

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



Telford & Wrekin Neighbourhood Programme

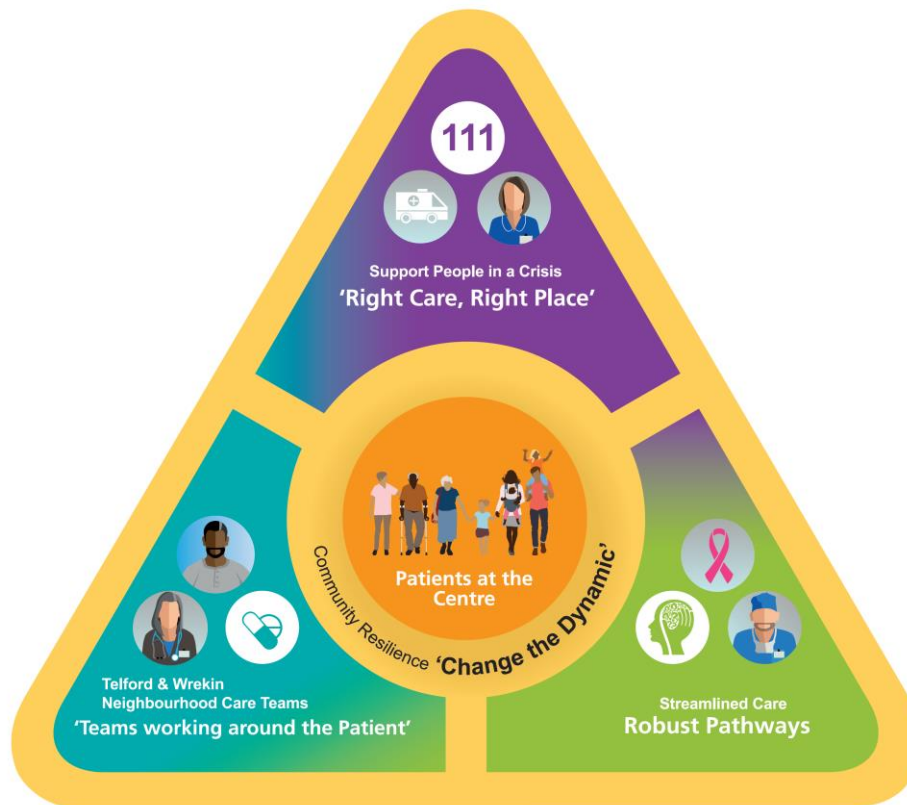
Exec Lead – Anna Hammond

Project Lead – Ruth Emery



Programme needs to:

1. Improve availability and access to activities that will prevent the development of poor health
2. Improve early identification of illness to stop further deterioration
3. Promote self-care/self-management
4. Demonstrably increase effective community support available to support out of hospital care
5. Enable Primary Care Resilience (feeds into Primary Care local strategy)
6. Reduce dependency on statutory services
7. Develop a sustainable workforce
8. Reduce social isolation
9. Empowerment for people and professionals
10. Introduce new roles and ways of working
11. Ensure robust information accessible for communities and the professionals working with them
12. Ensure there are services and activities available closer to home
13. Develop well connected services and communities



System Partners / Enablers need to:

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

Estates

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

Communications

- Support with health literacy including mental health awareness

Digital

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

Workforce

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

Prevention

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

Out of Hospital

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

Mental Health

Development of STP wide strategy and governance .

Practical project support for AC OOA framework for 0-25 mental health (must do quickly) and OOA adult mental health placements (longer term QIPP)
Crisis pathway for 16-18 year old children (including children who don't meet tier 4 threshold, those who have challenging behaviour and setting up PARA registers)

Encouraging Healthy Lifestyles

Targeting obesity, smoking and alcohol

Community Resilience

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

Direct Care in the Community

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

Specialty Review

To include Diabetes and Respiratory



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

Using the data to drive the change

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

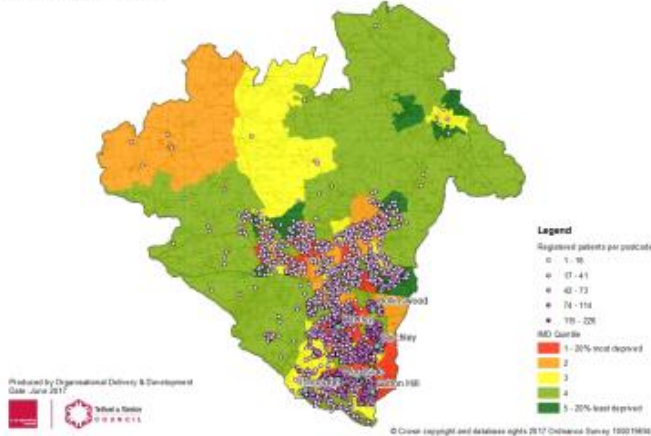


Dementia diagnosis rate (add more context)
Rising hospital admissions (add more context)



→ Diabetes outcomes need to be improved

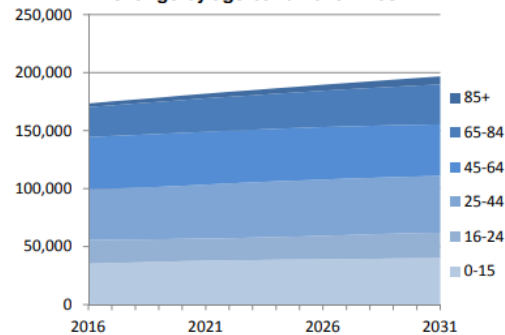
South East Telford



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

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

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



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

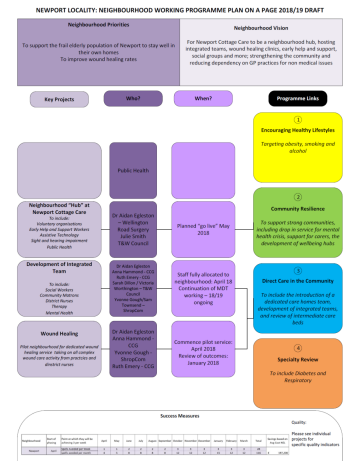
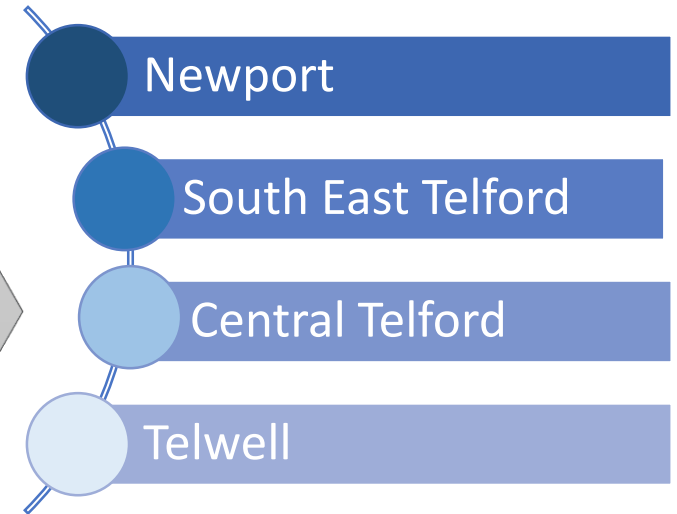




Telford Neighbourhoods – how it all fits together – delivering transformation

Case Study Examples to showcase progress

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





Primary Care Programme – GPFV

Exec Lead – Nicky Wilde & Rebecca Thornley

Project Leads – Phil Morgan

Updated Aug 2018
Next update– Oct 18



Programme needs to:

The GPFV programme has five main elements:

New models of care

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

Extended Access

- Ensuring that 100% of the population has access to GP (or other clinician) appointments 8am to 8pm Mon-Fri and at weekends/bank holidays (subject to local need) by Oct 1st 2018

Workforce

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

Resilience/Workload

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

Estates and Technology Transformation Fund

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

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

System Partners / Enablers need to:

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

Workforce

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

Digital Information and Technology

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

Estates Investment

- Working across key STP stakeholders (local authority, public health, secondary and community providers) to utilise and develop the current and future estate

The progress:

New models of care

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

Extended Access

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

Workforce

- An STP Workforce Plan has been submitted with projects designed to address the recruitment and retention targets
- The CCGs are working with the STP workforce group to explore the possibility of developing banks for GPs and other clinicians.

Resilience/Workload

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

Estates and Technology Transformation Fund

- A programme to install VOiP, VDI and WiFi across practices is being implemented
- Funding for 2018/19 projects (Skype and Telehealth) has been agreed
- Good progress has been made on a number of estates projects to address growing population GMS needs and to link with hospital service transformation

Interventions and process change milestones

Increased levels of working at scale between practices

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

Targets for workforce recruitment and retention across primary care met

Successful implementation of the GPFV 10 High Impact Actions

Successful implementation of ETTF funded IT and estates projects

Risks to delivery

Risks

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

Data

Extended Access

- Over 90% of the registered population currently has access to GP (or other clinician) appointments 8am to 8pm Mon-Fri and at need – both CCGs are confident of achieving 100% access by 1st October 2018

Workforce

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

Resilience/Workload

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

Estates and Technology Transformation Fund

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



Local Maternity System

Exec Lead – Chris Morris

Programme Lead – Fiona Ellis



Maternity Core Deliverables Overall RAG

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

Milestones

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

Key

Complete	The Deliverable or Milestone has been completed within specified timeframe
On Track	The Deliverable or Milestone is currently on track to completed within specified timeframe
At Risk	The Deliverable or Milestone is currently at risk of not being completed within specified timeframe
Will not be met	The Deliverable or Milestone will currently not be completed within specified timeframe



Local Maternity System

Exec Lead – Chris Morris

Programme Lead – Fiona Ellis



Risks

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

Activities

Key activities this reporting period	Key activities next reporting period
<ol style="list-style-type: none"> 1. LMS Transformation Midwife is in post to support delivery of transformation projects, including continuity of carer. 2. Continuity of carer project launched. 3. Co-production workshop took place to agree approach to working in co-production. 4. Additional scanning resource in place. 	<ol style="list-style-type: none"> 1. Commence Continuity of Carer Pilot. 2. Recruit transformation champions (front line staff with protected hours for LMS activities). 3. Complete implementation of projects funded through additional £150k non recurrent funding. 4. Implement AMU pilot (bringing it closer to consultant unit) 5. Deliver implementation plan for Specialist Perinatal Mental Health service. 6. Launch initiatives to increase midwife led births (Shrewsbury MLU refurbishment, emergency situation training for midwives, AMU pilot)

Challenges; learning; & good news

Further issues & challenges / learning / good news	Comments
Existing pressures in maternity services mean that the pace and scale of transformation may not be in line with national requirements.	
Funding of £251,467 confirmed for Specialist Perinatal Mental Health service for 2018/19 (joint with Staffordshire LMS).	
Health and Wellbeing Initiatives through LMS funding launched. Public Health and smoking cessation midwifery support increased from 1 st September.	



Core Deliverables

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



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



Elective Care Transformation – full details in next update

Exec Lead – Julie Davies

PMO Contact – Jill Barker



Programme needs to:

8 workstreams identified

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

System Partners / Enablers need to:

The progress:

- Initial draft submission to NHSE

Key Interventions / Milestones

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

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

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

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

Aligned incentives contract in place with RJAH from 1st April 2018

Risks to delivery



Acute Reconfiguration - Future Fit

Executive Lead – Debbie Vogler

Programme Manager – Andrea Webster



Programme needs to:

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

System Partners / Enablers need to:

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

The progress:

- The consultation process commenced on 30th May and will run until 11th September having been extended by one week to support additional requested engagement events.
- Public exhibition and Pop-up events have been held across Shropshire, Telford and Powys engaging with the public and raising awareness of the consultation.
- A mid point review took place in July to determine progress
- All key priorities and Leads to support development of the DMBC have been identified and working with the Programme Director to evidence plans and progress is being made.
- Ambulance modelling work being completed by ORH with all providers fully engaged supporting delivery of the work.
- Formal post consultation process is being formalised with advice from NHSE

Key Interventions / Milestones

Approval to proceed to formal consultation by NHSE and commenced on 4th May

Consultation exercise completed and results analysed and report available to inform DMBC (Consultation ends 4 September 2018). Date for analysis and report TBC

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

All key actions arising from external reviews of the programme completed

Development of DMBC (date tbc)

Risks to delivery

Risks

FF Team capacity and resource needs to be maintained to support delivery of the programme – current capacity is at acceptable level. Significant political and campaign opposition to the proposals, impacting on programme reputation in the media with significant resource required to manage emails, letters and media responses – Additional resources have been identified and a media plan is in place to ensure factual and correct information and responses are readily in the public domain. The Care Closer to Home and Neighbourhood working models and the Future Fit strategy need to formally report on progress of alignment to primary care strategic planning when considering workforce mobilisation and out of hospital activity modelling.

Data



Urgent and Emergency Care

System Improvements

Plan on a Page

Mixed formats of plan on a page to reduce duplication



Urgent & Emergency Care – Transformation Programme

Implementation of UEC High Impact Changes

- Demand & Capacity Review
 - Stranded Patients
 - ED Systems & Processes
 - Red2Green / SAFER
 - Integrated Discharge Team
 - IV Therapies in the Community
 - Frailty
 - Frailty Team at ED front door
 - Reduce admissions / readmissions from care homes
 - Trusted Assessors
-
- Further details around the Urgent & Emergency Care work programme are available by contacting maggie.durrant@nhs.net



High impact change model

Managing transfers of care between hospital and home





Stranded Patient Flash Report

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

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

Current Position

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

Progress

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



Stranded Patient Flash Report

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Date of Report:	21/08/2018	% improvement in admitted performance target 4%		

Cont.

Key Issues/Risks

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

Key Items for next week

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



Taskforce- Steering Group Report

Project Overview				Overall Project Status
Project Title:	Improving ED Processes	Deadline:	06.04.18	<div>AMBER</div>
Exec Lead:	Nigel Lee	Project Lead:	Rebecca Houlston	
Clinical Lead:	Dr Kumaran Subramanian	Project Group:	Urgent Care Improvement Programme	
Date of Report:	22nd August 2018	% improvement in admitted performance target		

3B. Progress, Issues/Risks, and Decisions

Key Items completed this week/since the last report

- Daily cross site huddles continue – circulated to Execs daily
- External Exec level huddles with external attendance
- ED summit internal clinical summit group and external risk summit group
- ED recovery document developed – inclusive of action plans (also revised to include recent NHSI visit)
- Weekly ED performance meeting to review further actions
- Weekly report describing minors performance for w/c 13/08/18
- Acute Medicine Workforce review
- Review of Medical Staffing deep dive with Katy Molland – job plan/DCC review of middle grade doctors and consultants
- Paediatric review of attendances
- Audit of patients that leave without being seen

Key Issues / Risks

- ED middle grade overnight gaps continue to be a significant issue – next gap from 27th August at RSH continuing through the rest of August/early September on both sites, solution to cover PRH with SHO's only overnight is not supported by Paeds, Anaesthetics or Radiology. Gaps during the day are occurring more often with some days left without any cover.
- Since April 2018 there have been 44 night shifts where there has been no overnight middle grade
- External reporting minors vs non admitted
- Data quality including ECDS acuity issues – Ongoing risk due to lack of changes on SEMA
- Data quality – ambulance breaches
- ED workforce status – impact upon ability to deliver required process changes
- Operational Team capacity to deliver required process changes
- Constant changes to medical rota to cover key shifts resulting in gaps 'within hours' is resulting in significant delays to be seen
- Financial impact of highly escalated salaries for overseas doctors and locums
- Additional physio clinics following the ED clinics no longer being in place – increased attendances under review and now added to the risk register
- Admin backlogs in both ED – quality and financial risk
- Nursing gaps – average of 44% agency used per week
- Await confirmation from Exec meeting as to funding for streaming nurse and if the service can continue

All risks mitigated where possible.



Taskforce- Steering Group Report

Project Overview				Overall Project Status
Project Title:	Improving ED Processes	Deadline:	06.04.18	<div>AMBER</div>
Exec Lead:	Nigel Lee	Project Lead:	Rebecca Houlston	
Clinical Lead:	Dr Kumaran Subramanian	Project Group:	Urgent Care Improvement Programme	
Date of Report:	22nd August 2018	% improvement in admitted performance target		

Cont.

Key Items for next week
<ul style="list-style-type: none">• Progress actions in recovery plan• Review key actions from medical deep dive• Deliver any changes to pathways following decision around business continuity• All patients to be managed against professional SOP's/ professional standards – circulation of SOP required to all clinicians• On-going recruitment drive and review of potential locums and nurses• Continue to push internal ED actions to improve non admitted and minors performance• Review next steps for business continuity



Red2Green/Safer

Project Overview – IMPROVING FLOW STEERING GROUP				Overall Project Status
Project Title:	Objective 3 - Red 2 Green/SAFER	Deadline:		<div>AMBER</div>
Exec Lead:	Deidre Fowler	Project Lead:	Rachael Brown	
Clinical Lead:	To be agreed for each site	Project Group:	Improving patient flow	
Date of Report:	22nd August 2018	% improvement in admitted performance target 4%		

3B. Progress, Issues/Risks, and Decisions

Key Items completed this week/since the last report

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

Key Issues / Risks

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

Key Items for Next Week

- Continue to work with the identified wards to understand processes, key issues and effectiveness with a view to making further improvements
- Stranded patient reviews both care groups, with weekly metrics, and escalation.
- Check, chase, challenge approach and process.
- Ward manager meetings



Integrated Discharge Team

Exec Lead – Claire Old

Programme Leads – Sara Dillon & Tanya Miles

01 October 2018



SaTH needs to:

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

System needs to:

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

The progress:

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

Overall status

Amber

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

Interventions and process changes

Set criteria met nurse discharge especially at weekends

Operational intermediate process and framework review and system wide agreement to new framework.

Training across all partners regarding new intermediate care process.

Red, amber, green process for all intermediate care pathways with twice weekly monitoring and MDT's. tracker post out to advert.

Point prevalence/audit to review progress against new framework

SaTH therapists to goal set for minimum 72 hours post discharge

Transfer by relative/Red Cross should be default unless otherwise indicated

Anticipatory equipment planning and prescribed meds with person day before discharge

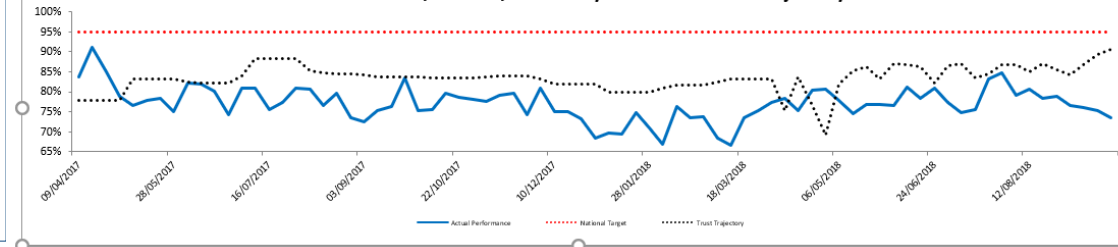
Risks to delivery

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

Data

Shropshire A&E Dashboard

SaTH A&E 17/18 & 18/19 Weekly Performance Vs. Trajectory





Programme needs to:

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

System Partners / Enablers need to:

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

The progress:

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

Key Interventions / Milestones

Phase 1;
Business case and plan to be presented July 2018

Phase 1;
Commence delivery October 2018

Phases 2,3,4
Dates to be determined

Risks to delivery

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

Data

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

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



Frailty Programme

Exec Lead – Fran Beck

Programme Lead – Michael Bennett / Emma Pyrah

Programme needs to:

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

System Partners / Enablers need to:

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

The progress:

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

Key Interventions / Milestones

Further develop Frailty at Front Door to maximise avoidable admissions and reduce length of stay on RSH site

Develop and implement Frailty at Front Door at PRH to maximise avoidable admissions and reduce length of stay on PRH

Implement DTOC High Impact Changes Action Plan to ensure achieving a Mature RAG rating by Q4

Care Homes actively utilising the NHS111 * 6 line for telephone clinical advice from the NHS111

Funding for Frailty team at Front Door at PRH to enable implementation and evaluation

Risks to delivery

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

Data

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



Transformation Enablers

System Improvements

Plan on a Page



Digital Enabling Programme

Exec Lead –

Clinical Lead -

Programme Lead – Rob Gray



Programme needs to:

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

System Partners / Enablers need to:

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

The Progress:

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

Key Interventions / Milestones

Oct-18. LDR refreshed and new Digital Programme defined. HSLI bid created and applied for.

Nov-18. Summary Care Record enhancement initiative started, and visible in secondary care, starting with A&E.

Dec-18. Network - shared procurement in place. Corporate Wifi access for all orgs planned for all sites

Jan-19. draw down funds for HSLI projects.

Jan-19. Defined Procurement process started for Electronic Patient Record systems for SaTH and RJAH to support shared access to Integrated care records

Risks to delivery

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

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

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

Executive Strategic Direction is unclear.

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

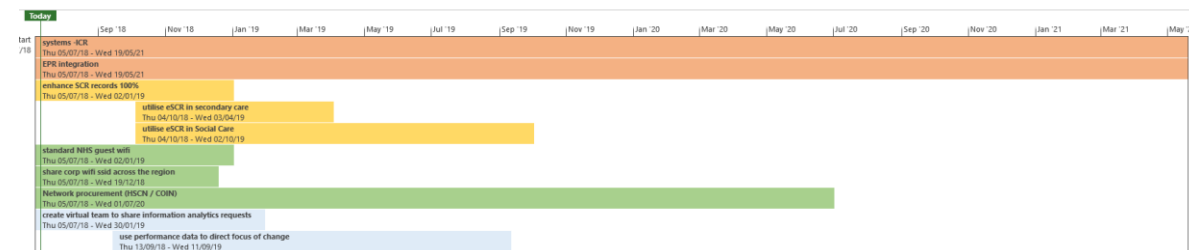
Complex governance arrangement (STP is not an executive group with delegated authority.)

Actions:

DEG SRO, Exec Lead and co-chairs appointed

Data

Outline programme plan.





Programme needs to:

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

System Partners / Enablers need to:

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

The progress:

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

Key Interventions / Milestones

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

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

Overarching and adopted Estate Strategy aligning with the estate outcomes and key STP outcomes

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

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

Risks to delivery

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





Strategic Estates Progress so far

The STP Estates Strategy has been a key piece of working with:

“ALL SYSTEM PARTNERS”

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

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





Programme needs to:

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

System Partners / Enablers need to:

- 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),
- Sponsor and support the collaboration on key priorities, initially by sponsoring the CSU's diagnostic and option appraisal process.
- Have an 'open book' approach to data and information to enable opportunity assessment,
- Develop the relationship with other STP stakeholders to assess the opportunity for wider public sector benefits,
- Agree a change programme in due course.

The progress:

- The group, on behalf of the STP health partners have commissioned a piece of 'value added' work via Midlands and Lancs CSU to appraise the options for rationalising the 'back office' in health organisations. Time scales are now firmer and are outlined below. With a project plan developed to underpin the work.
- Back Office work stream meetings suspended until the initial reporting of the CSU diagnostic has reached a point where it is appropriate to review progress (meeting scheduled for 24th Sept).
- Individual STP work streams are working on discrete aspects of rationalisation or collaboration (estates and workforce)
- All providers are using benchmarking data to support decision making, with the most recent national submission for corporate benchmarking (Model Hospital) due to be submitted by STP health providers by the 17th July.

Key Interventions / Milestones

Commence CSU diagnostic – Summer 18

Data sharing to underpin the data analysis and diagnostic (Aug 18)

Initiate director/ senior team interviews (Sept 18)

Evaluate CSU diagnostic conclusions and agree programme of change – Autumn /Winter 18

Implement change programme – Winter 18 onwards

Risks to delivery

Risks

The scale of opportunity will not be realised due to;

- Lack of collaboration beyond health on procurement.
- Willingness to share data to support the CSU review.
- Capacity and will to drive ideas forward across organisations at pace
- Lack of willingness to collaborate on a joint agenda and give or pass on sovereignty by individual organisations.
- 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** which supports Future Fit options linking acute and community models.
2. Develop and implement a system **Organisational Development Plan** to support new ways of working.
3. Develop **workforce sustainability** through the identification of learning and development, education and training needs and through supporting system programmes to implement change and support transformation.

System Partners / Enablers need to:

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

The progress:

- Agreement between STP partners on **priority areas** through the Strategic Workforce Group.
- **System-wide Workforce Strategy** – Baseline data being worked up via HEE.
- **Mental Health Workforce Plan** – Submitted with no requirement to resubmit. MH Delivery Plan now being addressed.
- **STP OD Group** - now set up with priorities being planned.
- **Local Maternity Services (LMS) Transformation Plan** developed. First draft of WFP taken to LMS Board and WF sub group meetings in progress. Leadership & Cultural Development Plan to follow in Autumn 2018.
- **GP Forward View Workforce Plan** has identified projects to address recruitment and retention targets and bids have been submitted to support GP recruitment, retention and resilience programmes.
- **2017/18 workforce investment programme** of £817,600 covering both primary care and acute services being delivered.
- **2018/19 workforce investment** scoping exercise in progress.
- **STP/LWAB** relaunched with priorities refreshed.
- **Education & Development Group** – Identification of priorities and development of Multidisciplinary Preceptorship Framework, Shared Learning Assets and Shared Statutory and Mandatory training projects.
- **Training Hub** – Re-establishment of the Shropshire and T&W Training Hub provision within the STP PMO.

Key Interventions / Milestones

Complete the **workforce profile data** gathering and individual specialist workforce plans. Aligning with Future Fit Programme.

Leadership and OD Programme with the King's Fund completed. NHSI (ACT Academy) **TCSL Programme** change management tools being used.

Development of **Shared Recruitment** project and **Collaborative Bank** – Project Briefs developed with partner engagement.

Implementation of a pilot **Rotational Apprenticeship Programme** with September 2018 start.

Delivery of **2018/19 STP/LWAB funded priority areas** and development of a **shared training/learning** offer to meet system needs and promote integrated working.

Risks to delivery

Risks:

- Planning without knowledge of future finances and service redesign/configuration. Future Fit Consultation ends in September 2018.
- Varying levels of stakeholder engagement driven by different approaches to Workforce and access to data.
- Ability to fund workforce development activities both in terms of finance and time.
- Risk to quality of STP submissions due to a lack of clarity around requirements.
- Timely decisions in respect of funding which affects education, development and recruitment.

Actions:

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

Data

Shropshire Workforce Baseline:

STW system workforce baseline developed by HEE Workforce Intelligence Team utilising data from NHSI operational plans (workforce plan) for acute/community and mental health services, NHS Digital for primary care and NMDS for social care. Data presented at July meeting of Strategic Workforce Group and LWAB. The data provides demographic information, nurse to bed ratio and a comparison with the 17 LWABs across Midlands and East. A focused session with workforce planners to review the data and provide a response to HEE is currently being arranged.

Individual areas of workforce:

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



Local Health Economy End of Life and Palliative Care Strategy

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

The Shrewsbury and Telford Hospital NHS Trust



Shropshire Community Health NHS Trust

National Ambitions

Individual care

Fair access to care

Comfort and Wellbeing

Coordinated care

All staff care

Caring Community

Living Well
HELPS --->
Dying Better

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

- Documentation provides clarity to all regarding patients' preferences/goals for living
- Important conversations
- Identify key worker
- Patient and carer access to documentation
- Shared electronic records

Ensure equal access to palliative and end of life care

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

Establish 'Living Well' concept: support advanced & anticipatory care planning & timely access to services

- Culture of care is enablement
- Programs for palliative rehabilitation are established
- Expand homecare models to support a preference to die at home; further develop H@H service
- Provide necessary medication and associated documented administration authority

Work in partnership to ensure that care is coordinated between services

- Facilitated by Local Health Economy End of Life Group supported by CCGs
- Services compliment not replicate each other
- There is shared accessible documentation where possible (RESPECT, EOL care plan, PPC) and Flagging
- Integration of H@H with the Hospice Outreach Service

Ensure a competent workforce

- Identify education needs across services ; Establish education programmes
- Robust systems for appraisal and CPD across groups; System learning from Significant Adverse Events

Recognise compassionate communities voluntary support as an extension to services

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

National Foundations

Personalised care planning

Shared records

Evidence and information

Those important to the dying person

Education and training

24/7 access

Co-design

Leadership





The programme needs to:

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

System Partners / Enablers need to:

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

6. Work together to make best use of resource and expertise

The progress:

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

Telford & Wrekin – Healthy Telford

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

Shropshire – Healthy Lives

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

Opportunities

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

Key Interventions / Milestones

Developing local Health & Wellbeing Intelligence
Population health management

Develop and Deliver System CVD, Diabetes and Obesity Strategy

Deliver the prevention expectations of cancer strategy

Develop system social prescribing infrastructure

Development of a system plan to reduce harm related to alcohol

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

Risks to delivery

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