Shropshire, Telford & Wrekin
Sustainability & Transformation programme
Date of Report: Feb 2018
Updated 16 02 2018

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

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

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

2nd Feb 2018
Planning Guidance for refreshing of STP Plans 18/19 is now available
https://www.england.nhs.uk/wp-content/uploads/2018/02/planning-guidance-18-19.pdf
Its key that as an STP we understand how the planning guidance fits with our STP plans – we should be cross checking that we are referring to the guidance within all system plans for Shropshire, Telford & Wrekin.

Key points to note:

Integrated System Working

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

- ensure a system-wide approach to operating plans
- work with local clinical leaders to implement service improvements
- identify system-wide efficiency opportunities
- undertake a strategic, system-wide review of estates
- take further steps to enhance the capability of the system including stronger governance and aligned decision-making, and greater engagement with communities and other partners
- NHS England will be making a further non-recurrent allocation within each STP to support its leadership in 2018/19 on the same basis as last year.

Integrated Care Systems

5.2 ***We will reinforce the move towards system working 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***

5.3 We are now using 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.

5.4 We see Integrated Care Systems as key to sustainable improvements in health and care by:

- creating more robust cross-organisational arrangements to tackle the systemic challenges facing the NHS;
- supporting population health management approaches that facilitate the integration of services focused on populations that are at risk of developing acute illness and hospitalisation;
- delivering more care through re-designed community-based and home-based services, including in partnership with social care, the voluntary and community sector; and
- allowing systems to take collective responsibility for financial and operational performance and health outcomes.

5.7 Integrated Care Systems will be supported by new financial arrangements:

- all Integrated Care Systems will work within a system control total
- in 2018/19, systems are encouraged to adopt a fully system-based approach
- systems adopting this full incentive structure will operate under a more autonomous regulatory relationship with NHS England and NHS Improvement.
- all approved Integrated Care Systems will be required to operate under these fully-developed system control total incentive structures by 2019/20.

However, in 2018/19 systems that are not ready to proceed with full system incentives and shared intervention arrangements will alternatively be allowed to adopt an interim approach under which only the additional funding that has been put into the PSF (£650 million in aggregate) will be linked to system financial performance. On this option, no payment will be made from this enhanced funding unless the system as a whole meets its control total. If individual trusts or CCGs miss their organisational control totals, but the system still achieves overall, their share will be apportioned in consultation with the system leadership. However, on this interim option if the individual trusts or CCGs meet their organisational control totals, but the system does not overall, they will retain access to the relevant share of the existing £1.8 billion PSF and any applicable CSF awards.

New Integrated Care Systems

5.8 There is strong appetite amongst other systems to join the Integrated Care System development programme and we anticipate that additional systems will wish to join during 2018/19 as they demonstrate their ability to take collective responsibility for financial and operational performance and health outcomes. STPs that can demonstrate their readiness to join the programme should speak to their regional teams to confirm expressions of interest from all organisations in the STP. We will aim to review any applications to join the programme by March 2018. We envisage that over time Integrated Care Systems will replace STPs.

5.9 The next cohort of Integrated Care Systems will be selected from STPs with:

- strong leadership, with mature relationships including with local government. The leadership team should have effective ways of involving clinicians and staff, the third sector, service users and the public. It should also have the right capability and infrastructure to execute on priorities;
- a track record of delivery, with evidence of tangible progress towards delivering the priorities in Next Steps on the Five Year Forward View. These systems should be meeting NHS Constitution standards or provide confidence that by working as an integrated system they are more likely to be recovered;
- strong financial management, with a collective commitment from CCGs and providers to system planning and shared financial risk management, supported by a system control total and system operating plan;
- a coherent and defined population that reflects patient flows and, where possible, is contiguous with local government boundaries; and
- compelling plans to integrate primary care, mental health, social care and hospital services using population health approaches to redesign care around people at risk of becoming acutely unwell. These models will necessarily require the widespread involvement of primary care, through incipient networks.

Public Engagement

5.10 As systems make shifts towards more integrated care, we expect them 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.

STP Director's Update to STP Partnership Board
Feb 2018

Phil Evans, STP/Future Fit Director

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

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

RAG rating		Key Updates / Issues / risks Last Updated: 16/02/2018
1.0	Sharing a Patient Story – where available and approved for wider sharing	
2.0	**Overall STP Programme Governance**	

2.1	STP Programme Structure & Reporting
	STP PMO Contact
	Phil.Evans1@nhs.net
	Jo.Harding1@nhs.net
		• NHS Planning Guidance issued in Feb 18, highlights how thinking is moving from STP's (Sustainability & Transformation Partnerships) towards Integrated Care Systems (ICS) see detail above.
		• STP Programme Structure, Leadership and agreed system priorities are being refreshed.
		• Governance and decision making processes are being reviewed to establish clear lines of responsibility and communication across all organisations.
		• Terms of Reference for the following groups are being refreshed to reflect system partnerships and collaboration across our system
		  ○ Clinical Design Group is evolving in to a STP Clinical Strategy Group
		  ○ STP Partnership Board is evolving to become a System Leadership Group
		  ○ Finance Group is evolving in to a Strategic Finance Group
		• There is more work to do with regard to the Programme Delivery Board and alignment with System priorities but the intention is that this will be closely aligned with the Clinical Strategy Group with oversight and support from the System Leadership Group.
		• Further System leadership Sessions are taking place in Feb & March, facilitated by The Kings Fund, outputs from this will be shared when available.

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

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		average of 1000 visitors each month https://healthytelford.wordpress.com • A network of 36 trained Community Health Champions across Telford and Wrekin, working with each other and their wider communities **Social Prescribing** *Newport* • Establishment of the Newport & District Community Patient Group to support co-production of the programme • A Weekly link worker clinic at Newport Cottage Care. Referrals are slow and more work is required on partner engagement and developing pathways. Clients are presenting with low level mental health issues, anxiety, depression, loneliness & isolation (including carers) • Collaborative working between Newport Rotary and Walking for Health to establish a 'Bench to Bench Project' to enable inactive residents to begin gentle graduated physical activity. Local volunteers are mapping benches and producing paper maps which will be around the community. It is envisaged that led walks will start in the New Year. • Nordic Walking group: local resident now qualified as Nordic Walk Leader and leading weekly walks • Feed the Birds - In Partnership with Shropshire Wildlife Trust and Community Participation Team. 3 Volunteers trained in Newport who will be matched to isolated clients in their local areas • A Pilot programme is being developed with Wrekin Housing Trust Retirement living schemes in Wellington. More physically able residents are volunteering to work across schemes to support isolated residents on other local schemes. 3 Volunteers are being recruited across 2 pilot schemes in Wellington. When this is evaluated it is hoped to expand to the Newport schemes. *Central East Telford* • Citizen's Advice clinics running successfully within Donnington and Charlton Medical Practices • Music to movement sessions for the inactive at Donnington surgery. Patients are being signposted from Long Term Conditions reviews. 9-10 attendees. • Branches are now linked in • A local community focus group has been established – with support volunteers are mapping community assets • Meeting held with Shawbirch PPG – very supportive, GPs interested in developing some ideas & have requested meeting in the new year. **Healthy Lifestyles Service** • The Healthy Lifestyle Service includes a small number of Healthy Lifestyle Advisors. • There are just 2 GP surgeries who do not have a dedicated HLA but discussions are in place to address this. In addition to this some GP clinics have increased from 1 half-day session to 2 full days due to the clinics being 100% booked and the GP's being encouraged by the positive outcomes of patients resulting in more referrals. • Positive links with Speciality Consultants at Princess Royal Hospital have been developed – resulting in an increase in referrals of patients from their clinics Since April the service has delivered brief interventions to 19,911 people (2016/17 outturn position was 19,263); completed 2,082 Health Checks; worked with over 1000 adults to develop personalised healthy lifestyle plans and made 7,617 onward referrals to community based support. The team are now operating at full capacity.

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		• 100 adults have participated in creative arts programmes as part of the Building Better Opportunities Programme. A large number of participants experienced poor mental health, issues with physical disability and pain management, substance misuse and rehabilitation, or socially isolated **Workstream 2 – Neighbourhood Teams** • Directly bookable slots for GPs to access Early Help and Support Workers has commenced in some GP practices, which is gradually being rolled out to all practices. • Estates workshop has taken place with GPs, SSSFT, ShropCom to scope estates provision across the locality and gain an understanding of services delivered and where from, and consider where estates could overlap between health and the local authority to support collaborative working. • Two MOUs have been drafted – one for the Neighbourhoods (i.e. how the practices will work together as a neighbourhood), and the second for the operation of the Neighbourhood Teams • Service specification for Neighbourhood Teams currently underway, due for completion by the end of November. • The CCG is working with the Strategy Unit to develop an evaluation strategy to measure the impact of neighbourhood working, to ensure robust, real measurables are in place for the programme. • Work continues to progress with Social Prescribing, including 100 reception staff trained in Making Every Contact Count (MECC) and further training scheduled for January. • MDT meetings have commenced in Newport Neighbourhood (includes mental health, community nursing, social care, therapists etc.) to support patients at risk of admission to hospital, and identify ways that patients can be supported who have been identified by a risk stratification tool. • First draft of Alliance Agreement for integrated teams has been drafted and is currently being reviewed by stakeholders. **Workstream 3 – Systematic specialty review** **Diabetes** STP Area won £200k in funding over two years to increase Diabetes Structured Education and achievement of NICE Treatment Targets (TT) and we also developed locally a CCG GP Incentive scheme to improve TT achievement. The following work has been taking place to support patients to be managed more optimally: • Additional specialist support and advice via neighbourhood level MDT (support to primary care) with case reviews and consultant clinics • individualised practice support (e.g. visits to practices to discuss their results, share best practice and identify training/support needs) • New Three Tiered Diabetes Model of Care has been developed, we are working with ShropCom to mobilise a pilot, or demonstrator site, in at least one of the four neighbourhoods, commencing 2nd April 2018.Workstream 1 - Community Resilience & Prevention
3.2	Shropshire Neighbourhood (Out of Hospital Programme) Last Updated by Lisa Wicks 13/11/17	**Workstream 1 - Community Resilience & Prevention** **Working across organisations to connect vulnerable or at risk communities with support to improve health and wellbeing outcomes.** • **Resilient communities** – developing and making best use of local assets in communities; developing hyper local directories and community connectors – on going

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

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		A health needs assessment for Shropshire has also been commissioned to inform the out of hospital model of care.
3.3	Powys Neighbourhood Last updated by Rhiannon Jones Amanda Edwards 09/02/2018 STP PMO Contact Andrea.webster5@nhs.net	The rural geography of Powys and the complex commissioning arrangements have always driven the health board's strategic approach to bringing care closer to home wherever possible and this remains a key strategic aim. We are seeking to shift the balance of outpatient, day care, diagnostic and elective inpatient services to community or primary and community settings to improve access and quality of care within Powys, and to reduce demand on acute services. Moving healthcare closer to home is important in addressing the pressures of future demand and ensuring people get care and support in an environment which best meets their needs, this may also avoid further costs in the longer run of expensive hospital environments. The delivery of the future model is reliant on six things: ▪ Whole system commissioning approach - which joins up services, deliver services more locally and provides access to specialist care outside of Powys. ▪ Care Co-ordination approach which works on a scale of need i.e. increases if people have complex needs. This will help people to navigate through the health and care system in a timely and effective way - accessing the right level of support based on their needs. ▪ Electronic Records and health and care interfaces which provide handheld records for individuals, enables sharing of information more easily between health and care professionals and real time access to test results. ▪ Integrated teams – working within local communities to support care closer to home, agile and responsive to meet individuals future needs. ▪ Partnerships and collaborative working to collectively work towards the best interests of the local population. ▪ Specialist Access to advice and guidance from professionals in secondary care to enable us to reduce demand on their services and where appropriate enabling us to treat people earlier. Crucial to the successful delivery of services within Powys is ensuring the sustainability of clinical in-reach services. Neighbouring secondary care providers in England and Wales play a key role in providing clinical in-reach services delivered within Powys. Such services need to be modernised to ensure they are on a sustainable footing including new approaches to pre-referral advice and support; outpatient clinics; and follow up. The Health Board will continue to work with neighbouring providers through local and regional structures as well as through commissioning arrangements to develop, improve and increase where possible the services provided in community settings in Powys. **Care Co-ordination and Flow Management** There have been major challenges in key delivery areas during 2017/18, particularly with waiting times for treatment; cancer waits in some specialties; and in keeping pace with unscheduled care demand. These pressures are not unique to Powys, but experienced throughout the United Kingdom. Locally, much of this increased demand is generated by the system's inability to adequately care for the growing number of elderly frail

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		patients. The impact on our ability to manage flow for all patients (planned, urgent and emergency care needs) across the system are significant. Some of the key areas to focus on in 2018/19 to recover a more timely access to services include: ▪ Reducing the number of patients being admitted to Acute Care/DGH's that could be managed via alternative pathways. ▪ Working with ambulance services to make sure patients are directed to the best place to meet their needs to reduce delays for ambulances at hospitals. ▪ Reducing waiting times for patients requiring outpatient assessment, diagnostic investigation or planned surgery. ▪ Reducing variation in cancer waiting times. ▪ Reducing the number of patients waiting for outpatient follow up: ▪ Reducing the average Length of Stay in the Community Hospitals. ▪ Reducing non-Mental Health Delayed Transfers of Care. ▪ Improving care coordination and community flow, by measuring demand and capacity. These challenges illustrate that current service models need to evolve to meet changing needs for health services, particularly reviewing traditional systems and approaches. **Health and Care Coordination Hub** When requiring secondary care, Powys patients are admitted to any one of the six other health boards in Wales or the two main NHS Trusts in England. This makes the prioritisation and coordination of repatriation complex. The Coordination Hub will ensure a more efficient way of managing the timely repatriation of Powys patients from other health board's DGH / acute hospital beds in Wales and England and manage flow in and out of Community Hospitals in collaboration with PCC. It will increase our ability to ensure the length of stay in a DGH / acute care bed for Powys patients is minimised, as patients who are admitted will be transferred to the most appropriate setting in a timely way as soon as they no longer need acute hospital care. This will support a 'home first' ethos and a 'discharge to assess' model of care. The Coordination Hub will hold and manage bed and service capacity data from across the health and social care system in Powys. It will act as the central point for referral and allocation of community hospital beds, assessments of need, packages of care, residential and nursing home beds, for those who are currently in a DGH /acute care bed in Wales and England. By providing one single source of real time admission, transfer and discharge data that can be accessed and acted upon, a more effective method of prioritisation and allocation will be implemented. The Health and Care Coordination Hub will be established in 2018.
4.0	**Programme Delivery – Acute & Specialist – in Hospital Transformation**	
4.1	Local Maternity Services Last update: Programme Lead – Fiona Ellis 16/02/2017	• Transformation Plan –Funding bids have now been submitted to NHS England on 31st January 2018 for non-recurrent funding in 2018/19. The amount available has not been confirmed. A refreshed LMS Plan has also been submitted to NHS England on the 12th February along with the KLOE assurance document.

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		• Maternity and Newborn Service Reconfiguration – Proposals to re-model Midwife Led Services have been endorsed by both Shropshire CCG and Telford and Wrekin Governing Bodies. A period of consultation is now being planned however we have been informed that we are required to follow NHS England's process and timeline for decision to consult, this will elongate the timeline that had been anticipated previously. Neonatal and Consultant led unit reviews have commenced. • Perinatal Mental Health – A funding bid is currently being finalised in preparation for the Wave 2 bidding opportunity for Perinatal Mental Health funding. We have also received confirmation from NHS England that we have been awarded £1,000 for the development of a West Midlands Perinatal Mental Health User forum group. • Digital Roadmap – an expression of interest has been submitted to NHS Digital to apply for funding to assist with the development of our Patient Electronic Records project.
4.2	Muscular Skeletal Services Updates to be provided by Sabrina Brown 12/02/2017 STP PMO Contact maggie.durrant@nhs.net	• The MSK Transformation Programme has made good progress from December through to January and the key highlights are as follows: **MSK Programme Board:** • A task and finish group is being put together to finalise the communications strategy for the MSK programme which will include patient education, engagement and clinical pathway information. The plan is to collate the information in readiness for the go live of the new CCG website in April. **SOOS:** • The redesign and expansion of the Shropshire Orthopaedic Outreach service (SOOS) went live on the 22nd January 2018 in Shrewsbury A formal start date for SOOS to operate in the South of the County has been agreed (for 19 March 2018) • SOOS patient flow is improving with plans to bring down to 4 weeks by March 2018 • The recruitment timeline remains on track and new staff have begun to arrive into the service which increases the available capacity • Spoke clinics across the county are being explored and links are been made with the STP health needs and estates work **MSK Triage** • Plans remain on track to mobilise full MSK triage from April 2018 in line with the requirements of the mandated elective care high impact intervention **Physiotherapy** • Demand and capacity exercise of the current provision of physiotherapy services in Shropshire is due by early March. **MSK Value Based Commissioning:** • The updated value based commissioning policy was approved at the January Clinical Commissioning Committee to reflect the latest MSK guidance and evidence.
4.3	Urgent Emergency Care Updates to be provided by Claire Old via A&E Delivery Group 16/02/2018	The **High Impact Changes** agreed at the A&E Board are: • Workforce (agreed that our group would feed into the STP group to avoid duplication). – Dawn Clarke • Frailty – Fran beck • ED Systems and processes – Sara Biffen & Nigel Lee

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		• Stranded patients – Edwin Borman • SAFER as standard (including Red2Green) – Deidre Fowler • Capacity and demand review – Julie Davies • Developing the integrated discharge team – Local Authorities As part of the above, the highest priorities are Stranded patients including getting patients home for lunch. An executive lead will take the lead accountability for each of the above workstreams and report to the A&E Delivery Board (some of these are identified above). The delivery will be through task and finish groups.
4.4	Future Fit / Sustainable Services Programme Updates provided by Phil Evans Last update provided by Pam Schreier 16/02/2018 STP PMO Contact pam.schreier1@nhs.net	• All information has been provided to NHSE and no further requests for additional information are expected. • Conversations continue between SaTH, NHSI and the Treasury regarding capital funding ahead of approval to proceed. • All public facing consultation documents and the PCBC has been signed off in draft and await NHSE approval. • Public facing consultation materials and the website continue to be developed and all necessary translations into Welsh being progressed. • The consultation plan and event planner are being developed with public facing, deliberative and third party events being added as information becomes available. Early drafts of this were shared for feedback with the Joint HOSC. • A Future Fit Communications and Engagement Stakeholder Reference Group has been formed and met for the first time. Members took away a number of actions including reviewing the stakeholder matrix, the development website, marketing materials and venues for pop-up events • We have written to all voluntary and community sector organisations across Shropshire, Telford & Wrekin and mid Wales to ask for their support during the consultation and to let us know of any meetings and events we can attend • The Future Fit team are continuing to update community groups with the latest progress on Future Fit at a number of meetings including Shropshire Disability Network and the Church Stretton Healthy Lives meeting. •
5.0	**Programme Delivery – Enablement of Transformation**	

5.1	Digital Enablement Group
	Last updated by Rob Gray
	12/12/17
	
	STP PMO Contact
	robgray@nhs.net
		• Office 365 tenant created.
		• STP team members account setup. Guidelines created and sent to get all team members connected and sharing content. STP Team sharepoint site
		• Work done to structure the information from the STP groups, starting with collation of key structures. This has so far highlighted:
		  ○ 39 organisations involved with the STP (9 core orgs)
		  ○ 32 groups (not including task & finish workstreams)
		  ○ 124 people across the 5 groups analysed so far.
		  ○ The list of programmes are growing, each will have a definition of purpose and benefits. Each one will also have a list of projects approved to advance one or more programmes. Where funds are required, these projects & programmes will be used to create bid requests.
		  ○ We have started creating a list of bids, and a list of funding items made available. We should learn lessons from successful bids.
		• New Bids.

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		○ We have added a bid for the development of a process to discharge electronically to social care. £280k shared between SATH and the 2 councils running Liquid Logic systems. • Group progress **DEG** ○ Programme definitions being populated. ○ Measurement of current status Universal Capabilities in progress. **Design Authority (DA)** ○ EoL system specification on hold until EoL group completes and agrees their strategy. They will than assist DA in creating the process specification. **Clinical Professional Reference (GPRG)** ○ Workshop scheduled end of February to define requirements for related projects, the **Information Governance** ○ data sharing gateway project in progress. Pilot agreement between GPs and Shropdoc used to prove usefulness. Key risks: · lack of project managers offered by contributing organisations. · Lack of attendance at group meetings
5.2	Strategic Workforce Group Last updated by Sara Edwards 05/02/17 STP PMO Contact Sara.edwards3@nhs.net	**Strategic Workforce Group** • SaTH have agreed to employ the first cohort of apprentices to enable the Agile Workforce Programme to continue at pace. We are receiving some extra support from HEE with this to feed into the national programme. Ongoing. • First iteration of **Mental Health Plan** submitted. Meeting held with stakeholders agreeing strategy for March submission. Programme is in place to address submission requirements with STP PMO co-ordination of information and stakeholder input to produce the next stage of the Plan. • Many requests for plans are coming through with Cancer Plans next on the horizon. Workforce Group discussing strategy for completing these requests on next agenda along with a plan to produce a system wide baseline by March 18. • There is a need to revise TOR for the Strategic Workforce Group. • STP System Wide Workforce Strategy- collaboration of STP organisations with agreement to share workforce plans/strategies as an initial step to gather existing information and data whilst waiting for guidelines for submission. STP PMO to co-ordinate. **System Organisational Development workstream** • **Transformational Change through System Leadership** application was successful. NHSE are supporting a Team to enhance our neighbourhood Programmes of work. Participants include STP PMO, ShropCom, SCCG, T&WCCG Programme will include out of hospital care for Adults ○ The Kings Fund are supporting **STP system wide OD including System Leaders programme**. A full debrief from the 22nd Nov King's Fund session is now available. **Training & Development Workstream** Funding bids have been received by HEE and all allocations made in draft prior to final sign off in mid January. Final allocation is expected to be £522,600.

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		Discreet workforce modelling project Discussions to be held this month with Neighbourhoods Lead for T&W area regarding analysis and modelling for the Newport geographical area.
5.3	Strategic Estates Group Last updated by Becky Jones 07/02/18 STP PMO Contact maggie.durrant@nhs.net	• Baseline data validation has continued to provide the baseline information for the Workbook and asset mapping. • A great deal of work has gone into completing the Estates Workbook. The Workbook is a living document and as such can be regularly updated. It will therefore be a standing item at the LEF and work will continue to ensure it is up-to-date. The submission in March will have to be a 'current position' rather than a complete position. The importance of the workbook has increased over the last few weeks and there is now a requirement for a them to be reviewed by the Centre before being submitted. This is to ensure that the Workbook is providing enough information required to be able to support the STP in any future estate capital funding requests. The review will take place in March 2018 and, once any suggested comments made have been implemented, the Workbook can be submitted and must then be attached to all OBCs. • Close work continues with Shropshire Council on the asset mapping work and linkages being made with master planning team • Shropshire Community Needs Workshop planned for 27 February and a great deal of work has been put in to making this as productive and effective as possible • Telford & Wrekin Community Needs Workshop planned for 17 April and is starting to be brought together, learning lessons from the Shropshire Workshop • Data mapping progressing well and identifying ways to share data across health and Councils as well as wider public sector to enable programme of mapping to continue and opportunities to be identified • Presentation to Voluntary Sector Assembly on 16 Jan to ensure stakeholder engagement went extremely well and are now building up excellent links with voluntary sector colleagues to ensure the maximum • LEF Joint Chairs, Amanda Alamanos (NHSE) and Tim Smith (Shropshire C) now in place • Strengthening links with other workstreams continues • Now have a Project Manager and project group in place for Whitchurch project following successful awarding of One Public Estate (OPE) funding. This is a huge step and has required a great deal of work with a number of partners and stakeholders to get to this position. This also is a clear step from strategy towards delivery, showing how the programme is moving forwards. This is a real step forwards **Key risks** Engagement is not being fully embraced which will impact upon the success of the programme
5.4	Strategic Back Office Updated provided by Ros Preen 07/02/17	Next update will be provided following the next meeting on 27th February A refocus is required for the new year, facilitated by; • The more substantive STP PMO support arrangements starting to have traction both directly for the group but also generally across the work streams, • The ability to review the refreshed health provider corporate service data which was submitted to NHS Improvement at the end of November and will enable further benchmarking to be undertaken, and

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		• A quick conversation with Midlands and Lancs CSU to explore their support model which is up and running in 4 STP footprints (meeting being scheduled for January) The group acknowledges the contributing/associated work going on in other enabling work streams, principally; • Workforce in relation to their focus on looking at options to support collaborative bank and recruitment processes (still in early stages), and • Integrating our 'public estate' through the Estates work stream. • It is anticipated that the Digital work stream could at some point bring into its remit a focus on the IM&T 'back office' which will require further support The Back Office working group will meet in January and will be looking for options in the rest of the 'back office' and to expand thinking around the Carter agenda/ model hospital etc taking into account all of the above.
5.5	Communication & Engagement Group Last updated by Pam Schreier 15/12/17 STP PMO Contact pam.schreier1@nhs.net	**At the workstream meeting on 15 February** • a six month refresh of the terms of reference and the risk register were circulated for comments. • an update was given by the STP Programme Director on the King's Fund activity and Future Fit resources • communications and engagement strategy is likely to be expected by NHS England by the end of March. The first draft is in development and clarification is being sought on FY18/19 communications and engagement budget allocation • NHS70 – Dave Burrows updated on the plans for the Fun Day to be hosted by SaTH. Individual organisations have been asked to support the day and the STP PMO will discuss its involvement at the next STP PMO team meeting **Future Fit update** • A Future Fit Communications and Engagement Stakeholder Reference Group has been formed and met for the first time. Members took away a number of actions including reviewing the stakeholder matrix, the development website, marketing materials and venues for pop-up events • We have written to all voluntary and community sector organisations across Shropshire, Telford & Wrekin and mid Wales to ask for their support during the consultation and to let us know of any meetings and events we can attend • The Future Fit team are continuing to update community groups with the latest progress on Future Fit at a number of meetings including Shropshire Disability Network and the Church Stretton Healthy Lives meeting.
5.6	STP "System" Finance Group Last update 16/02/2018 STP PMO Contact Paul.gilmore1@nhs.net	• ToR reference now updated to reflect system wide working • Work has commenced on establishing a working document detailing system financial position • System Financial Risk register has been established • Links with STP Work streams has been established to support system financial understanding, particularly, Estates & LMS • Work has commenced on drafting NHSE Finance system plans

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5.7	STP Clinical Design Group Last updated by Paul Gilmore ?/02/18 STP PMO Contact Jo.harding1@nhs.net	• Agreed to review TORs in light of STP focus rather than just FF • Agreed view from the group that the group needs to evolve to become and STP Clinical Design Group with wider representation from Clinical Leads with clear tasks to support delivery of system transformation. • Focus needs to be on system wide pathway development
6.0	**Cross Cutting Work Programmes of work**	
6.1	GP5YFV Nicky Wilde Last updated 16/01/2018 STP PMO Contact Sara.edwards3@nhs.net	Following assurance of the Primary Care Workforce Plan by the NHSE Assurance Panel in November 2017, further detail has been requested, by the end of January 2018, on trajectories for both GP recruitment and non-doctor clinician recruitment. There is also a requirement to refresh the plan to reflect these trajectories by the middle of February 2018. The two CCGs have established a Workforce Working Group to ensure that these deadlines are met. The Group will be working with GPs and Practice Managers over the coming months to develop a more medium-term approach to developing the Primary Care workforce. This needs to involve better integration with the wider STP approach to workforce as well as linking with the emerging Neighbourhood Working models being developed by both CCGs.
6.2	Mental Health Collen Manhuwa Frances Sutherland STP PMO Contact Sara.edwards3@nhs.net Andrea.webster5@nhs.net	• Mental Health Workforce Planning submission is required fully worked up by end of March 18 • First meeting of this group took place on 9th Jan where system wide representation attended to contribute to the development of this plan • Clinical lead identified as Cathy Riley from SSSFT • Programme is in place to address submission requirements with STP PMO co-ordination of information and stakeholder input to produce the next stage of the Plan.
6.3	Transforming Care Programme Manager Di Beasley	• Initial meeting is planned for 20th Feb to understand the programme
6.4	Frailty Updates to be provided by Michael Bennet (1&2) Emma Pyrah (3&4) 05/01/18 Gemma McIver STP PMO Contact Andrea.webster5@nhs.net	5 Work streams within the Frailty Programme of work Wider end to end Frailty Programme Board reinstated – first meeting scheduled 21.12.17 (Programme Exec lead Fran Beck) **Workstream 1 - Prevention & Primary Care** • CSU developed Frailty tool to support electronic Frailty Index (eFI) completion and risk stratification of frail patients • Frailty risk stratification being piloted within identified neighbourhood to target support to high risk patients • *My Health Record* (Frailty card) being developed to capture baseline information of patients. Plan to pilot in specific care homes when agreed **Workstream 2 - Crisis / admission avoidance** • Review of Intermediate Care Team pathways and processes to support admission avoidance. T&W ICT includes BRC and Carers Support Worker

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		• Addition capacity of teams via iBCF monies • T&W commissioned Care Home MDT to deliver training, skill development, clinical assessment and admission avoidance from care homes • T&W ICT daily attendance in ED to support admission avoidance **Workstream 3 - Flow through acute hospital** • Phase 2 of the Frailty Front Door at RSH operational service relaunch on 13th November 2017 supported by the Acute Frailty Network. Phased increase from 10am-2pm to 9am-5pm Mon-Fri during November as workforce comes on stream. • Memorandum of Understanding agreed at A&E Delivery Board setting out all key stakeholder partners commitments and responsibilities in phase 2 of this project from November 17 – March 2018 and an additional pump priming funding. • Data recording and reporting schedule agreed and formal reporting to the project group to commence from 6.12.17. • PDSA programme and timeline to be agreed by 13.12.17. • Weekly frailty leads meeting refocused to concentrate on Frailty Front Door (project lead Emma Pyrah). Patient rep joined the group on 1.12.17. • Progress on SaTH2Home and other interventions to improve flow reported directly to A&E Delivery Group **Workstream 4 – Discharge to Assess** • Fact Finding Assessment (FFA) and process refreshed and updated documentation implemented. • D2A reset session held with stakeholder partners in November 2017 to revisit the original D2A principles from 2015 and confirm they remain fit for purpose. Revised set of underpinning principles and processes to be signed off at the next meeting 29.12.17. • Shropshire Council have commissioned an additional 20 pathway 3 beds (interim placements for patients requiring complex assessments) which increases capacity for discharge and the ability to identify patient's potential for rehabilitation/enablement. • Shropcom are working with Shropshire LA to introduce from December a trusted assessor role for care homes, supported by SPIC. • T&W re-commissioned domiciliary care for P1 discharges • Detailed action plan against the LGA 8 High Impact Changes in development. Concern expressed that the system does not have a formal reporting mechanism for progress on this when it is a mandated requirement which is reported on through NHSE and BCF formal routes. To be discussed at A&E Delivery Group. • D2A Task & Finish Group continues to meet monthly **Workstream 5- End of Life** Priority area is to develop RESPECT
6.5	End of Life	The **whole systems EoL** group has now nominated a new chair Dr Derek Willis (Professor and Palliative Care Consultant at Severn Hospice) he will

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	Update provided by Cath Molineux 06/02/2017 STP PMO Contact Andrea.webster5@nhs.net	take over from Paul Cronin (CEO) and chair the next group in April. Some further discussions are needed to clarify who this group reports to. A subgroup from this group has developed a draft whole systems strategy in the form of a strategy on a page linked to the national agenda of 6 ambitions document. Further work has started on the action plan from the whole systems strategy document. The aim is for this to go to the frailty board in April. **The RESPECT** implementation subgroup has identified that to implement this effectively across all organisations a project management approach is required. This is transformational work as it embeds the concept of 'planning ahead' and will have potential impact in reducing the demand on acute services and unnecessary high cost interventions. SCHT within the scope of their strategy are exploring the role of the volunteers in eol care in a community setting, linking with the compassionate communities concept. The principles of the concept is, no one should die alone. The service will provide companionship in the last days and hours of life. This is in early stages of model development. The aim is to test a prototype in the neighbour hood locality(Newport) and one Community hospital when the model has been developed. This will require support from the CCG'S and STP. **'Ensuring our services provide high quality care that is affordable and sustainable' (Shropshire STP)** The SCHT Palliative and EOL Strategy for adults 2017-2020 is not about trying harder and doing better for the last few days of life but by doing things differently further upstream. This approach needs to be taken across the whole system, in the pathways for people with long term conditions/co-morbidities/cancer and also integrated into the neighbourhood team approach. Systems and practitioners need to work upstream with all patients with any type of long term condition/co-morbidities, so treatment options and decisions have been previously discussed and mapped out. Actual care will be appropriate to preferred care options, already discussed and planned ahead for and reduce very significantly the number of inappropriate high cost interventions being delivered and the number attending A/E because treatment options will be managed proactively and less reactively. Upstream working is recognising as early as possible in any disease trajectory when a person is in at least in the last 12 months of life. This approach reduces the current position where there is a crisis in the last few days and weeks of life and that person will end up in hospital. The STP already sets out the demographics depicting the rise in our older population, those with Long Term conditions and increase in single households and the unsustainability of the current and future demand. **Data is required to quantify this; for example:** • Those attending AE and the nature of emergency admissions and interventions costed and used inappropriately; • The types and numbers of high cost LTC interventions where the patient dies within a certain time limit when other care and treatment options could have been used. • Those being admitted 3 times a year or more(particularly those patients with severe frailty). What are expected outcomes as result of implementing this approach: • Improved patient/family/carer/partner experience

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		• Appropriate use of interventions for all LTC/Cancer/Co-morbidities-disease trajectories • Care and treatment options are planned ahead • Increase in number of people who have an advance care plan reflecting their wishes and preferences including where they want to die. • Reduce demand on the acute sector • Having upstream/planning ahead conversations as an intervention-seen as a positive, with symptom management and still get a quality of life What happens if we don't do upstream working? Paying for inappropriate care- wasting limited resources. When appropriate for treatments to continue or when to stop. Making most of restrictive resources. Demand on acute services continues to rise. **Current Situation** • Shropshire does have a system EoL Group but does not yet have an Eol Strategy for Shropshire. • The EoL group has been working on smaller issues that arise ie discharge meds for patients coming home from SaTH etc etc. • The Community Trust have a strategy and the hospice are just refreshing theirs, it is recognised that a wider system strategy joining together the priorities from each organisation is required. A small group met and developed a list of strategic objectives from the two existing strategies and the Ambitions for Palliative and end of life care (2015/20) to provide local direction for 3-5 years. These are: • To ensure equal access to palliative and end of life care. o Systems to identify patients for referral o Access Criteria o Processes for referral o Referral documents o Frailty • Ensure access is based on need not condition. o Establish a needs based model that identifies phase of illness and a system for prioritization o Links with non-cancer specialists • Establish systems of prognostication to identifying patients in the last year of life. o GSF register o Frailty register o Important conversations • Establish the concept of 'Living Well' o Documentation supports / directs the professional to identify patients' preferences/goals for living o Culture of care is enablement o Programs for palliative rehabilitation are established • Further develop homecare models to support a preference to be cared for and die at home o Hospice to continue to develop the H@H service o H@H is placed on a sustainable financial footing o Integration of H@H with the Hospice Outreach Service • Ensure a competent workforce o Identify education needs across services o Robust systems for appraisal and CPD across groups o Establish education programs

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		• Establish systems that support advanced and anticipatory care planning and timely access to services.
		  ○ Identify key worker
		  ○ Consider joint documentation (patent held?)
		• Work in partnership to ensure that care is coordinated between services.
		  ○ Commissioning
		  ○ Services compliment not replicate each other
		  ○ There is shared documentation where possible (RESPECT, EOL care plan, PPC)
		• Consider compassionate communities voluntary support as an extension to services
		  ○ Severn Hospice continued roll out of coco
		  ○ Volunteering is seen as an arm to wider services
		  ○ Clinical services refer to established volunteer support

Key (based on STP PMO system intelligence)

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