System Operational Plan
Shropshire, Telford & Wrekin STP

April 2019

Board Version of submitted STP Plan

T&W Health & Wellbeing Board 6th June 2019

Our system plan has input from the following System Partners as well as wider stakeholders

NHS Shropshire Clinical Commissioning Group

NHS Telford and Wrekin Clinical Commissioning Group

NHS Shropshire Community Health NHS Trust

NHS Midlands Partnership NHS Foundation Trust
A Keele University Teaching Trust

healthwatch Telford and Wrekin

NHS Health Education England

Telford & Wrekin Council

healthwatch Shropshire

NHS The Shrewsbury and Telford Hospital NHS Trust

NHS The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

NHS West Midlands Ambulance Service University NHS Foundation Trust

Shropshire Council

Contents

Foreword by: Sir Neil McKay, Shropshire, Telford & Wrekin STP Independent Chair

This 19/20 system operating Plan forms the first year of our refreshed STP LTP due in the autumn 2019.

The Shropshire, Telford & Wrekin STP have worked collaboratively to bring single organisational operating plans from all system partners, including **Local Authority** plans in to an aligned narrative description that captures the following:

- System Priorities& Deliverables
- System understanding of activity assumptions
- System understanding of capacity planning
- System understanding of strategic workforce planning
- System Financial understanding and agreed approach to risk management
- Understanding of efficiencies and our collective responsibility to deliver those.

In order to develop from an STP to an **Integrated Care System**, we are required to structure and manage ourselves differently going forward.

Our system will make better use of our collective data to inform the initial **Bronze Data Packs** and later in the year the **Population Health & Prevention Dashboard**, both designed to improve our system business intelligence, understanding and planning for improved outcomes.

As part of our LTP refresh, our system will be revisiting our ambitions and the expected outcomes for our population served. In conjunction with our local authority colleagues, we will focus on developing **Place Based Integrated Care**, ensuring quality services are supporting health and wellbeing, whilst improving health inequalities.

Details of these will be available in our LTP later this year.

- **System leadership capacity & capability** across all organisations is fundamental to our success and we will be completing two key programmes to support our strategic development in this area:
  - **System Commissioning Capability Programme**
  - **System ICS Development Programme**
- Transformation across all that we do to achieve ICS status by 2021/2022 is our goal. Our focus will be on system delivery and enablement to achieve high quality outcomes for our population whilst making best use of our collective system resources in order to get best value for every £ spent.
- System financial recovery is inherent in all our ambitions and plans and we are implementing a structure to support delivery of efficiencies.
- The Long Term Plan refresh is our opportunity to work as a system, to meet our challenges of a growing elderly population with increasingly complex needs. Our system expertise (health, social care & wider stakeholders) will come together via our system **Clinical Strategy Group** that will in turn inform our **System Programme Delivery Group,** this will be the engine room of our system transformation.
- This plan has the support and sign-off through all our system partners via **System Leadership Group** and corresponding individual organisational governance processes.
- Finally, this plan demonstrates how we will improve performance, quality, integrated place based working and financial recovery through 19/20.

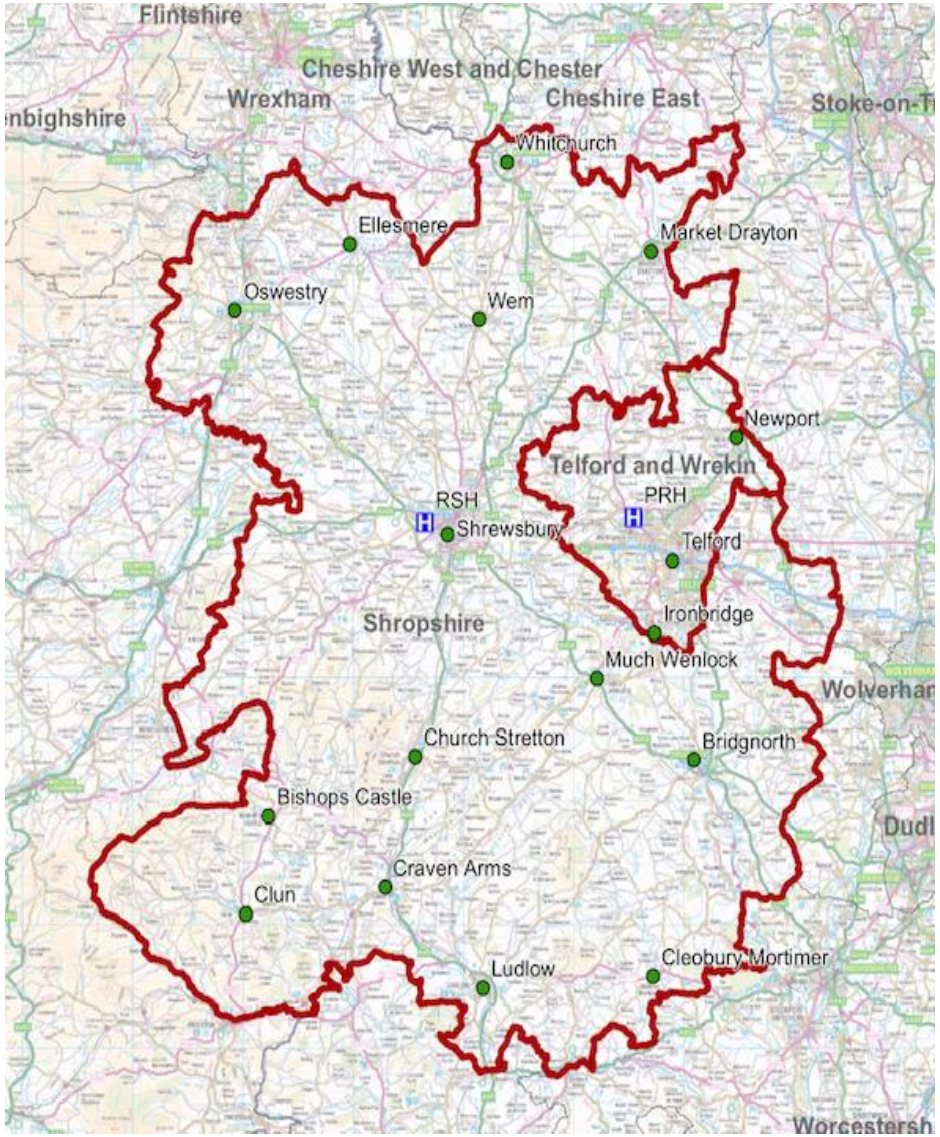
Sir Neil McKay, Independent Chair

Shropshire, Telford & Wrekin STP

2.
Context, Challenges, & ICS Development

Shropshire, Telford & Wrekin STP local context

- Shropshire, Telford & Wrekin STP can be characterised as a good place to live and work, with a good sense of community and volunteering, and the population we serve recognised as diverse, with challenges set by our geography and demography.
- Shropshire is a mostly rural county with 35% of the population living in villages, hamlets and dispersed dwellings; a relatively affluent county masks pockets of deprivation, growing food poverty, and rural isolation. Telford & Wrekin is predominantly urban with more than a quarter living in the 20% most deprived nationally and some living in the most deprived areas.
- The STP sits between some of the largest conurbations in the country (Birmingham to the South, Manchester and Merseyside to the North), as well as sharing its western border with Wales.
- The STP footprint is served by one acute provider (Shrewsbury & Telford Hospital NHST), one specialist provider (The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS FT) , one community health provider (Shropshire Community Health NHST) and one mental health provider (Midlands Partnership FT) The ambulance provider is West Midlands Ambulance Service FT.
- There are two CCGs across the footprint; Telford & Wrekin CCG has a large, younger urban population (173k) with some rural areas and is ranked amongst the 30% most deprived populations in England. Shropshire CCG (308k) covers a large rural population with problems of physical isolation and low population density and has a mix of rural and urban ageing populations.
- There are two corresponding local authorities in the footprint; Telford & Wrekin Council, and Shropshire Council
- There are two A&E sites within 28 minutes drive time of each other (Royal Shrewsbury Hospital and Princess Royal Hospital), both with growing volumes of attendances, regularly seeing 400-430 attendances across both sites each day.
- Residents of parts of the footprint will have reasonably long drive times to access acute services.
- The nearest major trauma centre is at Stoke on Trent (UHNM), in the neighbouring Staffordshire footprint.
- There are some high prevalence rates of mental health conditions identified in Shropshire, T&W; there is one mental health provider with a full coverage of services available within the footprint. In addition to minimum Tier 3 and 4 inpatient wards, specialist beds and Tier 4 secure/forensic services are provided.
- Shropshire/T&W has a good relationship with care providers facilitated by Shropshire Partners in Care (SPIC)



System Challenges

One of the significant challenges facing our system is the cultural shift required to move from overly medical care models to ones that align with the principles of prevention, self-help and early intervention. This applies equally to mental and physical health care, as does ensuring parity between physical and mental health care. Another challenge we face is that the system has struggled to make the cultural adjustment needed toward integrated working; this has been exacerbated by insufficient access to a substantive workforce which has impacted on quality, performance and finances. There are also reducing budgets in the care sector and complex political relationships across the system.

Demographics & geography:

- Ageing population: in the Shropshire Council area, 23% of the population is 65 years and over compared to the England average of 17.6% . T&W Council area has a greater number than average of young people but a rapidly growing older population.
- A largely rural Shropshire in contrast with a relatively urban T&W provides challenges to developing consistent, sustainable services with equity of access.
- Shropshire, T&W STP area can be described as a low wage economy; consequently the wider determinants of health including education, access to employment and housing are significant issues to consider when developing services that support good physical and mental health.

Operational performance

- A&E: workforce constraints with consultant and middle tier medical and nursing staff vacancies at SaTH have affected performance, with year to date 4-hour performance at 75.87%
- Cancer: the system is failing to deliver consistently against key cancer standards in all specialties due to challenges with staffing combined with high numbers of referrals

Financial position – the system is facing in year financial pressures:

- At the time of writing this plan, there remains a material gap from the collective Control Total of £21m deficit , driven largely by financial challenges within Shropshire CCG and Shrewsbury and Telford Hospitals Trust. This represents a deficit across the system of £48.6m, with a risk to delivery of £23.2m.
- The two local authorities have been required to make significant savings over recent years, compounded by significant rising costs in delivering social care for both children and adults.

Workforce

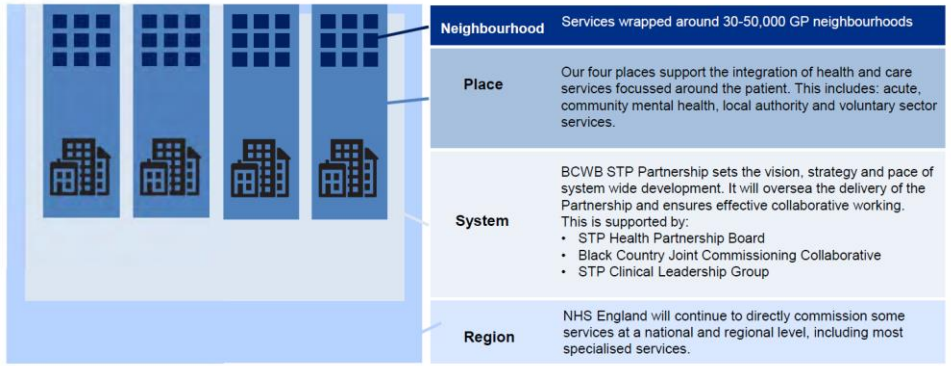
- All providers (including the social care and domiciliary sector) report issues recruiting qualified staff due in large part to the geography and demography of the area.

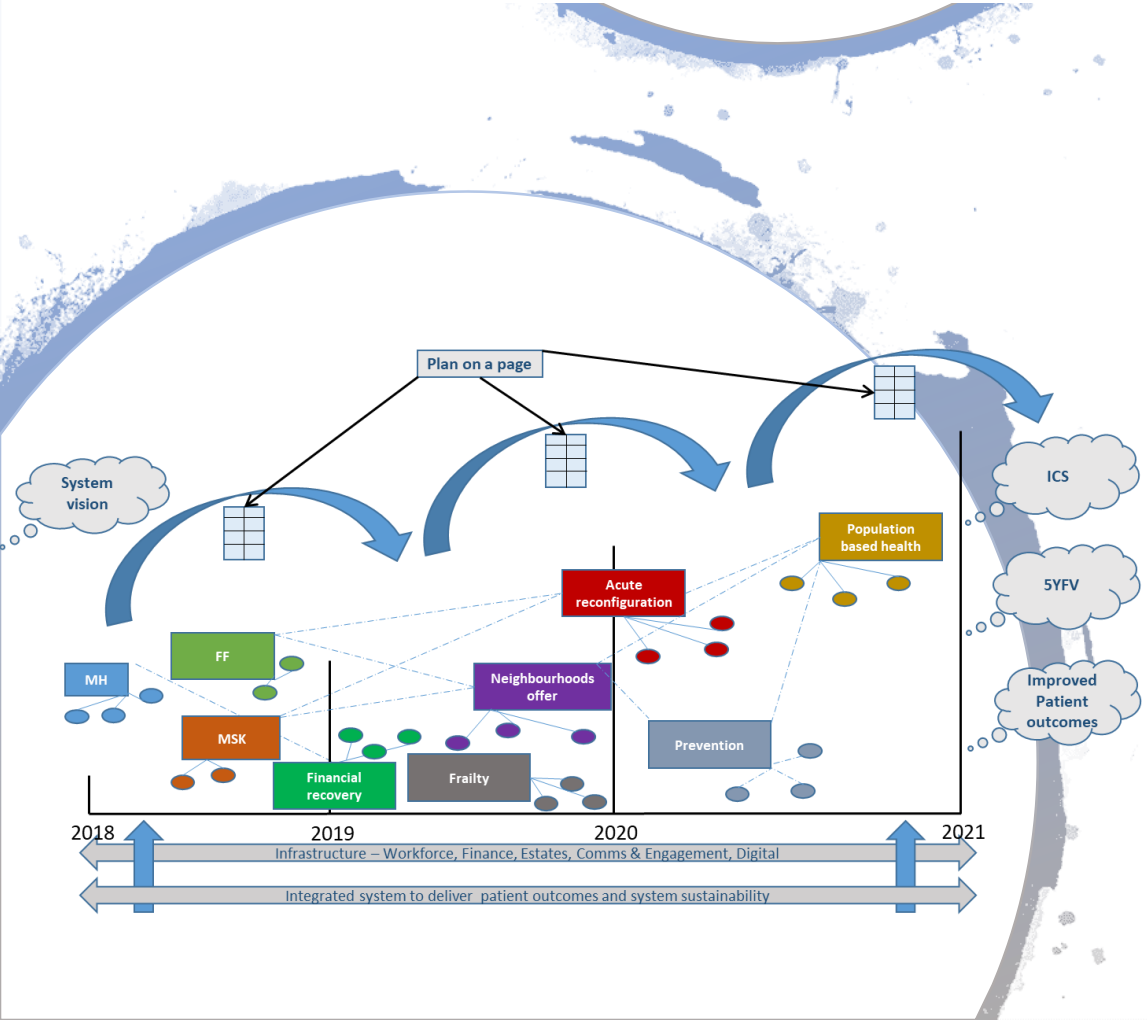
Quality

- Shrewsbury and Telford Hospital NHS Trust has recently been rated ‘inadequate’ by CQC and is in ‘special measures’, due to quality and leadership. The Trust is involved in an ongoing independent review into neonatal and maternal deaths.
- Shropshire Community Health NHS Trust is rated as ‘requires improvement’. The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is rated as good.
- 88% of care homes in Shropshire are rated good by CQC, as is the mental health care provided by MPFT (Midland Partnership NHS Foundation Trust)
- Healthwatch Shropshire and T&W both work to support and identify areas for quality improvement in our STP Footprint

Reconfiguration

- Public consultation on acute services reconfiguration (‘Future Fit’) completed; Final Decision Making Business Case approved by Joint Programme Board January 2019. Implementation over the next 5 years, subject to NHSI approval.
- Closer joint working between the two CCGs, exploring the options to move to a Single Strategic Commissioner. Interim Accountable Officer appointment for Shropshire County CCG commenced April 2019, following retirement of the incumbent.
- Midwifery-Led Units case for change just completed NHS England strategic sense check ahead of proposed reconfiguration consultation





Development towards an Integrated Care System

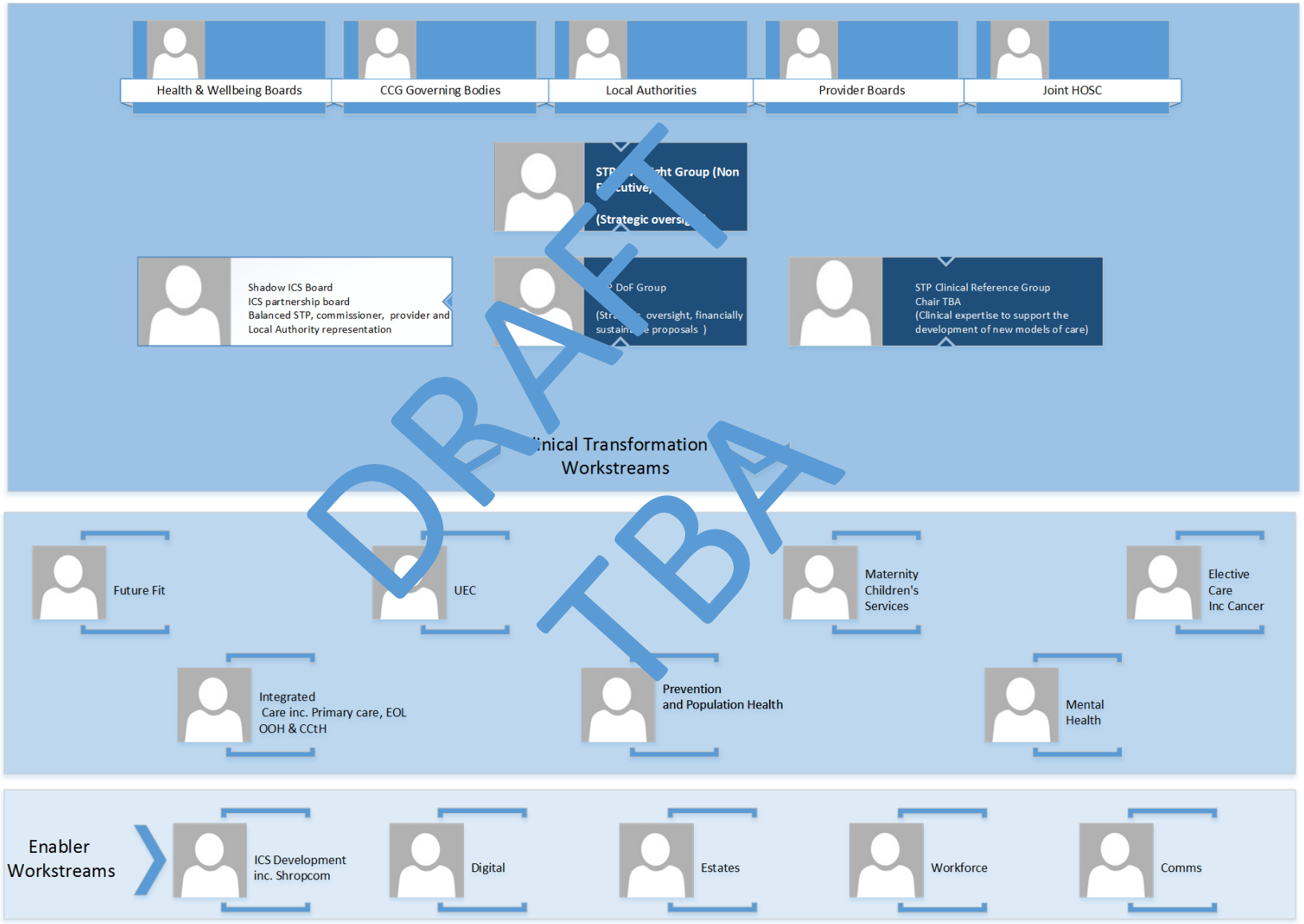
- **STP System Leadership** are progressing towards an Integrated Care System with aligned strategic thinking and delivery.
  - Shadow ICS board currently being developed
- **Renewed Governance and leadership**
  - STP governance refresh (in progress)
- **Commissioning Capability Programme**
  - Development of strategic commissioning and wider partner engagement to shape together
  - Strengthening the profile of mental health across the system
- **Integrated Care Development Programme**
  - Integrated Care System Development (ICSD) - A programme to develop long term behaviors and capabilities to progress the development of local ICS architecture.
  - Commissioning in our 'ICS System' commissioning arrangements to support our wider objectives in order to transform the quality of care delivery and improve health and wellbeing for our population.
    - Functions of the CCGs
    - Services the CCG provide
    - Teams are in the CCG and what are their areas of expertise
    - Merging STP/CCG resources where possible
- Understanding the optimal level/scale at which to commission and where greater efficiencies can be sought.
- **National Delivery Unit Data pack (Bronze Packs)** - a standard data analytical pack produced from national data sources provided to system to identify system opportunities that will contribute towards financial sustainability and improved health and wellbeing outcomes.

3.
System Structure, Governance & Performance

Future governance

- The current STP governance is a partnership between all current organisations in the system. Partners are prioritising the 2 key work programmes:-
    1. System Commissioning Capability Programme
    2. System ICS Development Programme
- We are also committed to working across the system on our **Integrated Place Based Care Programme**
- During 2019/20 we will design new system structures, including a ICS Strategic Commissioner and Place Based Alliances and the governance will evolve.
- The benefits will be:-
    - System efficiencies
    - System focus on Health AND Social Care
    - One strategic commissioner organisation able to drive improvements in performance and quality of care consistently to meet NHS constitutional and key Local Authority targets
    - Stronger local (place) arrangements to deliver care closer to home, as per Future Fit and individuals aspirations/wishes
    - Local synergy with other initiatives including development of Primary Care Networks, Population Health Management and wider prevention.

Refreshed System Governance (to be agreed)



The refreshed governance structure is currently being developed at the System Leadership Group (SLG) this will ensure a streamlined approach to our system transformation programmes this includes -

- Agreed standardised principles for each transformation workstream
    - Strategic oversight for all programmes
    - Specific Terms of Reference and membership for each workstream
    - CEO/AO lead for each programme
    - Dedicated Programme Management
    - Contributes to the LTP
    - Contributes to the implementation of the delivery plans
    - Each programme will have a clinical presence
- Quarterly Transformation checkpoint sessions
- Monthly Operational plan delivery meetings
- Quarterly Chair oversight meetings
- Monthly ICS Shadow board meetings to review and support each programme

Operational Plan Delivery Group

Governance

Delivery of the agreed Operational Plan will require robust integrated working across the whole system. To facilitate this the SLG have agreed an **Operational Plan Delivery Group**, which will be chaired by the STP Sustainability & Transformation Director and include senior Operational, Finance and Clinical representatives from each partner organisation.

This Group will:

- Monitor delivery against key milestones and performance targets
- Provide system support to collectively identify and implement mitigations required to ensure delivery of agreed plans
- Ensure balance of operational, financial and quality performance is maintained across the whole system

Implementation of this Group has been agreed in principle by SLG. We are progressing development with the support of nationally available programmes and resources.

Commissioning Capability

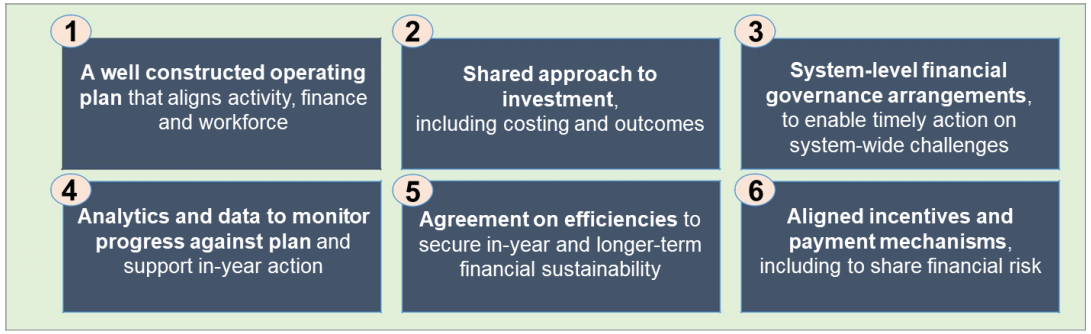
The system is currently considering the WSOA data pack (Bronze Pack) through the **System Commissioning Capability Programme** that includes health and local authority colleagues. Through this programme we are developing the skills and competencies that underpin the implementation of the **MCFR Framework.** This should position commissioners to fully support transition to the ICS.

Expected outcomes:

- All system efficiencies to be considered and actioned as agreed with system partners
- All efficiencies to be included in system financial position
- All risks to delivery to be identified and mitigated with system partners
- Population Health & Prevention Dashboard to be delivered later this year (expected Autumn 2019)

Managing Collective Financial Resources

- The Managing Collective Financial Resources (MCFR) framework has been developed to support systems to effectively manage their collective resources.
- The MCFR framework identifies six key activities that are critical to managing financial resources collectively. The framework is supported by a resource library of tools and case studies which will be updated regularly.



In addition to the six areas of system activity two additional factors have been identified as particularly important to whole system financial management.

These **factors** are:

- Implementation capacity and capability
- System leadership and culture

Shropshire and Telford & Wrekin STP Diagnostic: System Opportunity Overview – Bronze Pack

Key System Drivers / Summary Hypotheses

1 *Out of Hospital Care*

Lower social care and CHC spend, higher avoidable admissions and delayed discharged, with longer LoS for the elderly

The percentage of the **STP's population aged 60-79 (22%) is higher than the England average** (18%) and the growth rate for this segment is 6%, also higher than average (2%). **The percentage of population aged 80+ (6.2%), is higher than the average** (5%) and sees a growth rate of 2.4% against an average of 2.4% 2016.

The STP **spend on social care needs is c.£6m lower** than the national average (spend per head rate). **CHC spend is c.£0.2m higher** than the national average per 50,000 population at a STP level, **however c.£1.2m lower per 50,000 for Telford and Wrekin** CCG (2017/18).

Potentially **avoidable attendances at A&E referred from elsewhere in the system are c.45% higher compared to peers**, corresponding to a potential opportunity of 5,038 attendances compared to the best 5 peers (2016/17 Q4 - 2017/18 Q3).

Non-elective admissions per 1,000 are c.7-14% higher compared to the 5 best peers, a potential opportunity of 5,360 admissions. **Non-elective bed days are c.12% higher** for Shropshire CCG compared to peers, a potential opportunity of 19,043 bed days (17/18).

The **proportion of patients discharged to their usual place of residence is c.7% lower** compared to peers for Shropshire CCG, a potential opportunity of 758 discharges (2016/17 Q4 - 2017/18 Q3).

The **proportion of continuing healthcare eligibility decisions made within 28 days of the initial referral is below the England average** for both CCGs and lower compared to peers - a potential opportunity of 216 decisions compared to the 5 best peers (2017/18).

There has been a **decrease in the percentage of people in Telford & Wrekin (over 65) still at home 91 days after discharge** from hospital between 16/17 (71%) and 17/18 (62%).

2 *MSK*

Higher spend on MSK, widespread risk factors, higher prevalence and number of bed days/LoS

MSK is the second highest area of spend for the STP, c.£50m. Spend is c.£10m higher than the national average rate (2017/18).

Elective spend for MSK is higher compared to peers, a difference of £8.5m. c.87% of this spend (c.£7.4m) relates to Shropshire CCG (2017/18).

The STP **prevalence of obesity (18+), 10.8% is higher than the England average** (9.8%) (2017/18). The **percentage of physically inactive adults in Telford (30.3%) is higher than the England average** 22.2% (16/17).

21.5% of the STP population reports a long term MSK problem, higher than the England average of 18.5% (2018).

Shropshire CCG has a **higher number of bed days for MSK compared to peers**, a difference of 3,517 bed days (2017/18).

Shropshire CCG has a **higher number of MSK long stay patients (21+ days) compared to peers**, a difference of 17 patients (17/18).

For Robert Jones and Agnes Hunt Hospital elderly medicine the **% of day cases to all elective activity in elderly medicine is 31%**, below peer median (56%); **median LoS for elective admissions is 2 days**, below peer median (3) (Aug 18).

The **median length of stay for emergency admissions (elderly medicine) was higher than the peer median** (6 days) for Robert Jones and Agnus Hunt NHS Trust (9 days) (Aug 2018).

The **percentage of total STP elective MSK services sent to the independent sector, 9.6% is below the national average** (21.7%). There is geographical variation with **Telford & Wrekin sending a higher percentage than the average (25.7%) and Shropshire a lower percentage than the average (2.3%)** (17/18).

3 *Prevention and Detection*

Lower rates of detection, higher non-elective spend on circulation and respiratory services

Circulation and respiratory are the third and fourth highest expenditure areas in the STP (c.£84m in total). c.£3.5m more is spent on circulation and c£3m more on respiratory compared to national average rate (2017/18).

Non-elective spend on circulation and respiratory is higher compared to peers, c.£2.5m and c.£3.4m respectively (17/18).

Compared to peers, there is a potential opportunity to detect more patients with hypertension (5,640), coronary heart disease (3,128) and chronic obstructive pulmonary disease (2,279) (2016/17).

There are **opportunities compared to peers to improve circulation quality and outcome indicators** including the % of hypertension patients with BP >150/90 (2,686) (2016/17).

There are **opportunities compared to peers to improve across respiratory quality and outcome indicators including the uptake of over 65s receiving the PPV vaccine** (2,605 patients) (2016/17).

Compared to all local authorities, **Telford (123/149) is in the bottom quartile for tobacco control** (smoking prevalence and smoking status at time of delivery) and **Shropshire (103/149) is ranked "worse than average"** (2016/17).
Shropshire Council is 145th and Telford & Wrekin Council 96th out of 149 LAs for drug treatment summary (2016/17).

The number of **bed days is higher compared to peers for respiratory (6,170 days) and circulation (1,900)**. The number of **long stay patients (21 day +) for Telford CCG is higher compared to peers for respiratory** (27) (17/18).

Respiratory mortality is higher for Shropshire CCG compared to peers, with a potential opportunity of 43 patients (2012-14).

Using system data to drive system change - Bronze Pack

- **Mental health** c.£59m, c.£15m less than the 17/18 national average (spend per head rate).
  - The dementia prevalence (Shropshire CCG) 1.09% is in the highest quartile (16/17).
  - The dementia diagnosis rate for Telford CCG, 65.9% is lower than the national average (67.8%) (Aug 2018)
- **MSK** c.£50m, c.£10m more than the national average.
  - Fracture, hip and thigh, 3rd highest admission from care home
  - The percentage of STP population reporting a long term MSK problem, 21.5% is higher than the England average (18.5%) (2018).
  - The STP prevalence of obesity (18+), 10.8% is higher than the England average (9.8%) (2017/18).
- **Circulation** c.£42m, c.£3.5m more than the national average.
  - £0.73m opportunity for respiratory primary care prescribing (2017/18).
  - Non-elective spend on circulation and respiratory is higher compared to peers, a difference of c.£2.5m and c.£3.4m respectively (17/18).
  - The number of bed days is higher compared to peers for respiratory (6,170 days) and circulation (1,900) (17/18).
- **Respiratory** c.£40m, c.£3m more than the national average.
- **Gastrointestinal** c.£35m, c.£1m less than the national average.

There is lower spend for social care needs (c.£6m) and maternity and reproductive health (c.£3m) compared to the national average rate.

Public health indicators key highlights:

- **Healthy Life Expectancy in T&W significantly lower than Shropshire and lower than the national average**
- **Smoking at tine of delivery higher than national average Shropshire and T&W**
- **Obesity – adults higher than national average for both Shropshire and T&W, Children – higher than national average at reception (Shropshire), yr 6 T&W**
- **Prevalence of diagnosed hypertension all ages Shropshire higher than national average, T&W similar**
- **Alcohol harm T&W higher than national average**

CCG/Area	No. of GPs (WTE)		GPs per 10,000 Pop (HC)		% GPs over 55		% GPs over 65	
	Sept 15	Sept 18	Sept 15	Sept 18	Sept 15	Sept 18	Sept 15	Sept 18
Shropshire	194	202	8.0	8.5	21%	20%	0.5%	1.5%
Telford & Wrekin	103	101	5.9	6.4	17%	18%	0.5%	2%
North Midlands DCO	2,583	2,372	7.0	7.5	17%	18%	3%	3%

Area	Indicator	England	Shrop CCG	T&W CCG
Elderly pop %	% aged 60-79	18%	24%	19%
	% aged 80+	4.9%	6%	4%
Growth rate of Elderly pop	Annual growth pop 60-79	1%	2%	2%
	Annual growth 80+	2%	3%	3%

Using system data to drive system change - Performance

	Shropshire CCG					T&W CCG				
	Sep-18	Oct-18	Nov-18	Dec-18	Jan-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-18
RTT 18 Weks	91.46%	92.20%	92.17%	91.4%		91.10%	92.30%	91.97%	91.96%	
Number of 52 Week Waits	2	0	2	4		1	0	1	2	
Diagnostic Test Waiting Times	99.3%	99.0%	99.4%	99.1%		99.7%	99.3%	99.4%	99.5%	
A&E 4Hr -LHE all types	75.47%	75.71%	72.99%	70.61%	72.85%	75.47%	75.71%	72.99%	70.61%	72.85%
Cancer 2 Week Waits	86.7%	82.15%	84.5%	88.7%		89.17%	81.55%	85.40%	91.05%	
Cancer 2 Week Waits Breast	79.8%	35.6%	55.6%	87.7%		86.36%	36.67%	59.60%	91.11%	
Cancer 31 Day Waits All Cancers	99.4%	99.5%	98.4%	96.5%		97.8%	100.0%	97.5%	98.5%	
Cancer 62 Day Waits Urgent GP Ref	81.1%	73.0%	82.7%	84.7%		86.7%	75.0%	80.0%	90.9%	
MRSA	0	1	0	0	0	0	1	1	0	0
CDIF	4	4	4	2	2	3	1	0	4	1
E coli bacteraemia	21	36	25	19	15	9	13	7	14	9
Dementia Diagnosis Rate	70.5%	70.2%	70.2%	69.5%	69.8%	65.7%	66.3%	66.6%	66.3%	65.6%
DToC - SaTH	1.32%	1.78%	1.37%	1.52%		1.32%	1.78%	1.37%	1.52%	
EIP	66.7%	50.0%	100%	100%		100%	66.6%	100%	n/a	
IAPT Access	1.1%	1.5%	1.4%	1.2%	1.4%	1.8%	2.0%	1.7%	1.4%	2.0%
IAPT Recovery	57.6%	52.6%	50.2%	59.6%	53.7%	59.8%	57.9%	59.7%	60.6%	61.0%

4.
System Ambition & Priorities

System Leadership statement – agreed April 2019
(to be further refined and built upon as part of LTP refresh)

"The ambition of Shropshire, Telford & Wrekin STP is to deliver joined-up, transformed health and care services for local people. Our focus for the next 5 years will be to work with primary and community care, hospital services, social care, independent providers and the voluntary and community sector to deliver services at a place level; ensuring that local needs are understood and addressed with people being cared for and able to access services and support as close to where they live as possible"

To achieve this :
We will deliver our transformation in partnership across our organisations, working with our staff, engaging our population, and by setting good policy and outcomes frameworks.
Do all we can to listen to and understand the needs of our communities and staff.
Work together, utilising all our collective resources, to provide quality services and support.
Use data, evidence and insight to underpin decision making at every level

Shropshire, Telford & Wrekin, Priorities, Linked to the Long Term Plan

Programmes and Priorities:

Population health and wellbeing

- Working across health, care and the VCSE, to proactively support people to improve and maintain their health & wellbeing

Integrated Community Services

- Boosting 'out-of-hospital' care and dissolving the divide between commissioning and providing as well as primary and community health services
- Integrated working (physical, mental health and social care) working and primary care models; implementing multi-disciplinary neighbourhood care teams
- Ensuring all community services are safe, accessible and provide the most appropriate care.

Acute & Specialist Hospital Services

Redesigning and delivering urgent and emergency care, creating two vibrant 'centres of excellence'

- Delivering high quality, safe services
- Transforming and digitizing

Cancer	Outpatient care
Maternity and Paediatrics	MSK
Stroke/ Cardiology	ENT
Ophthalmology	Respiratory
Mental Health	Elective Care

Enabled by:

Strong **partnership working** across health, care, public, private and voluntary and community sector

Making the best use of **technology** to avoid people having to travel large distances where possible

Communicating with and involving local people in shaping their health and care services for the future

Supporting the **workforce** to be a highly responsive, happy, confident and capable workforce that provides excellent quality services, in the right place with the right skills, ensuring the workforce engages with local opportunities for the future

Improving and making more efficient our **back office** functions

Making better use of our **public estate**

Outcomes:

- Improved healthy life expectancy
- Improved system efficiencies
- Increased partnership working across all delivery & enablement programmes
- Living independently at home for longer

Measured by:

Quarterly Checkpoint review meetings

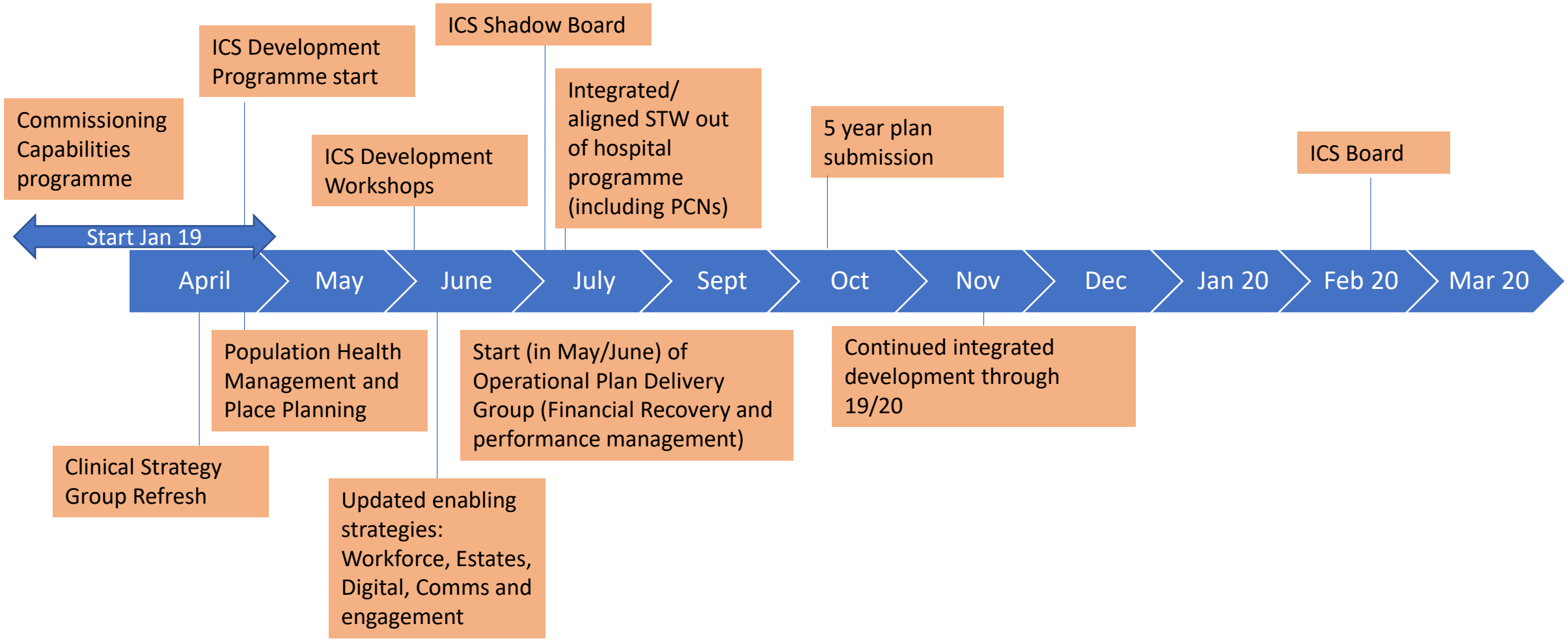
- Bronze pack/ right care
- Public Health Outcomes Framework
- Delivery Programmes
- Enablement Programmes

Governed by : *(proposed)*

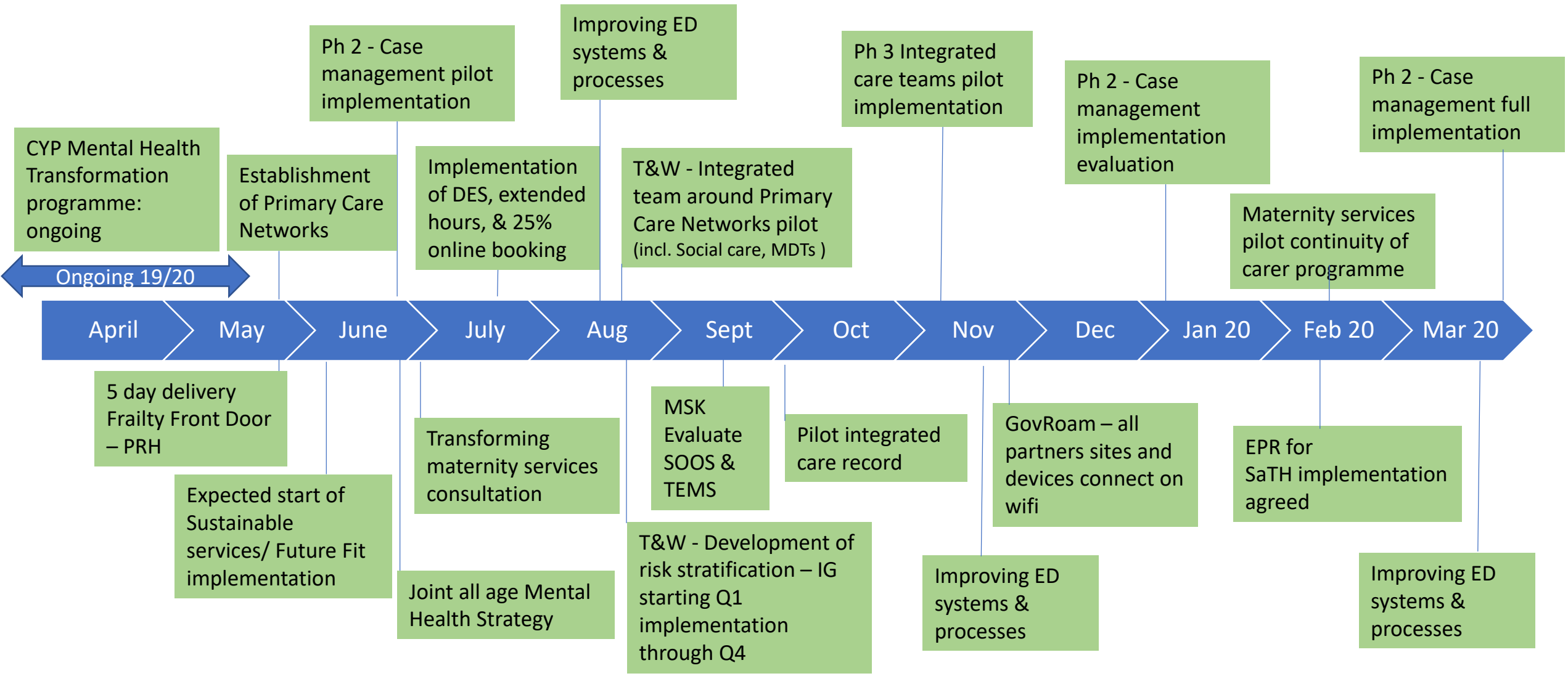
System ICS Shadow Partnership Board

- Shropshire CCG
- T&W CCG
- Shrewsbury & Telford Hospital
- Shropshire Community Health Trust
- Robert Jones and Agnes Hunt
- Midlands Partnership Foundation Trust
- Shropshire Council
- Telford and Wrekin Council

System development and governance 19/20; key highlights



System implementation timeline; key highlights



System approach to Quality

The system has a shared approach including:

- Individual Safety
- Individual & Patient Experience
- Effectiveness
- Well- Led
- Sustainability
- Equitable for all

Our Drivers for Quality include:

- Francis Report
- Berwick Report
- National Quality Board
- NHS Outcomes Framework
- Care Quality Commission Essential Standards
- NHS Assurance Framework
- CCG's Improvement & Assessment Framework
- NHS 10 Year Plan
- ASC outcomes framework
- Public Health Outcomes Framework

How we are working together as a system

- Shropshire LA and T&W LA address quality across commissioned services through contract monitoring in conjunction with CQC and Healthwatch
- Shropshire CCG and T&W CCG quality teams working together to address quality across commissioned services to further increase effectiveness, integration and alignment is being planned
- Quality leads are aligned to each provider contract linked with performance, contracting and finance leads with 'buddying' arrangements in place across the two CCG quality teams
- The quality and safety of provided services is assured through quality schedules, commissioning for quality and innovation indicators (CQUIN), monitoring of the quality impact of cost improvement schemes and site visits of major providers.
- Quality exception reports are received and discussed monthly at Board.
- Quality dashboards are monitored with named quality leads aligned
- Quality leads are aligned to each QIPP and finance leads.
- Service development programme linked with performance, contracting and a programme of site visits is in place

As a system we are committed to working together to:

- Improve the issues facing quality, safety and patient experience management
- Operationalise the local quality and assurance framework across all providers
- Drive actions required to address concerns on the quality risk register
- Drive the Enhanced health in Care Homes framework
- Complete Equality, Quality Impact Assessments at the start of commissioning and decommissioning processes.
- Review Root Cause Analysis of Serious Incidents and Never Events to ensure learning is shared across all agencies to drive forward service improvements and patient safety
- Escalate quality concerns and reports to Board, QSG, NHSE and NHSI as required
- Develop a robust Quality Strategy with clearly identified priorities and that takes into account the full system, health and care
- Use all available resources including Right Care Opportunities to deliver improved quality by removing unwarranted variation and improving outcomes at a population health level

Aspiration - Creating outstanding quality by:

- Culture change within our organisations to work in an integrated way, reducing medical models of care when appropriate, and supporting people in their community, delivering the best possible care and support for our population (inclusive of Social Care, Dom Care and Private Providers)
- New dynamic that strengthens communities and individuals ability to self-care
- Patients are at the centre – to sustain and improve primary care, including strengthening integrated multi-disciplinary working ensuring people stay at home
- Streamlined care, robust pathways – to ensure we commission sufficient capacity for planned care and improve patient experience of appointments
- Support people in crisis with the right care at the right place – to make sure people can navigate a simplified urgent care system to meet both physical and mental health needs
- Aspiration that all providers to reach outstanding levels of care for our communities

System Quality Focus

Approach to improving quality at SaTH

Delivering against our Must Do actions from the CQC inspection – specific focus on ITU, ED, Maternity
Improving ambulance handover time in ED
Reducing Corridor Care in ED
Improving Ambulatory care to reduce unnecessary admissions
Improving frailty pathways
Improving discharge to reduce unnecessary Length of stay and reduce further patients that stay in hospital over 7 and 21 days
Maintaining Day Surgery capacity throughout the year in order to reduce waits for surgery
Improving workforce numbers through international recruitment for nursing and medical staff
Improving staff experience and well being through delivery of the OD plan

Seven steps to improve quality

These seven steps set out what all of us need to do together to maintain and improve the quality of care that people experience. We have strong foundations to build on – not least, the impressive improvements in care quality we have seen in many areas in recent years – but there is also much more for all of us to do if we are to close the care and quality gap.

1. **Setting clear direction and priorities** based on evidence.
2. **Bringing clarity to quality,** setting standards for what high-quality care looks like across all health and care settings.
3. **Measuring and publishing quality,** harnessing information to improve care quality through performance and quality reporting systems.
4. **Recognising and rewarding quality.**
5. **Maintaining and safeguarding quality.**
6. **Building capability,** by improving leadership, management, professional and institutional culture, skills and behaviours to assure quality and sustain improvement.
7. **Staying ahead,** by developing research, innovation and planning to provide progressive, high-quality care.

Note: Health Foundation A Clear Road Ahead (2016) developed this modified version of the NHS Quality Framework.

Workforce

- Key challenges:
  - Staff retention and recruitment
  - **Cultural challenges within existing organisations and staff groups resistant to change; preparing a workforce with no boundaries across organisations**
  - **Cultural change to support out of hospital working**
  - **Cultural change to embed prevention, self-care utilisation and health coaching**
  - Reducing dependency of bank and temporary staffing
- Key priority areas-
  - Recruitment and retention, education, training and staff development
  - Leadership, culture and organisational development
  - Workforce information, planning and intelligence

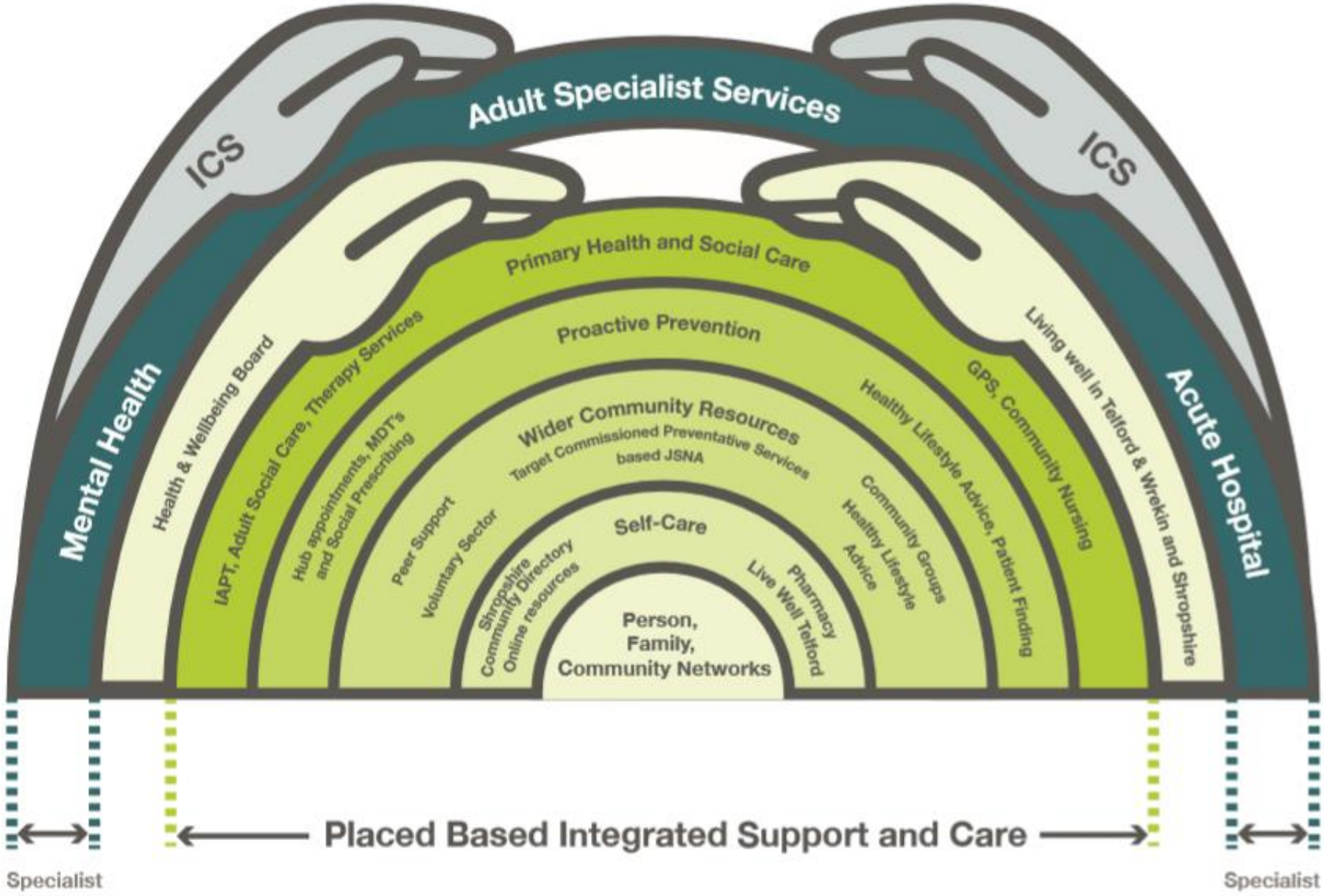
STW Process to improve quality

5.
Delivery Programmes

DRAFT - Vision of STW Integrated Support and Care Approach

As a STP we are developing a visual representation of how we are working in an place based integrated way; working in collaboration across organisations and with our communities.

This diagram is a draft of our joint vision that will be further developed for the 5 year plan.



Population health and prevention

Priorities:

1. Develop system architecture for population health, including a robust understanding of need through business intelligence and the JSNA
2. Working with the regional support offer to develop capacity and capability across Shropshire
3. Support improved working for prevention across all organisations; in particular
    - Embedding prevention through transformational work programmes, in particular Primary care and Community services
    - Develop our wider workforce in behaviour change and motivational interviewing
    - Proactively identify people at risk of ill health and behaviour change conversations, brief interventions
    - Prevent harm due to alcohol, obesity, CVD and poor mental health
    - Support culture change and new working practices that help people at the earliest opportunity
    - Support active signposting and develop a good understanding of how communities support people – linking to Social Prescribing
    - Work across organisations (including the VCSE) to prioritise support for key population groups – address inequity and inequalities by connecting with the national and regional population health management support mechanisms

Deliverables:

- Working with the regional support offer, deliver a prototype using the population health management approach to improving care
- Deliver system data repository, JSNA development and reporting processes
- Support for place based working with the local authorities (connected to primary care and community transformation);
- Deliver Stop smoking services for patients, expectant mothers, long term users of specialist mental health services and learning disabilities;
- Implement social prescribing, targeting CVD and weight loss services to people who need it most;
- Deliver greater uptake of the National Diabetes Prevention Programme;
- Ensuring children have the best start in life including access to mental health and early help support;
- Establish alcohol care teams in hospital and community

Primary care

Priorities:

1. Developing Primary Care Networks and New Models of Care (including the development of Care Closer to Home and Neighbourhood working)
2. Prevention and addressing Health Inequalities
3. Care Quality and Improvement
4. Improving Access to Primary Care – 7 days a week
5. Ensuring a workforce fit for the future
6. Improvements to technology and digital enablers
7. Ensuring high quality estate
8. Optimising workflow and addressing workload pressures in Primary Care
9. Ensuring quality and efficiency in prescribing

Deliverables:

- 100% coverage of Primary Care Networks by July 2019 including delivery of the extended hours Directed Enhanced Service
- Increase uptake of physical health checks and dementia diagnosis rates
- Meet the 7 core standard required in the extended access enhanced service including direct booking via 111
- Improvements to technology, digital enablers
- Deliver retention and recruitment programmes to secure a primary care workforce fit for the future including the enhancement of the primary care training hub
- Meet the required additional clinicians programme as outlined in the Long Term Plan .e.g social prescribing link workers and clinical pharmacists
- Deliver the requirements of use of technology e.g. 25% of appointments available online by July 2019, electronic repeat prescribing, implementation of the NHS App
- Completion of primary care estates review and full alignment with One Public Estate programme
- Delivery of the 10 high impact changes to support workflow optimisation
- Reduction in antimicrobial resistance and medication errors. Increase use of generic medicines and prescribe according to best practice

Out of hospital integrated care (including personalised health budgets and social prescribing)

Priorities:

- Developing a joint out of hospital integrated services that support the diverse population we serve; working collaboratively with Community Services, Acute Care, Primary Care, Social Care, Preventative services, and the VCS; this includes:
    - Integrated Place Programme (T&W)
    - Care Closer to Home (Shrops)
        - Phase 1 – Frailty at the Front Door (hospital service approach), Shropshire in progress, T&W in planning , delivery estimated June 2019
        - Phase 2 – Case management through demonstrator sites - Shropshire , June 2019
        - Phase 3 – Community services including admissions avoidance and delayed transfers, Autumn 2019
- Using data to drive the development of services (including case management and prevention services)
- Delivering admission avoidance , in reach and facilitated early discharge
- Developing joint personal health budgets governance and delivery with the Local Authorities
- Develop joint processes and commissioning for CHC (health and care)
- Connect social prescribing with out of hospital and primary care transformation programmes (Care Closer to Home and Neighbourhoods), and the Better Care Fund prevention strands and voluntary sector grants and contracts

Deliverables:

- Supporting the development of resilient communities, prevention and early help in conjunction with all partners
- Upscaling 'Frailty at the Front Door' to implement in PRH (already delivering in PRH)
- In collaboration with system partners, development and delivery integrated care models, including:
    1. Risk Stratification and case management
    2. Rapid Response
    3. Intermediate care/ hospital at home
    4. Care home support (including Care Home Advanced, Trusted Assessors, Care Home MDT)
    5. Social Prescribing and prevention services
- Implement an aligned programme across T&W and Shropshire
- Implement a robust system and governance for personal health budgets
- Implement new practices for jointly delivering CHC with local authority partners
- Progression of models of Social Prescribing by joining with out of hospital with additional funding, in connection with primary care and the local authorities
- Connect with data and infrastructure developments as part of Population Health Management programme

MSK Transformation Programme

Priorities:

- Ensure the model, priorities and resources relating to the vision and objectives for the MSK transformation programme
- Ensure there is strong patient and public engagement in the MSK Transformation programme
- Ensuring that an over-arching Communications and Engagement Strategy is in place and that key messages are circulated to partner organisations following each meeting.
- Ensure changes to the MSK services in Shropshire are based on clinical evidence and best practice (national and international)
- Monitor the impact of the transformation programme including unintended consequences/dis-benefits, and agree on an appropriate strategic response
- Ensure effective coordination of the planning and commissioning of services and operational delivery with a robust supporting infrastructure
- Engage with GP Clinical Directors, Academic Health Science Networks, inviting their representatives to attend Board meetings, as appropriate.
- Engage with clinical/operational teams to ensure all staff are aware of the strategy and their input required
- Review MSK services within community and secondary care;
- Transforming operational processes and developing a single service model for the whole MSK pathway, using the results of the review and the First Contact Practitioner pilot evaluation;
- Delivering referral targets;
- Delivering quality and financially sustainable services.

Deliverables:

- Establish STP MSK Programme Board
- Assess current delivery of services including TEMS (evaluation of SOOS completed with a provider review planned in the next 6 months)
- Assess resources for delivery – alignment of existing CCG and provider resource following the receipt of an agreed gap analysis
- Review current delivery board membership to ensure that the appropriate level of decision making can take place
- Scope of services to be determined within the agreed resource envelope
- Impact analysis throughout of implementation/changes
- Demand and capacity assessment of existing providers
- Development of a strategy to possibly consider the option to move to one integrated MSK provider
- Consider and support where necessary the reconfiguration and transformation programme to ensure the sustainability of services
- Review GIRFT outputs, Right Care and data sources to support changes/redesign
- Development of an agreed delivery outcome frameworks
- Completed MSK review;
- New single service model for MSK that integrates with community and secondary care;
- Continue to monitor progress and quality

Local Maternity System

Priorities:

- Improve Safety
  - Stillbirths and neonatal reduction
  - Reduction in brain injury
- Improve Choice and personalisation
  - enabling all women to have a personalised care plan and choice in the care they receive
- Increase midwife led births
  - increase the number of women giving births in a Midwife led unit
- Increasing investment in perinatal mental health
- Develop continuity of carer

Deliverables:

- Develop and progress the Midwife Led Unit Review
- Develop and implement pilot for continuity of carer programme
- Fully implement improvements in safety including Saving babies lives care bundle
- Deliver improvements in choice about maternity care, including by developing personalised care plans
- Implementing the neonatal quality improvement programme
- Develop workforce plan to improve core staffing with clear governance and reporting
- Developing a culture of learning and improvement

LMS Progress against KLOE 19 March 2019

Number of births				Key Lines of Enquiry																									
				Stillbirths and neonatal deaths					Intrapartum brain injuries					Key Lines of Enquiry								Key Lines of Enquiry							
														Number of personalised care plans				Number of women able to choose from three places of birth				Number of women receiving continuity of carer during pregnancy, birth and postnatally				Number of women giving birth in midwifery settings			
2015 baseline	2018/19	2019/20	2020/21	2015 baseline (and data source)	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021	Change in rate 2015 - 2020	Local baseline	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021	Change in rate 2015 - 2020	Local baseline	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021	Local baseline	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021	Local baseline	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021	Local baseline	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021
4887	4851	4827	4824	30	23	22	20		11	9	8	7		0	0	4827	4824	4887	4851	4827	4824	0	970	1,496	2,460	708	825	965	1,206
				6.15/1000	4.8/1000	4.5/1000 (	4.2/1000		2.2/1000	1.8/1000	1.7/1000	1.5/1000		0%	0%	100%	100%	100%	100%	100%	100%	0%	20%	31%	51%	14%	17%	20%	25%

A&E performance and trajectory- 19/20 – Top Three Priorities:

1. Workforce

Options being enacted to mitigate the challenges

- Frailty at the front door at PRH
- Protect Streaming workforce
- Plans in notes and clinical criteria for discharge
- Achieve Pre-12 discharge potential on all wards
- Achieve further reductions in length of stay by:
  - Discharging patients requiring IV therapy to community slots
  - Achieving the potential in PRH stranded patient reduction
- CDU capacity created in Head and Neck theatres at RSH from the 8th of April to release bed capacity in acute medicine.
- Space Utilisation prioritisation
- Workforce models to support the current workforce challenges

2. Acute Care /Frailty Model

Options being enacted to mitigate the challenges-

- Achieve Acute Medicine and Ambulatory care potential (project group facilitated by ECIST commenced 14th March). This will require additional acute medical workforce.
- Recruitment of doctors from India and nurses from Southern Ireland
- Approval of workforce business cases for ED staffing and Acute Medicine staffing.
- Transfer of stroke neuro-rehabilitation to the community and further development of early supported discharge(Whole system approach)
- Development of cardiology SDEC /heart failure/respiratory acute (from 6 A's audit).
- Development of cardiology direct access service (from 6 A's audit).
- Development of ambulatory and 72 hour frailty service across both sites (requires workforce).
- Development of a 24 hour CDU model (requires workforce)

3. ED systems and processes

Urgent & Emergency Care

The ambition for Urgent & Emergency Care is to:
Provide enhanced system-wide urgent and emergency care that ensures our patients are cared for in the most appropriate setting by skilled workforce able to meet their needs, develop services that are based on best practice, demand and capacity analysis and the needs of our local population with an overarching ambition to support all patients Home First.

Prioritise:	Improve care:	Improve Experience:
1. ED Systems and Processes	We aim to implement standardised best practice, enhance our workforce and appropriate capacity to improve emergency care provision resulting in improved patient outcomes and satisfaction, appropriate staffing, capacity and improved recruitment and retention of skilled staff to meet the needs of our patients.	• Improved system working • Improved access to clinically appropriate services • Reduced ambulance handover time • Reduce ambulance conveyance • Reduced attendances and inappropriate admissions • Increased number of patients being treated in SDEC • Improved identification and management of frail older adults • Increased home first • Improved patient outcomes • Reduced mortality and morbidity • Improved patient and carer satisfaction • Improved team working and staff morale • Meet the A&E 4 hour quality standard to avoid waiting.
2. Frailty	We aim to have a fully functioning Frailty Front Door Service for 5 days a week at both sites by May 2019. We aim to extend this service to run 7 days a week by October 2019. We will work with the STP Out of Hospital Group to co-design a whole system frailty pathway and service model.	
3. Ambulance	We aim to ensure that we maximise the opportunity to avoid conveyance to ED so that patients arriving by ambulance to ED are appropriate, and enjoy a seamless handover to ED without delay.	
4. Acute Medical, Short-stay and Same Day Emergency Care (SDEC)	We aim to develop and implement an enhanced Acute Medical, Short-Stay and Same Day Emergency Care (SDEC) model based on national best practice and needs of the local population.	
5. Care closer to home	We aim to enhance and embed 'Home First' services to enable all our clinically appropriate patients to be offered a home first solution that meets their needs.	
6. Discharge management	We aim to ensure that patients stay in hospital for the minimum time required to manage their presenting problem while avoiding the secondary harms arising from hospitalisation and ensuring as soon as they are safe to transfer they have the opportunity to be discharged to their usual place of residence and / or access to step-down services for re-ablement which maximises independence is required.	

Urgent & Emergency Care

Priorities: *continued from last year's high impact changes

- ED Systems and processes *
- Frailty at the front door *
- Ambulance Demand *
- Same Day Emergency Care/Acute Assessment/Short Stay
- Home First (Care closer to Home)
- Discharge Management

Enabling programmes:

- Demand and Capacity
- Improvement in Informatics

Deliverables:

- Successful recruitment to the workforce
- Improved patient outcomes
- Reduced mortality
- Reduced attendances and inappropriate admissions
- Improved staff morale
- Improved patient / carer satisfaction
- Improving access to Same Day Emergency Care (SDEC)
- Improvement and development of frailty at the front door programme
- Sustained improvement in the reduction in long stays
- Improving the data available and use effectively to inform clinical decision making and future priority planning
- Improve discharge planning from moment of admission to prevent deconditioning and ensure a timely, **home first** approach for as many patients as possible
- Improve ED systems and processes to ensure efficient and effective care for patients
- Identify and manage constraints identified throughout the patient journey to ensure timely and effective care
- Effectively match capacity and demand through the use of data and intelligence
- Better use data to avoid conveyance and ensure patients are treated in the right place in the first instance.
- Decreased deconditioning . Complications of hospitalisation will reduce
- Meet the 4 hour A&E Quality standard.

Cancer & Referral to Treatment

Cancer Priorities:

Ambition – fewer people to be diagnosed with preventable cancers; improve mortality rates and improve patient experience

Priorities:

- Deliver the Living with and Beyond Cancer;
- Deliver cancer services that are accessible, timely and sustainable;
- Workforce and capacity – testing new ways of system working that will deliver more timely care;
- Improve against performance targets;
- Explore opportunities for improving urological cancer through joint working across the system
- In conjunction with the Cancer Alliance implement best practice pathways in priority areas

Deliverables:

- Implement a holistic needs assessment and care plan
- Develop treatment summaries to guide patients and GPs post treatment
- Develop and deliver the living well offer – providing advice, support and signposting
- Deliver the cancer care review – between the GP (or nurse) and patient
- Deliver person centred follow – up tailored to the patients
- Develop joint working processes for urological cancer
- Develop a system wide cancer strategy
- Implement best practice pathways for Lung, Prostate, Colorectal and Upper GI

RTT Priorities:

- Streamlined care;
  - Outpatient activity
  - Cancer treatment
  - Musculoskeletal (MSK) services
  - Neurology
  - Local Maternity Services
- Robust pathways;
  - Achieving targets
    - 18 week referral targets – consultant lead treatment
    - 6 week diagnostic test target
    - 52 week treatment target
- Commission sufficient capacity;
- Improve patient experience of appointments and treatments;
  - Outpatient redesign

Deliverables:

- Monitor the acute trusts waiting list to ensure at the end of March 2020 does not exceed the waiting list at the end of March 2018
- Work with providers to develop a process for identifying patients exceeding 6 months on the waiting list and offering them an opportunity to move to an alternative provider
- Develop a process for identifying patients approaching 40 weeks on the waiting list to ensure no patient exceeds 52 weeks

Outpatient Redesign

- The CCGs plan to undertake a programme of work in relation to outpatients redesign. A task and finish group has been established with SaTH & RJAH to look at what changes can be made. The CCGs intend to use this task and finish group to undertake the following actions:
- Identify area where non face to face appointments can be implemented
- Explore areas where patient led follow ups can be implemented
- Develop process for identifying unnecessary frequent attenders (such as mental health) and implement mitigating actions for these patients
- Align diagnostics with appointments
- Use national outpatient improvement dashboard to improve clinic utilisation
- Use the learning from the IBD app project to roll out to other areas
- Identify technology opportunities in relation to outpatient appointments

Mental Health (Children and Adults) and Learning Disabilities & Autism

Priorities:
One of the key cultural challenges for mental health services is determining what mental health conditions should be treated in secondary services and what are treated within the community and primary care. Mental health services have been successful in moving from hospital/campus models of care to helping people recover in their own homes. We want to continue this through a choice of least restrictive environments and safe environments for short term interventions which the majority of people require. Equally, for those people who experience learning disabilities or autism, these long term conditions require access to both specialist and mainstream services where reasonable adjustments have been made to enable equality of access.
Our priorities are:

1. Ensuring a great start for children and young people and appropriate services for children and young people (CYP) when needed
2. Delivering person centred care, that takes into account mental and physical health
3. Creating open door access; understanding where people can get help, support, services they need (including prevention, primary care, community, online, vcs)
4. Ensuring Mental Health is integrated into neighbourhood models of care
5. Ensuring that carers are supported as an integral part of system planning, delivery and support
6. Ensuring a joined up, confident and appropriate workforce for the STP patch including prevention, support and evidence based care for people in the communities where they live.
7. Ensuring that people with learning disabilities and autism have access to the support and services they need
8. Creating time for front line practitioners to care

Deliverables:

- Improved mental health of children and young people through the delivery of the CYP transformation plan including:
  - Delivery of the CYP Transformation Plan
  - Improved Development of local SEND partnership arrangements
  - Review and joint work on complex care needs for children and adults
- Improved access to services and community support for people with emotional and mental health issues by:
  - Developing and implementing a system all age Mental Health Strategy and embedding mental health pathways into neighbourhood models of care
  - Strengthening out of hours crisis response and reduce admission where possible
  - Increasing investment and developing an integrated model of delivery to support STP priorities (e.g. physical health, IAPT), in communities
  - Realigning the existing workforce to support the development of preventative models, and transformed secondary care (including social care)
  - Strengthening relationships and integration with community services including primary care, local authority, charities, the third and voluntary sectors
  - Expansion of IAPT services in partnership with primary care and physical health services
  - Increased access rates to IPS, IAP, EIP
  - Trauma informed pathways for adults and CYP
- Reduced number of suicides and attempted suicides by implementing the suicide prevention strategy and action plan
- Improved outcomes for people with dementia by developing and implementing a Dementia Strategy including the delivery of newly developed dementia services.

End of Life

Priorities:

- Reducing the number of people dying in acute hospital
- Supporting Care Homes (competencies, skills, confidence)
- Supporting out of hospital programmes to include end of life pathways, training and support
- Partnership working with all partners including hospices and the wider the voluntary and community sector

Deliverables:

Recommended Summary Plan for Emergency Care and Treatment (Respect)

- Implementation of the national ReSPECT model of care led by the STP End of Life Programme through partnership working
- Workforce support through the development and implementation of an education programme to deliver ReSPECT training and resources for the system utilising a train the trainer model including all system partners
- This will ensure a standardised and consistent process of transition and adoption of ReSPECT
- EOLC and Swan Scheme education programmes developed and delivered across system partners supported by the End of Life Care Handbook
- EOLC Volunteers trained at SaTH and Shropshire Community Health NHS Trust (looking to scale across the social care workforce)
- System-wide access to Sage and Thyme training including communication tools and techniques for all partners acute, community, hospices, council and domiciliary care.

Contribution of carers

The contribution 'carers' of all ages make to society cannot be underestimated. Locally, we acknowledge and value what carers provide day to day and the impact this has on their own lives. We believe that supporting carers is everyone's responsibility and important in the considerations of all our strategic planning and service delivery.

We must ensure:

- Carers are recognised through all of services
- Supported to maintain their caring role and to maintain their wellbeing
- Are able to contribute to service planning and individual care as appropriate

Voluntary and Community Sector

Working with the voluntary and community sector

In Shropshire and T&W voluntary, community and enterprise sector (VCSE) exists in abundance. The people of Shropshire recognise the role, importance and power of communities and the organisations that support our local areas to thrive. The role of services is to ensure that the VCSE is supported so that it can continue to thrive. When we work together, we can achieve great things. As a partnership we will continue to work with the VCSE, communities and people to support:

- **The development and delivery of services**
- **Commissioning**
- **Delivery of services in communities**
- **Understanding of population need**
- **Wider determinants of health**

6.
System Enablement

System strategic approach to Workforce

The system workforce objectives are:

- To ensure the planning, recruitment and development of an engaged, talented and compassionate workforce for the future system
- To develop a sustainable future workforce who are equipped to meet the needs of our communities

Our **STP People Strategy** sets out how local organisations delivering health and social care services plan to work better together to ensure the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place to deliver quality and sustainable services to members of the public.

- The Strategy identifies four key areas for collective working; 1) Attract, Recruit and Retain; Agile Workforce, 2) Workforce Planning and Modelling, 3) Learning through Education, Development and Training Opportunities and 4) Organisational Development and Leadership including Equality and Diversity. The Strategy is underpinned by principles of system-wide, cooperation and collaboration, improvement and innovation, integration and redesign.
- As a result of achieving the ambition outlined in our People Strategy, we hope to succeed in:
    - Realising the vision of the People Strategy and new models of care
    - Improving outcomes for service users, families and staff
    - Building a better understanding of system workforce
    - Optimising our system workforce
    - Supporting and enabling service improvement and redesign, especially across boundaries
- Since the publication of the NHS Long Term Plan work continues to ensure the People Strategy reflects the ambitions and intentions outlined in the plan e.g. digital workforce and the volunteer workforce are new areas of focus that will be included within the next iteration of the People Strategy which remains a live document.

Primary Care

- Significant improvement in the quality of workforce data and ability to set targets and trajectories, & appointment of Primary Care workforce leads
- Success in funding proposals for running retention programmes for GPs
- Success in attracting funding for new Clinical Pharmacists
- Introduction of the Physician Associate internship with four PAs to be placed in local practices
- Significant increase in engagement with GP trainees with plans for fellowships and post-qualification support
- Improved engagement with GP Nurses via established GP Nurse Educators/Facilitators and delivery of GP Nurse 10-point action plan
- Upskilling of primary care workforce in independent prescribing, spirometry, management of long-term conditions, physical assessment and mentorship

- **Mental Health**
- Realignment of the mental health workforce to support person-centred approach to neighbourhood working
- Training delivered across services around effective care planning/ care co-ordination
- Development of system-wide mental health workforce plan which led to the establishment of an STP Mental Health Delivery Group
- HEE investment to support delivery of the mental health workforce development plan by upskilling the workforce to achieve Five Year Forward View for mental health
- Health awareness and first aid training made available across the system including health, social care, domiciliary care, fire service, police, ambulance
- Targeted recruitment for Shropshire area, focussing on selling Shropshire as a lifestyle and good place to work
- Focus on developing a new pathway for 0-25 (CYP) mental health including a workforce model

Our Local Workforce Challenges:

Fragility of workforce for acute provider across medical, nursing and therapies
Recruitment challenges and high vacancy rates, related to factors such as national workforce shortages, varying terms and conditions, geographical rurality, levels of morale
Cultural challenges within organisations, with some staff groups or individuals resistant to change
Morale and retention of staff as a result of major change or retendering within the system
An ageing workforce and a reduced community of suitable people to seek to attract
An uncertain future supply of staff, with difficulty attracting students to some courses, placements and recruitment to jobs upon qualifying
Different expectations of the younger workforce, e.g. increased part-time and flexible working
The image of health and social care in the general population

System People Strategy

Shropshire, Telford & Wrekin LWAB People Strategy

STP Workforce Leaders and Groups

Attract, recruit, retain

Retention Strategy
Collaborative **Recruitment**
'Team STW'; Employment Offer and Branding
Health and Wellbeing of our people
Agile Workforce; integrated, rotational and new roles
Collaborative Bank
System-wide **People Development Plan**
Widening Participation

Planning & Modelling

System-wide **workforce profile** (baseline)
Service/pathway specific **workforce plans**
Longer term collective planning and **forecasting**
Supply improvement
Workforce **modelling** tools
Benchmarking

Education

Redesign roles and skills
EDT needs for system
Current **EDT offer**; gaps & duplication
Develop **'core' system EDT offer**
System-wide approach to **induction**
Standardise statutory and mandatory training (**skills passport**)
System-wide approach to **Preceptorship**

OD & Leadership

Leadership; shared leadership development approach
STW STP **leadership offer**
Managing **talented people**
Service / Quality **Improvement Methodology**
Culture and values
Equality and diversity

Our Values

system-wide engagement, involvement and leadership; working in co-operation with all our stakeholders; stimulating continuous improvement and innovation for high quality person-centred delivery; driving forwards prevention and the integration of health and social care to create a more holistic approach for our people and communities; and supporting the redesign of roles and skills

OUTCOMES

- Realise the vision
- Improved outcomes for service users, families and staff
- Better understanding of system workforce
- Ability to optimise system workforce
- Support and enable service improvement and redesign, especially across boundaries

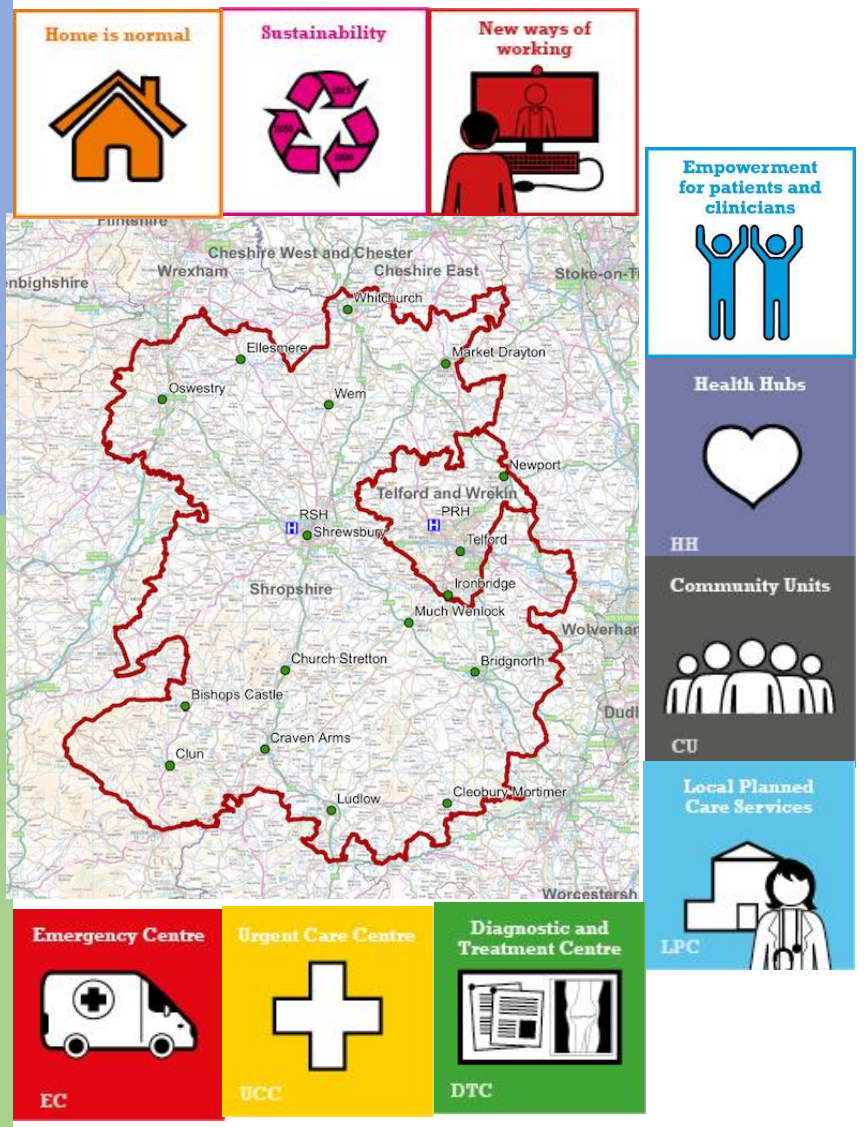
System Strategic Estates

Priorities:

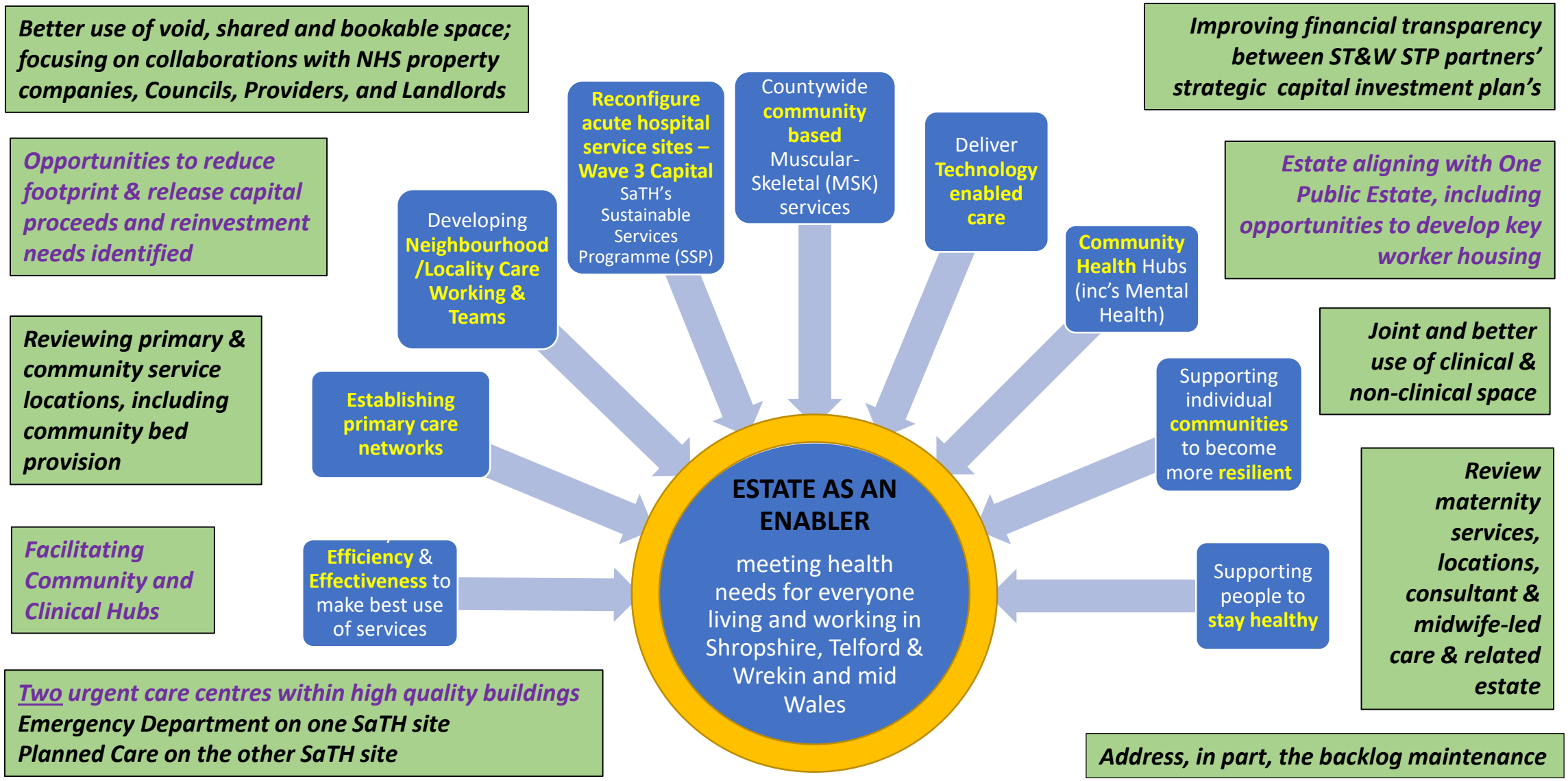
- Put people rather than buildings first, with population need at the heart of our estate focus
- Develop **'Place'** based integrated & co-ordinated healthcare estate, relevant to redesigned person, patient, service user and staff delivery pathways, embedded with decisions based on a wider system view; supported by hub solutions, backed up with One Public Estate philosophy, rather than organisational self-interest
- Ensure best system use of estate assets which are relevant, accessible, efficient, safe, fit for use & purpose
- Collaborate with system partners; examine & challenge organisational estate strategies and plans to identify all of the potential opportunities for improvement and rationalisation
- Support system delivery programmes leads in articulating & translating their system need into estate requirements
- Ensure capital plans & asset management align with clinical strategies
- Future proofing of GP services through closer working with Council planning teams to negate future planning problems down the line
- Establish a virtual STP estates team, based on supporting STP, rather than individual organisations

Deliverables:

- Submit Estates Strategy Checkpoint template by June 2019
- Resubmit the STP Estate Strategy Autumn 2019 for further assessment – must be rated as 'Good' in order to receive future STP estate capital
- Progress project pipelines with 'Place' health and social care hub concept as the driver, including the acute reconfiguration aspects associated with 'Future Fit' Wave 3 capital funding, co-ordinated by Sustainable Services Programme, Paul's Moss Whitchurch health and social care hub development, and primary care at scale projects
- Produce the refresh of the Estates Chapter for the STP Long Term Plan
- Improve system-wide potential disposal information, through creation of a system-wide occupancy planner, sharing of disposals, with a disposal plan and timetable to include an understanding of associated capital investment to release assets and lead to efficiency savings
- Support efficiency programmes, estate rationalisation strategies and utilisation plans to maximise the opportunity to create a system-wide capital plan
- Support the drive to make more efficient use of space and deliver the Carter metrics, with better use of void, shared and bookable space
- Create a matrix of existing leases, marking the break clause etc. to enable system planning to take place and better manage occupancy



STW STP Estates Implications



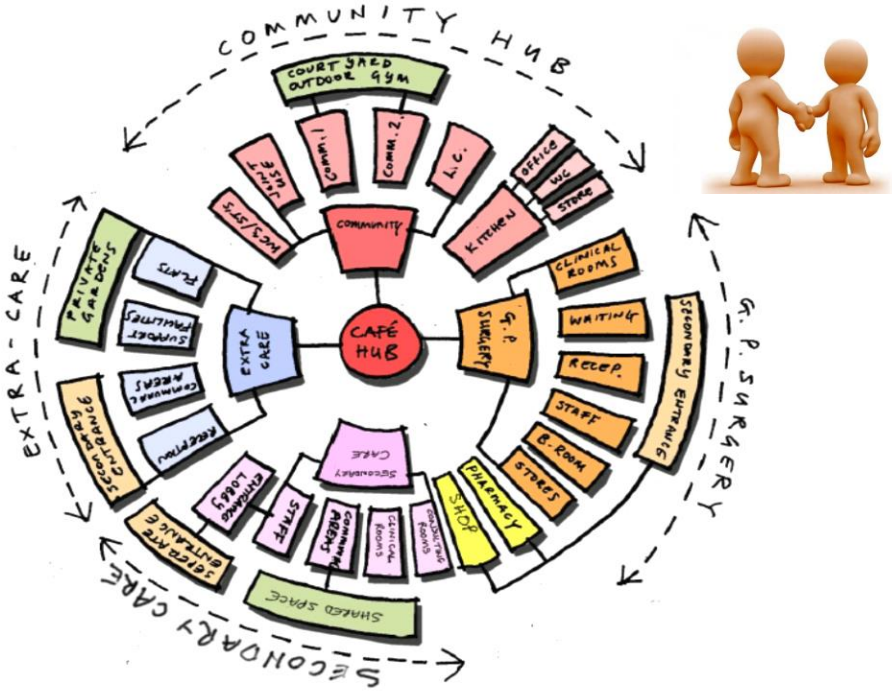
'People' and 'Place' not 'Building' focused

Estates focusing on long-term service transformation and efficiencies

- Fit for purpose, community hubs, based on community need
- Programme of opportunities, across patch, which will transform service delivery, deliver efficiencies and enable inward investment
- The proposed approach is one of prevention and wellness, building up communities, developing resilience and reducing the future cost of care with a clear focus on housing. Reduction in packages of care costs, less stress on future finances
- Increased self sufficiency through community support and independent living – housing type is hugely important
- Long term, generational change will reduce reliance on public services

How this can be delivered

- Through creating independent living opportunities and appropriate housing to give people the lives they want
- Enabling people and organisations to integrate, work together, share problems and solutions, all in one place – collaborative working across estates function, look at shared procurement
- Allowing generational change to occur whereby people look to their own community for support, not to the public services
- Bespoke financial model for each opportunity
- Funding opportunities through grants
- Recycle any capital receipts through identified surplus buildings



Principles of our community centric approach

- To put people at the heart of decisions
- Understand the needs of the people in each area
- Empowering the community to support its self
- Enabling a change in community culture
- Supporting people through social action
- Building capacity within the voluntary sector offer space to deliver
- Targeting the specific needs of individual communities
- Providing new models of ‘wrap around care’
- Developing the ‘Community Hub’
- Up-scaling and enhancing the primary care offer
- Providing joined-up public services delivered at a local level
- Incorporating specialist housing
- Developing housing models for step down care

System Digital Enablement

Priorities:

1. Developing and delivering an Integrated care record (MCR)

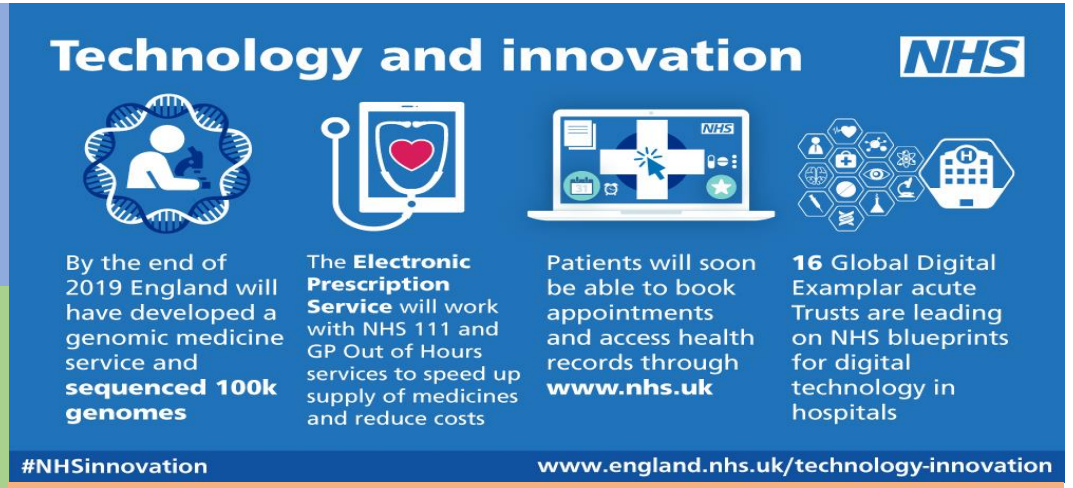
2. One approach to Information Governance and data sharing for our system

3.Business Intelligence and data sharing with a focus on one system-wide view and support for population health management and prevention

4. System wide approach to infrastructure & security.

Deliverables:

- Digital sufficiently embedded as enabler in all transformation programmes
- System data is available from all partners and informs integrated working and population health management
- Improved IG and data sharing
- Local Digital Roadmap for 2019; focussing on:
- People empowerment ("All people")
- Processes – workflow and efficiency
- Pace
- Digital shared care record available for appropriate use.
- Initial plan to include organisations already having Electronic Patient systems, to obtain early benefits. Other orgs to phase in later.
- A standard of infrastructure across all partner sites and devices to enable digital transformation.
- Early stages focussing in improving system access for mobile staff.
- Mobile enabled workforce.
- Progression towards Electronic Patient Record in Acute.
- Electronic patient management system in UEC to replace use of paper.
- Remove use of faxes across the STP area.



Next Steps:

- Deliver refreshed Local Digital Roadmap for 2019.
- Engage with out of hospital programmes to support and enable transformation.
- Continue to engage with Maternity Services to support and enable transformation.
- Create local digital infrastructure.
- Define plan to deliver shared care record.
- Investigate options for shared care records, including discussions with STP neighbours
- Communicate and disseminate information about system digital capabilities.
- Liaise with Academic Health Science Network (AHSN) to connect with proven digital transformation.

First GovRoam sites and devices go live (April) → LDR agreed (May 2019) → Pilot Integrated care record specified and out for funding (Sept 2019) → GovRoam – all partners sites and devices connect on wifi (Nov 2019) → EPR for SaTH implementation agreed (Feb 2020)

System Communication & Engagement

Priorities:

- Establish an initial infrastructure and operating arrangements to ensure that opportunity to build confidence and engagement are not missed
  - A refreshed visual identity, new website, twitter account and a regular Stakeholder Bulletin
  - Further developing our single, shared narrative and clear briefing to help inform stakeholders' understanding of the work underway
  - The new appointment of a C&E SRO for the C&E Workstream to represent the health and care system, allowing co-ordination and dissemination of communications messages and joint working on issues and challenges
  - Ensure continuous stakeholder engagement including seldom heard groups
  - Presence at events, speaking opportunities and networking events where appropriate
- To further develop the communications and engagement approach using the C&E Workstream
  - Manage communication and engagement capacity and support for STP programmes
  - Facilitate discussion between communication and engagement colleagues and effectively manage change
  - Ensure key messages are focused at a public and staff level and answer the question that audiences are asking
  - Produce communication materials to allow managers/stakeholders to communicate the key STP priorities and themes to include toolkits, website copy, social media tools, leaflets, videos and other specific materials as required for internal and external communications
  - Ensure a consistent approach, understanding and messaging across the system internally and externally
  - Share resources, best practice and share thinking to deliver effective campaigns for change
  - Cascade clear decisions and leadership messages to staff and partners
- Engage in the development and delivery of our refreshed system wide plan following the publication of the Long Term Plan
  - Utilising existing engagement channels/relationships such as Healthwatch, to continue to engage and use insights to inform decision making – undertake the work, share the findings, and act on it
  - Ensure wider stakeholder engagement and involvement in every delivery and enablement programme
  - Build awareness of the partnership working amongst the local voluntary and community sector organisation so that they can be closely involved in shaping strategy
  - Inform and involve all stakeholders in the development of the ICS and our emerging vision for health and care partnership in Shropshire, Telford & Wrekin so that the plan is best for our patients

Deliverables:

- Delivery of STP communications & engagement strategy
- Establish communications & engagement network
- Evidenced engagement within every programme of work
- Every organisation has increased awareness of system understanding of the transformation programme
- Increased understanding amongst Shropshire, Telford & Wrekin residents, staff and stakeholders of the challenge we face, our health and care partnership and our vision for future health and care services
- Increased understanding that we all have a role to play in developing how services may change and the importance of engaging in the debate about the future of health and care services in Shropshire, Telford & Wrekin
- Support consultations on service change

NHS
Long Term Plan
#NHSLongTermPlan

7.
Activity & Capacity Planning

System Approach to Capacity Planning

- The system is working together to understand shared capacity across collective resources
- Significant amount of work was undertaken across the system to model the capacity requirements for winter 2018/19 and this learning is being used to plan for 19/20
- Real time activity data has been used to develop this model given the significant, unpredicted growth in demand
- Further work is being undertaken to determine capacity requirements in acute and community settings
- Significant work is being done by the system to improve models of admissions avoidance, such as the ambulance conveyance reduction work. Improvement in ambulatory care models also being undertaken to minimise bed utilisation.
- The system are reviewing their assumptions and then reviewing for impact on workforce and finance to then create the plans for 2019/20
- Significant changes predicted and improvement in patient management by direction to out of hospital services will need to be profiled, in order to accurately forecast demand, e.g. 111, urgent treatment centres and Future Fit
- Use **valued care in mental health**; and **improving for excellence** to improve the emergency care of people with mental health

System Winter Planning Approach

- The Plan has been developed through robust engagement of all key system partners overseen by the A&E Delivery Group.
- In parallel, system demand and capacity modelling has been undertaken to determine predicted winter demand and required acute bed capacity to inform the bed bridge calculations.
- All Providers are asked to share their understanding of their demand and capacity over the winter months and provide an organisational winter plan which includes:
    - Additionally, and phasing of escalation
    - A workforce model to support 7-day working, senior decision making and escalation capacity
    - 7-day working
    - Christmas, New Year and Easter period
    - Options for further surge capacity if required

System Capacity Planning Modelling - Based on 92% occupancy

	April	May	June	July	August	Sep	Oct	Nov	Dec	Jan	Feb	Mar
beds available (core)	642	642	642	642	642	642	642	642	642	642	642	642
Total beds available for +1 day	589	589	589	589	589	589	589	589	589	589	589	589
BEDS REQUIRED with LOS 6 days	633	625	664	645	624	637	628	688	654	654	634	676
8% to reduce occupancy to 92%	683	675	717	697	674	688	678	743	707	706	685	730
BED GAP	-94	-86	-128	-108	-85	-99	-89	-154	-118	-117	-96	-141
Improvement schemes to bridge bed gap												
This Varies by month and includes schemes such as Acute medicin (Front door), frailty, Stranded Patients/Los Improvements												
Total Improvements	10	15	24	38	37	36	37	38	38	38	38	38
RESULTING BED GAP	-84	-71	-104	-70	-48	-63	-52	-116	-80	-79	-58	-103
Capacity schemes to bridge bed gap												
winter beds open all year	30	30	30	30	30	30	30	30	30	30	30	30
RSH ward 35				28	28	28	28	28	28	28	28	28
RESULTING BED GAP	-54	-41	-74	-12	10	-5	6	-58	-22	-21	0	-45
Additional solutions that can be in place as currently utilised as additional winter capacity												
care home beds	11	11	11	11	11	11	11	11	11	11	11	11
Hospital full protocol (without day surgery or AEC)	8	8	8					8	0	0	0	8
RESULTING GAP	-35	-22	-55	-1	21	6	17	-39	-11	-10	11	-26
Potential solutions that currently don't exist e.g. PRH additional capacity (from November), additional care home beds												
?additional community capacity	20	20	20									
PRH additonal capacity								28	28	28	28	28
rehab out of hospital				10	10	10	10	10	10	10	10	10
Potential GAP if these are accepted	-15	-2	-25	9	31	16	27	-1	27	28	49	12

System Capacity Planning Modelling - Based on 95% occupancy

	April	May	June	July	August	Sep	Oct	Nov	Dec	Jan	Feb	Mar
beds available (core)	642	642	642	642	642	642	642	642	642	642	642	642
Total beds available for +1 day	589	589	589	589	589	589	589	589	589	589	589	589
BEDS REQUIRED with LOS 6 days	633	625	664	645	624	637	628	688	654	654	634	676
5% to reduce occupancy to 95%	664	656	697	677	655	669	659	723	687	686	666	710
RESULTING BED GAP	-75	-67	-108	-88	-66	-80	-70	-134	-98	-97	-77	-121
Improvement schemes to bridge bed gap												
This Varies by month and includes schemes such as Acute medicin (Front door), frailty, Stranded Patients/Los Improvements												
Total Improvements	10	15	24	38	37	36	37	38	38	38	38	38
RESULTING BED GAP	-65	-52	-84	-50	-29	-44	-33	-96	-60	-59	-39	-83
Capacity schemes to bridge bed gap												
winter beds open all year	30	30	30	30	30	30	30	30	30	30	30	30
RSH ward 35				28	28	28	28	28	28	28	28	28
RESULTING BED GAP	-35	-22	-54	8	29	14	25	-38	-2	-1	19	-25
Additional solutions that can be in place as currently utilised as additional winter capacity												
care home beds	11	11	11	11	11	11	11	11	11	11	11	11
Hospital full protocol (without day surgery or AEC)	8	8	8					8	0	0	0	8
RESULTING BED GAP	-16	-3	-35	19	40	25	36	-19	9	10	30	-6
Potential solutions that currently don't exist e.g. PRH additional capacity (from November), additional care home beds												
?additional community capacity	20	20	20									
PRH additonal capacity								28	28	28	28	28
rehab out of hospital				10	10	10	10	10	10	10	10	10
POTENTIAL POSITION if these are accepted	4	7	-5	29	50	35	46	19	47	48	68	32

8.
System Finances

System Financial Position

£m	SCCG	TWCCG	SaTH	RJAH	SCHT	TOTAL
2019/20 Control Total	(12.3)	0.0	(17.4)	2.0	0.0	(27.7)
2019/20 Plan Surplus / (Deficit)	(23.8)	0.0	(24.3)	(0.5)	0.0	(48.6)
Variance to Control Total	**(11.5)**	**0.0**	**(6.9)**	**(2.5)**	**0.0**	**(20.9)**
Risk to Delivery:						
Unidentified CIP/QIPP	0.0	(4.9)	(7.8)	0.0	(2.0)	(14.7)
High/Medium Risk Schemes	(7.0)	(2.0)	(4.8)	(3.3)	(1.5)	(18.6)
Transformational Change Programmes	1.1	0.9	2.5	1.3	0.2	6.0
Contingencies/Reserves/Other	1.3	2.5	0.0	0.8	(0.5)	4.1
Total Risks to Delivery	**(4.6)**	**(3.5)**	**(10.1)**	**(1.2)**	**(3.8)**	**(23.2)**

Note:

- *All figures exclude PSF, FRF and MRET*
- *Issues referred for national resolution to NHSI/E have been included in the plans:*
  - *Resolution of national tariff (RJAH) - £2.5m*
  - *GP indemnity delegated budget adjustment (SCCG) - £1.5m*

  Favourable resolution of these issues would reduce the variance to Control Total
- *Confirmation of national solution required from NHSI/E regarding pay award funding for LA services (SCHT) - £0.5m*

- Delivery of current plans require total cost-out savings of £51.6m across the system. All organisations in the system continue to review QIPP/CIP plans to maximise deliverable savings in 2019/20 and to manage internal organisational cost pressures.
- Our transformational change programme identifies a pipeline of opportunities that can deliver up to £53m over the next four years. We are committed to accelerating the work on these programmes but this is unlikely to address in full the gap identified in 2019/20
- In recognition of the financial situation we continue to review a number of additional potential cost savings. However a number of these areas would impact on organisational performance and the delivery of constitutional targets and would therefore require full commitment from commissioners, providers and regulators.