# Shropshire, Telford & Wrekin STP

STP Directors Update

***August 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.

# Timeline of key STP activities June 17 – Dec 17

**Pre -June 17**
- STP Submission April 2017
- System OD Diagnostic undertaken
- 4 previous Interim STP Programme Directors

**June - July 17**
- STP Partners agreement to fund System PMO Resource
- Initial Governance structure published
- Programme Director appointed 1.0wte
- Head of PMO appointed 1.0 wte

**Oct 17**
- STP PMO Team approved
- First Directors Report published
- Kings Fund OD Phase 1 commences with system leaders
- Substantive PMO appointed 4.0 wte

**Nov 17**
- STP Delivery Group workshop with Kings Fund
- Review of Delivery & Enablement Groups
- Each work Programme offered STP Resource
- System UEC Director appointed 0.8wte

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

Key appointments to enable System Development / Improvement

# Timeline of key STP activities Jan 18 – Aug 18

## Jan-Mar 18

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

## April - May 18

- Successful Individual Placement Scheme Bid Wave 1 - £294,500 Wave 2 - £289,000
- Estates workbook system wide working

STP Estates Strategy (Workbook)
JULY 2018

- Future Fit consultation commences May 18
- STP leadership agree system priorities
- AHSN Innovation Implementation Lead funding £70k

## May - June 18

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

## July- Aug 18

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

# Timeline of key STP activities July 18 – Aug 18

## July-August 18

- SharePoint established for Shropshire Care Closer to Home Programme
- System Wide Elective Care Transformation Programme commences
- STP Clinical Strategy Group Work Programme agreed
- System Mental Health Lead identified

## August – Sept 18

- System wide Mental Health Programme initiated
- Future Fit Consultation concludes
- Community Services Review Programme on-going
- Community Services Review concludes
- Business Intelligence capability & Capacity Development

## Sept - Oct 18

- Future Fit Consultation analysis commences
- SharePoint established for Elective Care Transformation
- System Pharmacia Programme to commence
- STP Dashboard to inform conversation and system developments

## Oct – Nov 18

- System Winter Planning
- SharePoint established for Clinical Strategy Group
- SharePoint established for Urgent Care Tracker
- SharePoint offered as system way of working across a number of programmes supporting "Virtual" collaboration

# Shaping STP System Thinking

- STP Review meetings with NHSE & I
  - Next review meeting is 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

# STP Dashboard – Midlands & East only
# – no new report since April 2018 – awaiting refresh

**STP Progress Dashboard**
**April 2018 update**

Key:
- Highest performing
- (light blue)
- (mid blue)
- Lowest performing

| STP | Region | July 2017 baseline assessment | A&E waiting time performance | Referral to Treatment waiting time performance | Providers in special measures | CQC hospital performance | Healthcare associated infections - MRSA | Healthcare associated infections - c. difficile | Extended access | Patient satisfaction | Improving Access to Psychological Therapies recovery rate | Early Intervention in Psychosis 2-week waits | % of cancers diagnosed at stage 1 or 2 | Cancer one-year survival | 62-day waits | Cancer patient experience score | Emergency admissions rate | Emergency bed days rate | Delayed Transfers of Care rate | System-wide leadership | CCG/Trust performance vs. financial operating plan |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Hospital Performance | | | | | | Patient Focused Change | | | | | | | | Transformation | | | | |
| | | | Emergency | Elective | Safety | | | | General practice | | Mental health | | Cancer | | | | Prevention | | | Leadership | Finance |
| | | | Mar-18 YTD | Feb-18 | Apr-18 | Q2 1718 | Q4 16 - Q3 17 | Q4 16 - Q3 17 | Oct-17 | 2017 | Oct-17 to Dec-17 | Mar-17 to Feb-18 | 2016 | 2015 | 17-18 Q3 YTD | 2016 | Mar-17 to Feb-18 | Mar-17 to Feb-18 | Mar-17 to Feb-18 | Jun-17 | 16/17 |
| Derbyshire | M&E | Category 2 - advanced | 91.1% | 91.8% | No | 58 | 0.3 | 15.9 | 30.7% | 86.3% | 54.4% | 88.9% | 48.7% | 71.5% | 78.2% | 8.8 | 102 | 490 | 82 | 2 - Established | 0.9% |
| Shropshire and Telford and Wrekin | M&E | Category 3 - making progress | 78.7% | 90.3% | No | 60 | 0.0 | 10.5 | 49.6% | 85.9% | 55.7% | 35.9% | 50.0% | 71.7% | 83.7% | 8.7 | 92 | 414 | 96 | 2 - Established | -1.2% |
| Leicester, Leicestershire and Rutland | M&E | Category 2 - advanced | 84.5% | 88.1% | No | 50 | 0.6 | 13.2 | 65.2% | 81.8% | 51.2% | 72.7% | 50.3% | 71.3% | 79.9% | 8.6 | 97 | 501 | 112 | 1 - Advanced | 0.5% |
| Mid and South Essex | M&E | Category 2 - advanced | 86.2% | 85.3% | No | 60 | 2.6 | 14.1 | 21.8% | 81.1% | 50.6% | 77.1% | 54.2% | 71.8% | 72.6% | 8.8 | 95 | 440 | 113 | 2 - Established | 0.2% |
| Nottinghamshire | M&E | Category 2 - advanced | 86.6% | 92.4% | No | 58 | 0.6 | 17.2 | 26.1% | 85.7% | 54.0% | 73.0% | 50.0% | 71.5% | 83.2% | 8.6 | 93 | 492 | 124 | 1 - Advanced | 0.8% |
| Milton Keynes, Bedfordshire and Luton | M&E | Category 1 - outstanding | 94.3% | 90.2% | No | 66 | 0.9 | 4.5 | 27.2% | 81.2% | 48.7% | 89.4% | 55.0% | 71.4% | 85.5% | 8.6 | 109 | 521 | 127 | 1 - Advanced | 0.6% |
| The Black Country | M&E | Category 3 - making progress | 87.2% | 90.6% | Yes | 59 | 0.3 | 10.7 | 61.2% | 80.9% | 55.4% | 81.3% | 52.1% | 70.0% | 82.3% | 8.7 | 110 | 538 | 133 | 2 - Established | -0.1% |
| Norfolk and Waveney | M&E | Category 2 - advanced | 87.8% | 84.9% | Yes | 52 | 0.0 | 15.7 | 1.6% | 86.7% | 34.3% | 65.3% | 53.9% | 72.3% | 84.6% | 8.8 | 88 | 380 | 143 | 3 - Developing | -0.2% |
| Lincolnshire | M&E | Category 3 - making progress | 87.2% | 86.7% | Yes | 58 | 1.1 | 19.2 | 0.0% | 83.9% | 52.4% | 72.4% | 48.2% | 71.4% | 71.4% | 8.5 | 88 | 434 | 152 | 2 - Established | 0.0% |
| Suffolk and North East Essex | M&E | Category 2 - advanced | 90.8% | 88.2% | No | 51 | 1.0 | 15.7 | 65.3% | 85.9% | 50.0% | 76.1% | 55.5% | 72.0% | 80.0% | 8.8 | 91 | 411 | 152 | 2 - Established | 1.4% |
| Hertfordshire and West Essex | M&E | Category 3 - making progress | 80.4% | 88.1% | No | 57 | 0.9 | 14.4 | 34.5% | 84.7% | 51.6% | 72.5% | 54.8% | 72.8% | 82.5% | 8.6 | 88 | 448 | 171 | 2 - Established | -0.7% |
| Coventry and Warwickshire | M&E | Category 2 - advanced | 86.5% | 86.5% | No | 53 | 0.2 | 7.6 | 39.6% | 85.6% | 50.1% | 56.0% | 47.6% | 71.5% | 84.6% | 8.8 | 99 | 520 | 187 | 2 - Established | 1.1% |
| Herefordshire and Worcestershire | M&E | Category 2 - advanced | 79.8% | 83.5% | Yes | 53 | 0.6 | 13.1 | 62.9% | 88.3% | 51.9% | 80.0% | 53.4% | 72.5% | 74.3% | 8.7 | 83 | 385 | 190 | 1 - Advanced | -0.4% |
| Cambridgeshire and Peterborough | M&E | Category 2 - advanced | 85.1% | 89.7% | No | 63 | 0.8 | 17.4 | 28.0% | 85.9% | 52.3% | 78.4% | 56.1% | 74.0% | 85.1% | 8.8 | 89 | 444 | 192 | 1 - Advanced | -1.2% |
| Birmingham and Solihull | M&E | Category 2 - advanced | 88.6% | 91.0% | No | 56 | 0.5 | 14.1 | 19.6% | 82.4% | 53.2% | 71.6% | 55.5% | 70.7% | 83.0% | 8.77 | 126 | 566 | 209 | 2 - Established | 1.1% |
| Staffordshire | M&E | Category 4 - needs most improvement | 81.9% | 82.5% | No | 59 | 0.7 | 16.0 | 18.2% | 84.6% | 56.1% | 66.1% | 53.3% | 70.9% | 78.6% | 8.7 | 111 | 515 | 227 | 3 - Developing | -4.1% |
| Northamptonshire | M&E | Category 4 - needs most improvement | 87.2% | 86.7% | Yes | 58 | 0.0 | 10.1 | 0.0% | 82.6% | 43.4% | 91.7% | 46.3% | 71.7% | 81.8% | 8.6 | 110 | 663 | 301 | 4 - Early | -0.3% |

STP are working with CSU to develop a “System” reporting Dashboard, bespoke to the Programme of work
More details to follow in next update.

Dashboard: ICS Priority Metrics

Dashboards | Levels | Options

Dashboard Chosen: ICS Priority Metrics
Area Chosen: Lancashire & South Cumbria
Tile View Options

U&EC
- 4 Hour A&E Waits
- % Amb handover 15
- % NE acute admissions via A&E

Enhancing Quality of Life for People with Long Term Conditions
- % CPA 7 Days

RTT
- % Incomplete 18 Wks RTT
- % Dementia Prevalence
- % IAPT Access
- % IAPT Recovery
- % IAPT 6 Weeks Waits
- % IAPT 18 Weeks Waits
- Crisis Support Unit in Place
- IAPT Roll Out
- Number of CYPED Routine 4 Wks
- Number of CYPED Urgent 1 Wk

General Practice
- Convenient Access to GP Services
- Evening and weekend GP Appts
- Additional Drs in General Practice
- Additional GP trainees per year

Ensuring that People Have a Positive Experience of Care
- % Admitted completed 18 wk

Cancer
- % Cancer 2 Wks Breast
- % Cancer 31 Days Radiotherapy
- % Non Admitted Completed 18 Wk
- > 52 Wk Waits
- % Cancer 31 Days Surgery
- % 2 Wks Cancer Urgent

ICS Level: Lancashire & South Cumbria

4-Hour A&E Waiting Time Target (Monthly Aggregate based on HES 15/16 ratio)

| Provider | | |
|---|---|---|
| Value | Jul-18 | 83.39% |
| Target | Jul-18 | 95.00% |
| Forecast | Aug-18 | 83.69% |

| Commissioner | | |
|---|---|---|
| Value | Jul-18 | 83.37% |
| Target | Jul-18 | 95.00% |
| Forecast | Aug-18 | 83.60% |

4 Hour A&E Waits

Organisation

Actual | Linear Forecast

Provider | Commissioner

Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18

ICS | Integrated Care Partnerships \ Integrated Care Organisations

| Area | Provider | Commissioner |
|---|---|---|
| Lancashire & South Cumbria | 83.39% | 83.37% |
| Bay Health & Care Partners | 87.21% UHMB | 87.09% |
| Central Lancashire | 85.16% LTH | 85.05% |
| Fylde Coast | 80.66% BTH | 80.74% |
| Pennine Lancashire | 82.51% ELHT | 83.00% |
| West Lancashire | | 85.77% |

| Partnership | CCG | Value |
|---|---|---|
| Bay Health & Care Partners | Morecambe Bay CCG | 87.09% |
| Central Lancashire | Chorley & South Ribble CCG | 85.15% |
| Central Lancashire | Greater Preston CCG | 84.97% |
| Fylde Coast | Blackpool CCG | 80.67% |
| Fylde Coast | Fylde & Wyre CCG | 80.87% |
| Pennine Lancashire | Blackburn With Darwen C.. | 82.52% |
| Pennine Lancashire | East Lancashire CCG | 83.21% |
| West Lancashire | West Lancashire CCG | 85.77% |

# Transformation Delivery Programmes

The next set of slides show key programmes through a simple set of slides that captures high level programmes plans.

# Commissioner Led Transformation Programmes

# Shropshire – Care Closer to Home

### Phase 1

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

### Phase 2

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

### Phase 3

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

# Shropshire – Care Closer to Home - Progress

### 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.

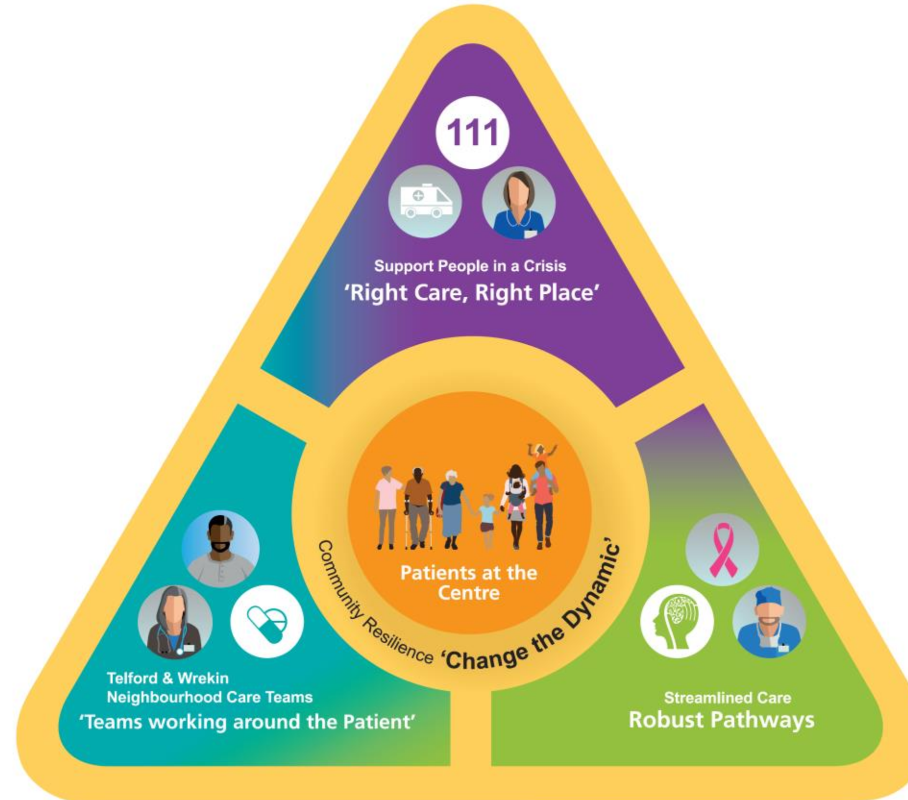
NHS
Shropshire
Clinical Commissioning Group

# 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) amd OOA adult mental health placements (longer term QIPP)

Crisis pathway for 16-18 year old children (including children who don't meet tier 4 threshold, those who have challenging behaviour and setting up PARA registers)

### Encouraging Healthy Lifestyles

*Targeting obesity, smoking and alcohol*

### Community Resilience

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

### Direct Care in the Community

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

### Specialty Review

*To include Diabetes and Respiratory*

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

## Using the data to drive the change

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

↑

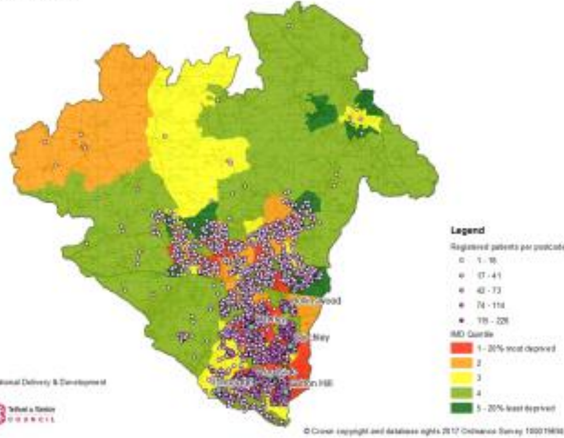
Dementia diagnosis rate (add more context)
Rising hospital admissions (add more context)

→ *Diabetes outcomes need to be improved*

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

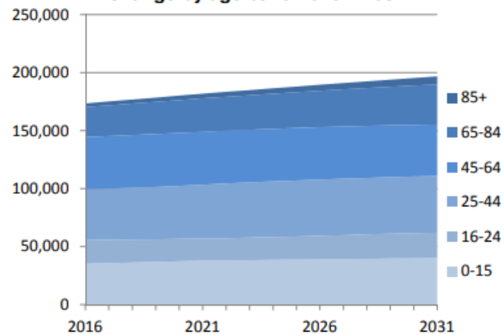
↓

South East Telford

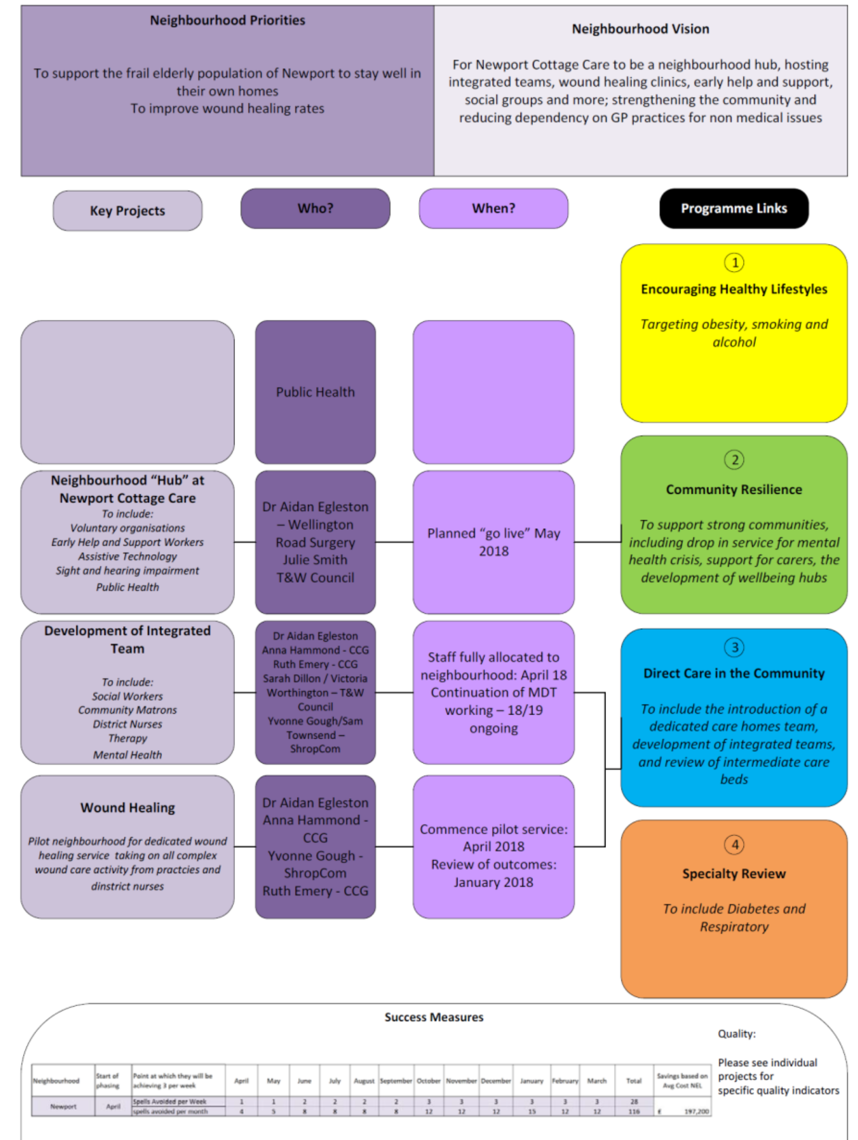



↑

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




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



**Neighbourhood Priorities**

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

**Neighbourhood Vision**

For Newport Cottage Care to be a neighbourhood hub, hosting integrated teams, wound healing clinics, early help and support, social groups and more; strengthening the community and reducing dependency on GP practices for non medical issues

| Key Projects | Who? | When? |
|---|---|---|
| | Public Health | |
| **Neighbourhood "Hub" at Newport Cottage Care** *To include: Voluntary organisations, Early Help and Support Workers, Assistive Technology, Sight and hearing impairment, Public Health* | Dr Aidan Egleston – Wellington Road Surgery; Julie Smith T&W Council | Planned "go live" May 2018 |
| **Development of Integrated Team** *To include: Social Workers, Community Matrons, District Nurses, Therapy, Mental Health* | Dr Aidan Egleston; Anna Hammond - CCG; Ruth Emery - CCG; Sarah Dillon / Victoria Worthington – T&W Council; Yvonne Gough/Sam Townsend – ShropCom | Staff fully allocated to neighbourhood: April 18; Continuation of MDT working – 18/19 ongoing |
| **Wound Healing** *Pilot neighbourhood for dedicated wound healing service taking on all complex wound care activity from practices and district nurses* | Dr Aidan Egleston; Anna Hammond - CCG; Yvonne Gough - ShropCom; Ruth Emery - CCG | Commence pilot service: April 2018; Review of outcomes: January 2018 |

**Programme Links**

① **Encouraging Healthy Lifestyles**
*Targeting obesity, smoking and alcohol*

② **Community Resilience**
*To support strong communities, including drop in service for mental health crisis, support for carers, the development of wellbeing hubs*

③ **Direct Care in the Community**
*To include the introduction of a dedicated care homes team, development of integrated teams, and review of intermediate care beds*

④ **Specialty Review**
*To include Diabetes and Respiratory*

**Success Measures**

| Neighbourhood | Start of phasing | Point at which they will be achieving 3 per week | April | May | June | July | August | September | October | November | December | January | February | March | Total | Savings based on Avg Cost NEL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Newport | April | Spells Avoided per Week | 1 | 1 | 2 | 2 | 2 | 2 | 3 | 3 | 3 | 3 | 3 | 3 | 28 | |
| | | spells avoided per month | 4 | 5 | 8 | 8 | 8 | 8 | 12 | 12 | 12 | 15 | 12 | 12 | 116 | £ 197,200 |

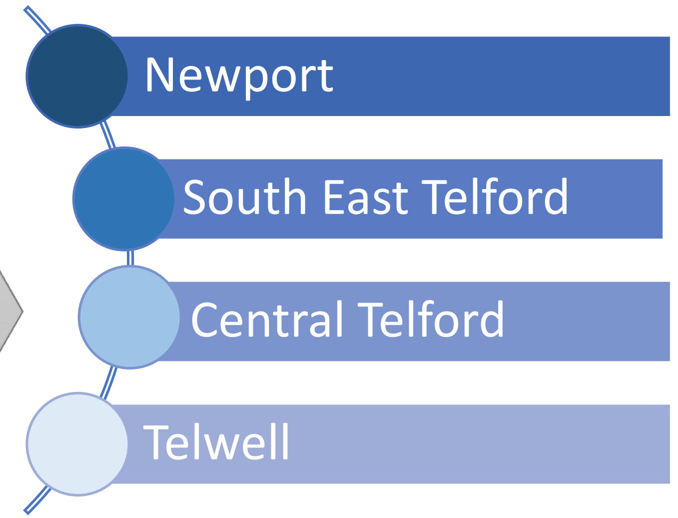
Quality:

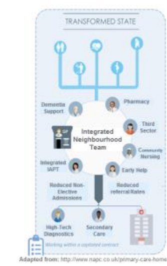
Please see individual projects for specific quality indicators

# Telford Neighbourhoods – how it all fits together – delivering transformation

**Case Study Examples to showcase progress**

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



# Primary Care Programme – GPFV

Updated Aug 2018
Next update– Oct 18

Exec Lead – Nicky Wilde & Rebecca Thornley

Project Leads – Phil Morgan

## Programme needs to:

The GPFV programme has five main elements:

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

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

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

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

**Estates and Technology Transformation Fund**
- Delivering against key physical and digital projects, funded through the ETTF

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

## System Partners / Enablers need to:

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

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

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

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

## The progress:

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

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

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

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

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

## Interventions and process change milestones

- Increased levels of working at scale between practices
- 100% of the population having access to GP appointments 8am to 8pm Mon-Fri and at weekends/bank holidays subject to local need
- Targets for workforce recruitment and retention across primary care met
- Successful implementation of the GPFV 10 High Impact Actions
- Successful implementation of ETTF funded IT and estates projects

## Risks to delivery

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

## Data

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

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

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

**Estates and Technology Transformation Fund**
- VOiP Telephony Project – T&W - 16 sites now live for VOiP and Wi-Fi; SCCG – 16 sites now live for VOiP and Wi-Fi

# Mental Health

Exec Lead – Clinical Lead - Professor Tony Elliot Project Lead –

NHS England NHS Improvement

## Programme needs to:

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

## System Partners / Enablers need to:

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

## The progress:

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

## 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

NHS England NHS Improvement

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

# Stranded Patient Flash Report

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

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

Current Position

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

Progress

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

# Stranded Patient Flash Report

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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 | AMBER |
| 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 | AMBER |
| **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 |
|---|
| • Progress actions in recovery plan<br>• Review key actions from medical deep dive<br>• Deliver any changes to pathways following decision around business continuity<br>• All patients to be managed against professional SOP's/ professional standards – circulation of SOP required to all clinicians<br>• On-going recruitment drive and review of potential locums and nurses<br>• Continue to push internal ED actions to improve non admitted and minors performance<br>• 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: | | AMBER |
| Exec Lead: | Deidre Fowler | Project Lead: | Rachael Brown | |
| Clinical Lead: | To be agreed for each site | Project Group: | Improving patient flow | |
| Date of Report: | 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 – Programme Leads – Sara Dillon & Tanya Miles

## 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. Haver a single narrative in the form of a system wide operational framework for intermediate care in Telford.

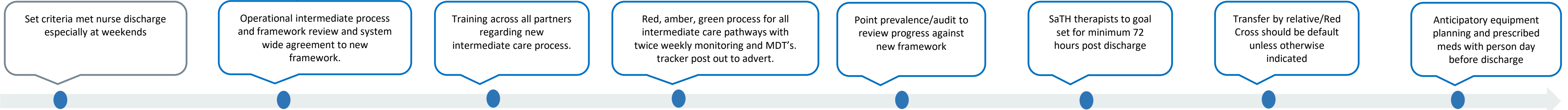
## System needs to:

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 inn 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

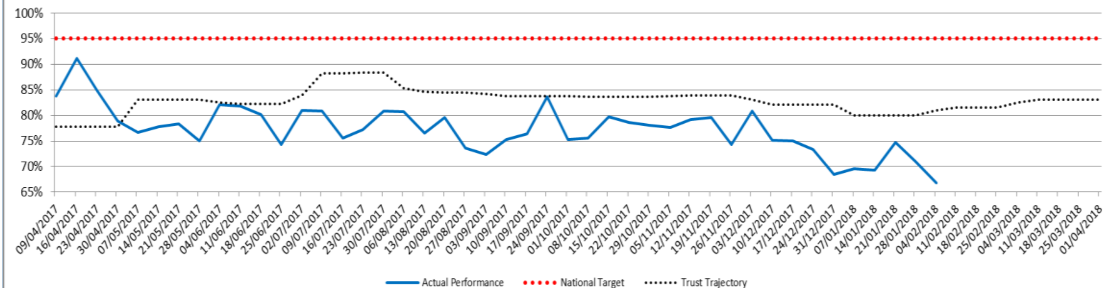



## Risks to delivery

**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



# UEC - IV Therapies

Updated May 2018

NHS England NHS Improvement

Exec Lead – Steve Gregory Project Board Chair – Yvonne Gough Project Lead – Mandee Worrell

## 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

NHS England    NHS Improvement

## Programme needs to:

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

## System Partners / Enablers need to:

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

## The progress:

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

## Key Interventions / Milestones

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

## Risks to delivery

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

## Data

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

# Transformation Enablers

System Improvements

Plan on a Page

# Digital Enabling Programme

Exec Lead – Clinical Lead - Programme Lead – Rob Gray

NHS England · NHS Improvement

## Programme needs to:

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

## System Partners / Enablers need to:

1. Ensure "Right Information available to the right person in the right time and location" enabling better outcomes for citizens.
2. Clarify the end vision and the level of commitment required from organisations.
3. Act as One! Agree the objectives of the enabling group 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:

- Universal Capabilities: target to significantly deliver by March-18 – successful. (9/10 see data below). New programme items to be decided in refreshed LDR.
- Continue direct engagement with NHS England, and NHS Digital for strategic direction.
- LDR refresh process started
    - Core team brainstorming
    - Full PB session with James Seaman - (worked on Manchester devolution) to help formulate.
    - Evaluation of some early infrastructure projects to enable future progress.
    - Owners nominated to define project scopes.
- Further meetings scheduled to refine vision, to support future plans.
- Agreement reached to utilise Summary Care Record with Additional Information (eSCR) to provide core GP info to all care settings.
    - Project 1. enhance SCR to near 100%.
    - Project 2. enable access in SaTH to eSCR with smartcard authorisation.

## Key Interventions / Milestones

- Oct-18. LDR refreshed and new Digital Programme defined. GP IT Forum also follows lead of LDR.
- 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 at all sites
- Jan-19. Procure started for Electronic Patient Record systems for SaTH and RJAH to support shared access to Integrated care records.

## Risks to delivery

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 is unclear.

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

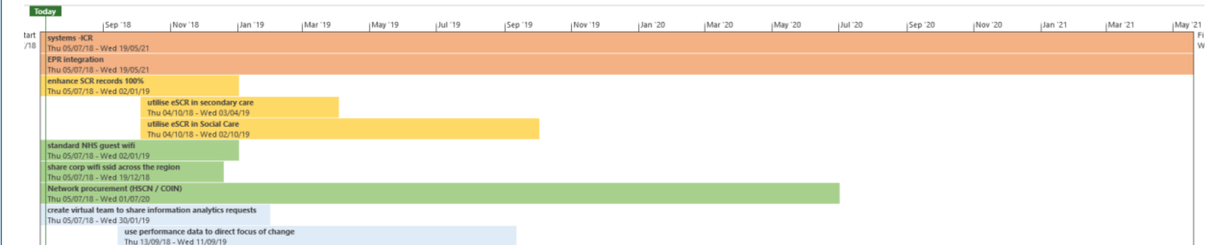
Complex governance arrangement (STP is not an executive group with delegated authority. )

Uncertain leadership of the DEG. No Exec or clinical leads, and no DEG CCIO position defined.

Actions:

## Data

Outline programme plan.



# Strategic Estates Programme

Updated August 2018
Next update– October 2018

NHS England | NHS Improvement

Exec Lead – Clive Wright | Programme Lead – Becky Jones

## Programme needs to:

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

## System Partners / Enablers need to:

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

## The progress:

- Estates Workbook/Strategy completed and submitted on time and now a living document
- Capital bid for Shawbirch submitted
- 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

NHS England NHS Improvement

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….

Demonstrates STP footprints priorities and how the estate will help to deliver on these

Agreed prioritisation process has been put in place to identify the preferred projects

linkages between the wider Future Fit programme are clearly made

This document is helping to bring different work programmes together

links are established into the wider work in terms of the One Public Estate

opportunity to link whole system together through effective partnership working

Sustainable Services Programme, Neighbourhood Working and Care Closer to Home projects

Shropshire, Telford & Wrekin Sustainability & Transformation Programme
STP Estates Strategy (Workbook)
JULY 2018
Five Year Forward View
#futureNHS

# Strategic Back Office

Updated June 2018 Next update–

Exec Lead – Ros Preen Programme Lead – Maggie Durrant

NHS England NHS Improvement

## Programme needs to:

- Update the planning assumptions made in the 5 year STP financial plan and identifying a more robust view on the scale of savings in the following areas;

**Corporate services** savings in the health economy, using recent benchmarking data,
**Shared recruitment** processes (by the Workforce Work stream)
**Procurement savings** through model hospital and PPIB data
**Estate rationalisation** (developed by the STP Estates Work stream)

- Develop an over view that makes it clear what exists in plans already and whether the programme can stretch the thinking to gain more operational and financial value ( e.g. target set to drive costs to the national median).

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

## System Partners / Enablers need to:

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

## The progress:

- The work stream has demonstrated good practice in collaborating and sharing information between NHS providers and the Local Authorities although LA engagement has diminished recently.
- Underpinning case for change still holds true, although it will be refreshed through the review detailed in the next bullet point to ensure this is the case.
- 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 yet to be determined.
- 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.
- Further thinking has been done on where other opportunities could also be possible in areas loosely named 'middle office', which link strongly into the estates and IT agenda as well as the workforce with regard to admin and reception functions.

## 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 – Summer 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)

# Strategic Workforce Programme

Updated August 2018 Next update - October 2018

NHS England NHS Improvement

Exec Sponsor – Jan Ditheridge Exec Lead – Victoria Maher Programme Manager – Sara Edwards

## Programme needs to:

1. Develop a system-wide **Strategic Transformation Workforce Plan** which supports Future Fit options linking acute and community models.
2. Develop and implement a system **Organisational Development Plan** to support new ways of working.
3. Develop **workforce sustainability** through the identification of learning and development, education and training needs and through supporting system programmes to implement change and support transformation.

## System Partners / Enablers need to:

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

## The progress:

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

## Key Interventions / Milestones

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

## Risks to delivery

**Risks:**

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

**Actions:**

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

## Data

**Shropshire Workforce Baseline:**

STW system workforce baseline developed by HEE Workforce Intelligence Team utilising data from NHSI operational plans (workforce plan) for acute/community and mental health services, NHS Digital for primary care and NMDS for social care.

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

**Individual areas of workforce:**

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

# Population Health & Prevention

System Leads –Kevin Lewis / Helen Onions
Programme Lead – Penny Bason

Updated April 2018 Next update– June 2018

NHS England NHS Improvement

## The programme needs to:

1. Develop our wider workforce to 'make every contact count' (MECC+) / proactive identification of people at risk of ill health and behaviour change conversations, brief interventions
2. Prevent harm due to alcohol, obesity and CVD
3. Support culture change and new working practices that help people at the earliest opportunity
4. Support active signposting and develop a good understanding of how communities support people – linking to Social Prescribing
5. Work across organisations (including the VCSE) to prioritise support for key population groups – address inequity and inequalities
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

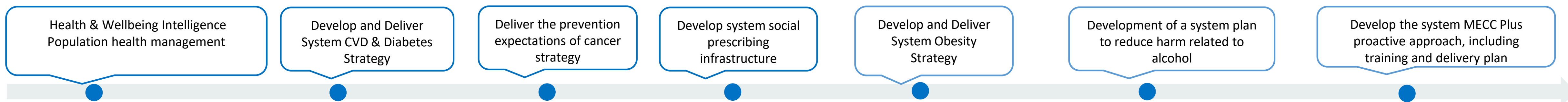
**Telford & Wrekin – Healthy Telford**
Borough-wide lifestyle offer
Twitter and blog – using social media to inspire behaviour change
Developing and nurturing our community health champions
Public Health Midwife, stop smoking support and maternal health advice

**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




## Risks to delivery

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



## Outcomes – how do we know it's working? DRAFT

Public Health Outcomes Framework
- Healthy life expectancy
- Health Equity
  - Smoking rates
  - Obesity – children and adults
  - Physical activity
  - Wellbeing measures – Social Prescribing
  - Reduction in GP attendances
  - Reduction in unplanned hospital admissions
  - Cancer rates
  - Harm due to alcohol – alcohol admission rates

## Connecting to other programmes

- Health and Wellbeing Boards Strategic Planning (both T&W and Shropshire)
- Better Care Fund (T&W and Shropshire)
- Rightcare
- STP Neighbourhoods and Out of Hospital Programmes – community development,
- GP 5 Year Forward View –
- Mental Health 5 Year Forward View – preventing
- Maternity Services Transformation
- Workforce – developing our
- Estates Partnership
- Musculoskeletal and Falls System Planning

Updated Version 4.0
August 2018

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

Draft – tba - changes

**STATUTORY ORGS**
**Requirement to adhere to own governance procedures**

**Provider Boards**
**Commissioner Boards**
**Local Authority Cabinets**

- **Telford & Wrekin CCG**
- **Telford & Wrekin LA**
- **SaTH**
- **RJAH**
- **ShropCom**
- **SSSFT**
- **Shropshire CCG**
- **Shropshire LA**

**STP**
**System Leadership Group**

**(System CEOs)**

Health & Wellbeing Boards

Joint Health Overview Scrutiny Committee

**STP**
**Clinical Strategy Group**

**(System Clinical Leads)**

## STP Transformation Programme Delivery Board

**Strategic Workforce Group**

**Communication & Engagement**

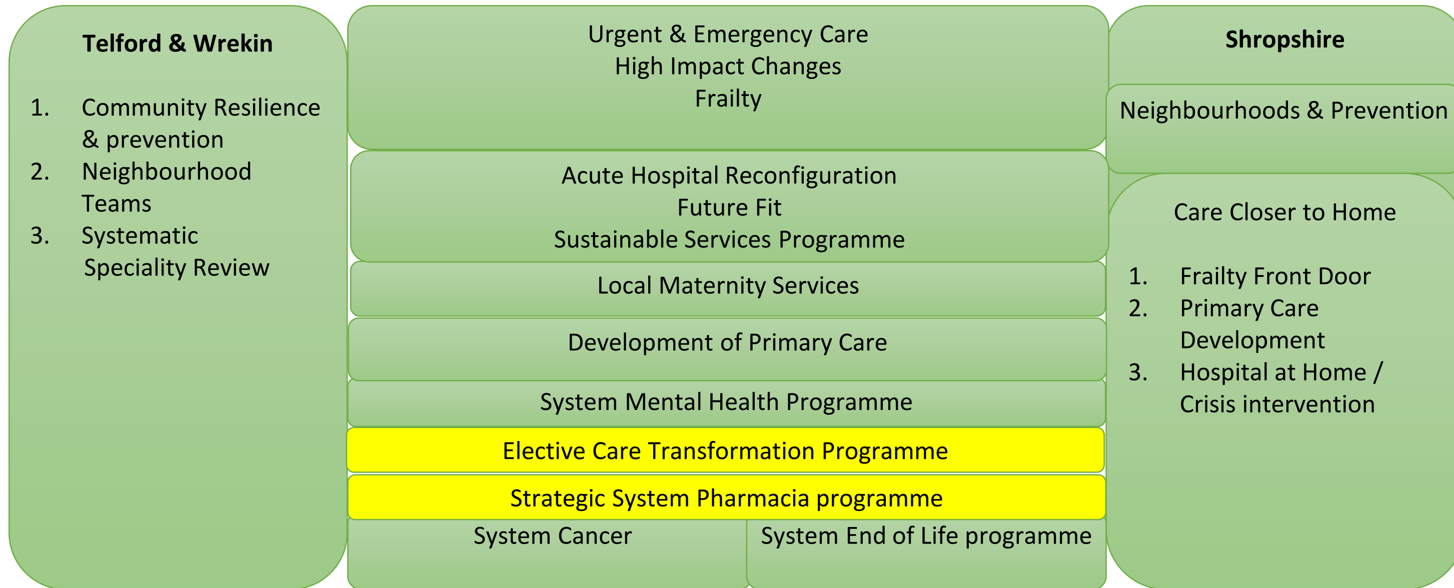
**System Back Office**

**Strategic Estates Group**

**Digital Enablement Group**

**System Finance Group**

**Population Health & Prevention**



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

***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 / Partnerships – Shropshire, Telford & Wrekin Update

- *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 ambition is simple:

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.