# Thames Valley Strategic Clinical Networks and Senate - Work Programme 2017 - 2019

**Introduction**

This two-year work programme represents the development of national priorities of NHS England as defined in the Five Year Forward View, its constituent programmes and local priorities as defined through the region's Sustainability & Transformation Plans (STP). The SCN acts as a convenor of clinical, patient and stakeholder leadership so as to build effective networks, provide advice and support to commissioners, harnessing best practice and assessing variation in experience and outcomes. This work is undertaken alongside partner involvement from Arm's Length Bodies such as Public Health England, Health Education England, Academic Health Science Networks and NHS Improvement. The focus given from NHS England to align circa 25% additional capacity to STPs requires the SCN's skills and experience to be used in a way that ensures involvement, influence and distributed leadership across the health system.

**National Priorities**

As national priorities have emerged against the Five Year Forward View, the TVSCN has focused attention on delivery across the following transformation programmes;

**Cancer Alliances** – the formation of the Cancer Alliance in the Thames Valley will exist to deliver the recommendations as set out in "Achieving World Class Cancer Outcomes: a strategy for England 2015-2020". The formation of the Alliance is crucial at this stage for partnership delivery and the work programme will focus on scoping and delivering on key workstreams in ***Prevention and Early Diagnosis, Recovery Package, Stratified Follow up pathways and Health Information Exchange programme (Digital)***. The funding allocated to these workstreams will be finalised by end of March 2017.

**Maternity** – the implementation of ***Local Maternity Systems*** across the two STP regions is based on the national strategy "Better Births – Improving outcomes of maternity services in England". This will build on the Maternity TVSCN and Clinical Senate's work programme from previous years based on capacity and stakeholder activities.

**Mental Health** – TVSCN are supporting mental health improvements spanning all stages of life. Improvement in Perinatal Mental Health will be seen from advancing education and training for generic and specialist staff in the Thames Valley alongside more rigorous benchmarking. For Children and Young People the implementation of the recommendations of "Future in Mind: Transformation of CYP Mental Health Services" including improving access to services, national data requirements as well as building on specific support for autism and looked after children. Adult mental health will focus on ***access to IAPT and EIP services, improving physical health in those with severe mental illness*** and supporting the STP aims in appropriate treatment and support. In dementia, the leadership ***to improve diagnosis rates and post diagnostic support*** continues with a focus on supporting quality improvement through "Dementia Friendly Practices" alongside embedding a broad base of local clinical leadership focussed on patient outcomes.

**Diabetes** – maintaining the focus on improving diabetes diagnosis and care to include better self-care and management. This will involve focus on the ***three treatment targets, structured patient education,*** learning from and sharing of local initiatives across the region and focussing on specific improvements such as ***improving access to specialist diabetes nursing teams for inpatients and multi-disciplinary effort in diabetic footcare.***

**Local Priorities**

TVSCN has established networks in End of Life Care and Long Term Conditions. Their work continues to support local and regional delivery in these areas including; embedding national ambitions for End of Life care across STP footprints and supporting the move to a 24/7 provision of end of life and palliative care across the Thames Valley. On Long Term Conditions, the support to Frimley STP and the wider aims of better management of long term conditions in CCG operating plans, the network continues to drive forward the "person-centred" care agenda through its delivery of care and support planning training across organisations in priority areas such as diabetes as well as scoping out to other networks including cancer and dementia.

**Thames Valley Clinical Senate**

The Clinical Senate will continue to provide local transformation programmes with clinical assurance as per the requirements of Stages 1 and 2 of the NHS England assurance of major service change. STP developments over the period will require Clinical Senate input and involvement in developing proposals for reconfigurations where proposed. The Clinical Senate also undertakes work pro-actively on topics of importance to the South Central region in areas such as community hospital development and harnessing best practice from other Senate areas including promotion of smoking cessation in secondary care.

**Transformation Programmes**

As NHS England South Central staff align to the wider transformation programmes under the cross cutting themes of the Five Year Forward View and STPs, the SCN provide specific support in the following areas;

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| **GP Forward View** | As per STP development – Care & Support Planning as delivered through SCN will play a continued role in TVSCN play an enabling role in transformation programme from communications, webinars, conferences and delivery of care and support planning |
| **Prevention** | Prevention work is ongoing across SCN's workstreams in areas such as obesity, smoking and exercise.<br>* TV Cancer Alliance has a strong prevention theme<br>* Stroke Network are working to deliver few strokes through prevention<br>* Diabetes – National Diabetes Prevention programme is championed through the diabetes network<br>*Mental Health networks are focussing on schools and maternity<br>*Obesity – Wider work is being done to ensure that over 2,000 clinicians hear the messages on evidence-based practice on tackling obesity |
| **Five Year Forward View for Mental Health** | The clinical network activities for perinatal mental health, children and young people, and adult mental health are closely aligned to this agenda |
| **Two Year Operations Plans** | TVSCN commissioning guidance captures networks activity and recommendations, alongside guidance from Arms Length Bodies (ALB) |
| **Urgent and Emergency Care** | Clinical and managerial leadership on End of Life Care is influencing the UEC agenda<br>Network leadership on 7 day services for Stroke & Vascular services actively supporting UEC |
| **New Models of Care** | TVSCN play an enabling role in transformation programme from communications, webinars, conferences and delivery of care and support planning |

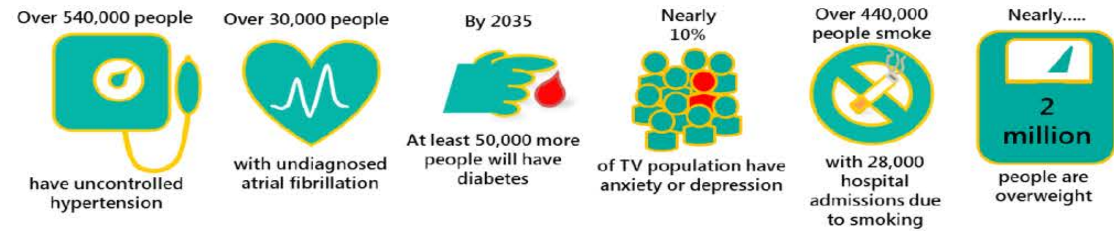
NHS

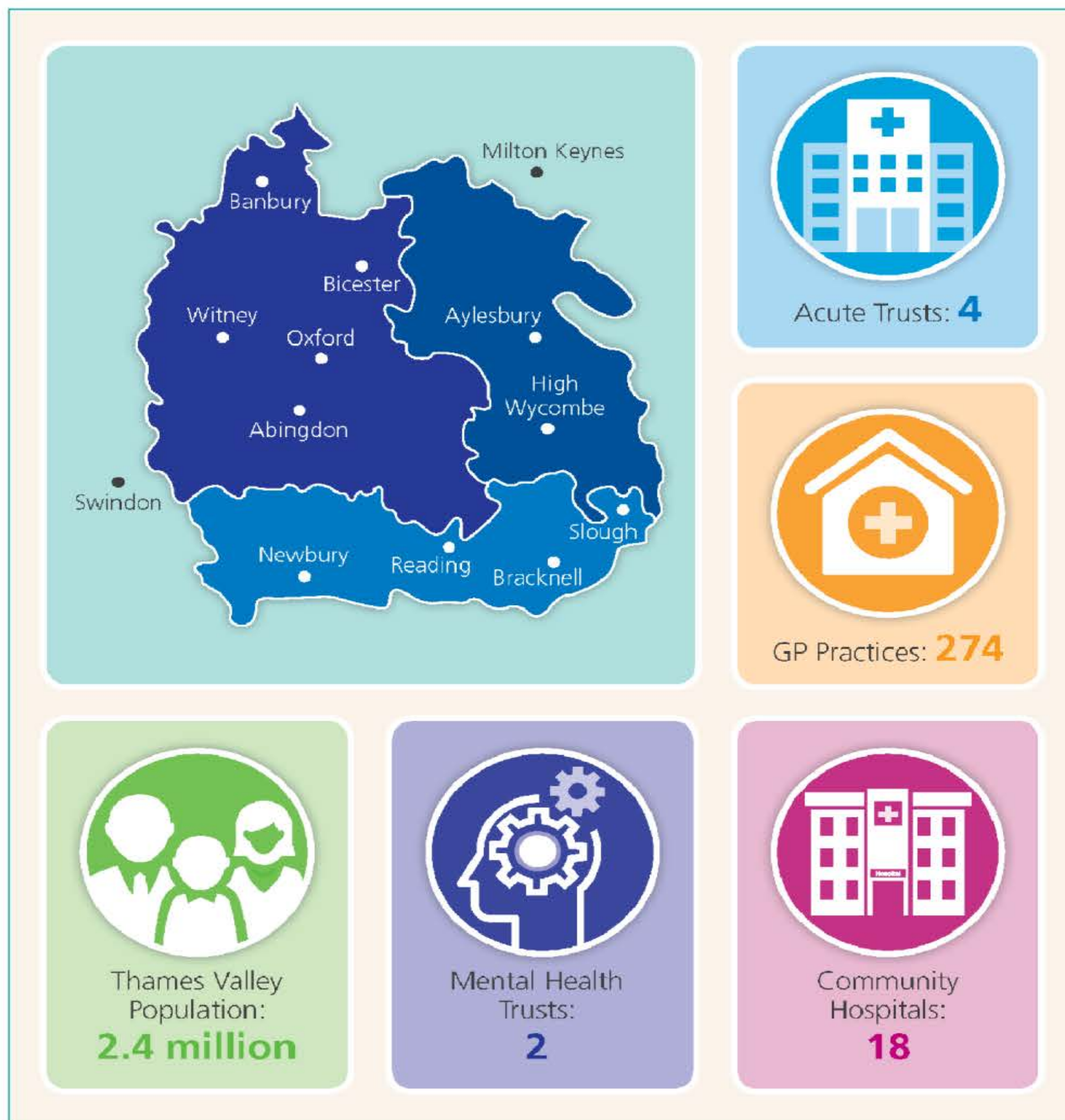
Thames Valley Strategic Clinical Networks and Clinical Senate

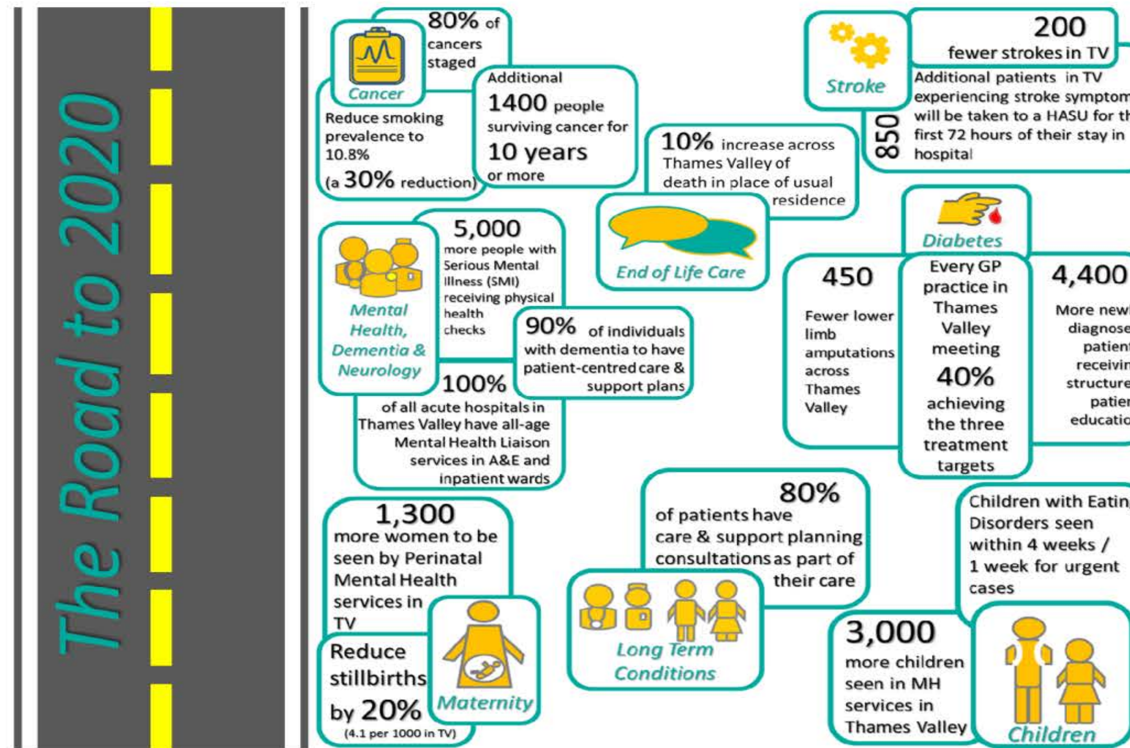
# Thames Valley Strategic Clinical Networks:

## The Road to 2020

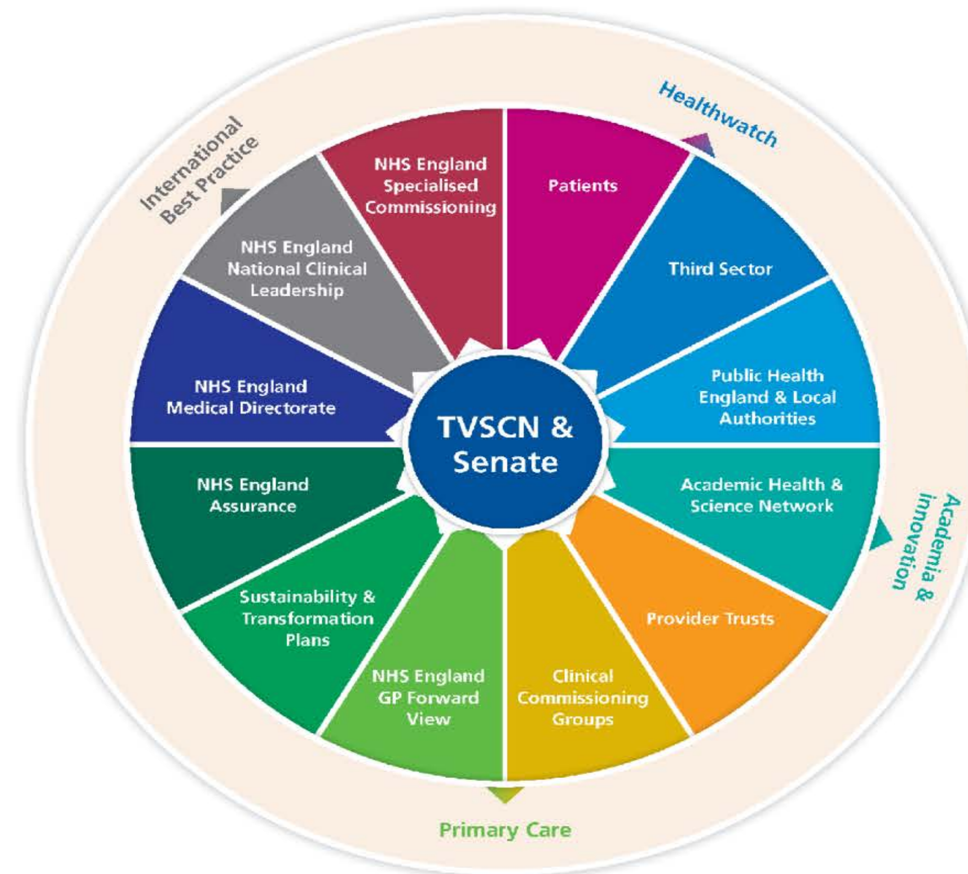
Some of the challenges across South Central




## Partnership wheel



**CANCER ALLIANCE (please note that elements in light grey are being led by other partners)**

| Workstream | Ambition | STP priorities: local links and interdependencies | National priorities: policy links and interdependencies | Contribution to the three gaps | Accountable lead & delivery lead | High level actions | Major milestones/Planned trajectory | Timescale | Status update (RAG) |
|---|---|---|---|---|---|---|---|---|---|
| **Infrastructure** | Estabish Thames Valley Cancer Alliance | **BOB STP**: Working with the SCN, OUH and Cancer Alliance to develop optimum specialised care pathways/improving value for patients.<br>**BSW**: Cancer Alliance governance arrangements established but further work is required in understanding future benefits | **Achieving World Class Cancer Outcomes (AWCCO)**: Establish Cancer Alliances across the country, bringing together key partners. | Care and quality gap | **Accountable**: Cancer Alliance Clinical Lead<br>**Delivery**: Cancer Alliance Manager | * Develop draft Alliance Development Plan, ToR including membership.<br>* Engage partners, patients and stakeholders.<br>* Agree Alliance delivery plan.<br>* Established Cancer Alliance to effect the transformational change needed to achieve world class cancer outcomes for the population of Thames Valley. | * Support the development and delivery of Cancer Alliances ensuring the programme of work is delivered.<br>* Hold Exec. Partners Engagement Workshop to agree ambitions.<br>* Hold wider stakeholder engagement event to share ambitions, prioritise taskforce requirements and update on bids. | Apr-17 | |
| **Intelligence** | Development of cancer dashboard of metrics | | **AWCCO**: NHS England, working with the other Arms Length Bodies, should develop a cancer dashboard of metrics at the CCG and provider level, to be reported and reviewed regularly by Cancer Alliances. | Care and quality gap; health and wellbeing gap | **Accountable**: Cancer Alliance Clinical Lead<br>**Delivery**: Cancer Alliance Manager | * Dashboard specifications drafted.<br>* Development and testing.<br>* Go Live. | * Coordinate dashboard scope for Alliances across South with CSU.<br>* Agree phases and testing period for Q1.<br>* Investigate opportunities to link with HIE Bid and national dashboard.<br>* Develop an effective interface across Alliance footprint with deliver of cancer waiting times being integral to the work of the Operational delivery group eg 85% meeting 62 day target and 96% meeting 31 day targets. | April 2017<br>May 2017<br>June 2017 | |
| **Key enablers** | Workforce assessment | **BOB STP**: Working to improve retention of existing staff and addressing skills shortages.<br>**Frimley STP**: Developing the workforce across the system so that it is able to deliver new models of care. | **Achieving World Class Cancer Outcomes**: Address critical workforce deficits & undertaking a strategic review of future workforce needs/skill mix. | Care and quality gap; health and wellbeing gap | **Accountable**: Cancer Alliance Clinical Lead<br>**Delivery**: Cancer Alliance Manager/HEE/Macmillan | * Comprehensive review of the delivery and workforce model: surgery, radiontherapy and oncology role of community and primary care.<br>* Develop new workforce models and education programme working with academic partners. | * Benchmark current workforce using WRAPT tool (medical, nursing, allied health professionals)<br>* Work in partnership with Macmillan and HEE to develop new roles and training, improve joint working, increase resilience, reduce duplication, aim for more common systems to be used by all. | 2018 | |
| **Key enablers & cancer transformation bid** | Health Information Exchange (Digital Cancer Record) | Population management/whole system intelligence/risk stratification and population health analysis; patient facing technology; HIE | | Funding and efficiency gap; care and quality gap; health and wellbeing gap | **Accountable**: Cancer Alliance Clinical Lead<br>**Delivery**: Cancer Alliance Manager | * Agree project team and supplier.<br>* Develop programme delivery plan. | * Merge/link all Trust cancer databases.<br>* Build cancer module in Connected Care.<br>* Develop common image sharing platform across the network.<br>* Develop population health analytics tool. | April 2017<br>May 2017 | |
| **Prevention/ Early diagnosis** | Reduction in variation in service provision to address cancer risk factors (smoking, alcohol, excess weight and lack of physical activity), delivered through working with local authority partners | **BOB STP**: The prevention priorities across BOB are mobility, obesity and physical activity (also incorporates tobacco).<br>**Frimley STP**: Obesity reduction programme setup throughout footprint.<br>* Reduction in smoking and alcohol consumption. | **FYFV**: The NHS will back hard-hitting national action on obesity, smoking, alcohol and other major health risks.<br>* Public Health England's new strategy sets out priorities for tackling obesity, smoking and harmful drinking.<br>**AWCCO**: We should aim to reduce adult smoking prevalence to less than 13% by 2020.<br>* An important part of local strategies will be health promotion around risk factors including smoking, alcohol, diet and physical activity.<br>* Public Health England should work with the Government and a wide range of other stakeholders to develop and deliver a national action plan to address obesity.<br>* Development of a national strategy to address alcohol consumption. | Health and wellbeing gap; care and quality gap; funding and efficiency gap | **Accountable**: Cancer Alliance Clinical Lead<br>**Delivery**: Prevention & Early Diagnosis Clinical Lead/QIL | * Alliance Prevention & Early Diagnosis Clinical Lead to develop a prevention work programme in collaboration with all members.<br>* Work with systems to establish multidisciplinary alcohol care teams in all acute hospitals to coordinate the care acriss departments and enables rapid access to personalised 'brief advice' and referral to specialist services in other settings.<br>* Work with HEE and other partners to explore development of training programme for all local healthcare professionals/practitioners to deliver Very Brief Advice on smoking and know where to refer or signpost people to if they are interested in taking action to stop or reduce their smoking. | * Support implementation of Make Every Contact Count in all healthcare settings to support people to reduce their risk of cancer through healthy choices by ensuring individuals who are presenting with cancer symptoms and those who receive a cancer diagnosis are asked about smoking behaviours, informed of the help available to help them to stop and provided with the necessary support.<br>* CCGs and LAs facilitate local agreements with GPs to screen patients on alcohol consumption (eg Alcohol Disorder Identification Test (AUDIT-C scratch card), with medical staff trained to offer and provide Very Brief Advice and refer to local specialist services as required.<br>* Develop healthy eating education programme to be delivered in schools.<br>* Secure continues investment in evidence-based stop smoking services ensuring promotion widely to all smokers, but particularly those in priority groups eg pregnant women, people with long term conditions (https://www.solutions4health.co.uk/products-and-services/smoking-cessation-services/).<br>* Ensure all secondary care providers follow NICE guidance in relation to the identification and referral of smokers, cessation and access to stop smoking medications (https://www.nice.org.uk/guidance/ph10/chapter/4-recommendations?unlid=5394742312016466221#smoking-cessation-services-2).<br>* Ensure 2000 clinicians who interact with patients with cancer hear the Susan Jebb brief interventions message. | June 2017<br>September 2017<br>2018 | |

**CANCER ALLIANCE**

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| **Prevention** | Reducing smoking: Smoking rates reduced to 10.8%. This equates to a total reduction of 110,720 smokers. | **BOB STP**: Savings of £1.7m attributable to a reduction in smoking.<br>* All areas reducing avoidable admissions from smoking.<br>**Frimley STP**: Develop and roll out programme to reduce the number of people smoking. | **FYFV**: Spearheading a radical upgrade in prevention and public health. | Health and wellbeing gap; funding and efficiency gap (savings of £1.7m by 2020 for BOB as detailed in their STP) | **Accountable**: Cancer Alliance Clinical Lead<br>**Delivery**: Prevention & Early Diagnosis Clinical Lead/QIL | * Undertake analysis of smoking cessation provision - identify gaps.<br>* Develop recommendations of initiatives to CCGs based on findings and prevalence. | * Link with Public Health Stop smoking and health promotion teams and charity partners to undertake analysis of smoking cessation provision across the region.<br>* Develop local action plans which include events in targeted areas, e.g. libraries, one stop shops, A& E dept. etc.<br>* Develop incentives for practices to identify smokers from their smoking status on patient records to create a virtual smoking register.<br>* CCG analysis to understand the prevalence in practices to develop a plan that targets initiatives and actions on those with highest rates of smoking or the poorest quit success, eg work places, schools, deprived areas.<br>* Utilise CRUK facilitators to deliver training for practice and community nurses and pharmacists on behaviour change and Very Brief Advice. | July 2017<br>September 2017 | |
| **Prevention/ Early diagnosis** | Chemo-prevention drugs prescribed as recommended by NICE | | **AWCCO**: NHS England should work through CCGs to ensure that GPs are appropriately prescribing chemo-preventative agents to reduce the risk of invasive breast cancer where their use is established through NICE guidelines. | Care and quality gap | **Accountable**: Cancer Alliance Clinical Lead<br>**Delivery**: Cancer Alliance Manager | * Work with Medicines Management Team to undertake audit of prescribing across Thames Valley to ensure no variation in prescribing practice and identify any issues around appropriate 'end dates'. | * Ensure GPs are prescribing and patient information leaflet on chemoprevention for women at an increased risk of familial breast cancer is available. | Oct-17 | |
| **Early diagnosis** | Optimal uptake of cervical screening programme, including roll out of primary HPV from 2018/19 | **BOB STP**: Increasing cervical screening uptake. | **Achieving World Class Cancer Outcomes**: Public Health England and NHS England should drive rapid roll-out of primary HPV testing into the cervical screening programme. | Health and wellbeing gap | **Accountable**: Cancer Alliance Clinical Lead<br>**Delivery**: Prevention & Early Diagnosis Clinical Lead/QIL | * Develop primary care workforce continuous education cycle.<br>* Deliver targeted interventions to increase awareness of signs and symptoms.<br>* Develop focused work, at targeted population to maximise uptake and reduce variations in screening. | * Alliance Patient Engagement Lead to investigate opportunities to work in partnership with other commissioners and provider services to develop local campaigns/awareness and education session to minimise variation in screening uptake at GP practice level with a particular focus on areas with poor uptake levels.<br>* Alliance Patient Engagement Lead to test approach to population engagement in early detection and awareness in area of highest deprivation and lowest engagement with health prevention.<br>* Work with practices to implement interventions such as: using an Every Contact Counts strategy, flag overdue screening tests on patient records and make available to view by GP receptionists when patients call to book other appointments and/or order prescriptions; nominating a Practice Nurse to become a 'Screening Champion'.<br>* Work with GPs to develop approaches to support women with learning disabilities and consider whether it would be more appropriate to send an Easy Read leaflet and invitation letter to the parent or carer; offer a visit to the practice in advance of an appointment for a screening test.<br>* Support practices to participate in national awareness weeks – | Roll out of primary HPV from 2018/19.<br><br>June 2017<br>September 2017<br>January 2018 | |

**CANCER ALLIANCE**

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| **Early diagnosis** | Optimal uptake of bowel and breast screening programmes, including roll out of FIT into bowel cancer screening programme | **BOB STP**: Reduce preventable diseases, improved uptake of screening programmes. | **FYFV**: We will also work to expand access to screening by extending breast cancer screening to additional age groups.<br>**AWCCO**: An ambition of 75% uptake for FIT in the bowel cancer screening programme by 2020.<br>* NHS England should incentivise GPs to take responsibility for driving increased uptake of FIT and bowel scope in their population. | Health and wellbeing gap; funding and efficiency gap | **Accountable**: Cancer Alliance Clinical Lead<br>**Delivery**: Prevention & Early Diagnosis Clinical Lead/QIL | * Monitor uptake rates and engage with NHS England and Public heath England on any prosed changes to commissioning responsibilities.<br>* Identify programmes where uptake is low and target initiatives to increase, jointly with Public Health England. | * Promote breast, bowel and cervical cancer screening programmes with a particular focus on areas of high incidence and poorer outcomes.<br>* Develop a local strategy to improve screening uptake in specific programmes for vulnerable populations, eg learning disability.<br>* Use of Community Health Activists/direct patient letter - have recent successful experience of this in Slough, where bowel screening uptake increased by between 5-7% in some practices.<br>* Alliance patient engagement coordinator to test approach to population engagement in early detection and awareness in area of highest deprivation and lowest engagement with health prevention. | Quarterly<br>May 2017 | |
| **Early diagnosis & cancer transformation bid** | Implementation of NICE referral guidelines which reduce the threshold of risk which should trigger an urgent cancer referral, including increased provision of GP direct access to key investigative tests for suspected cancer<br><br>Increase the proportion of staged cancers to 80%, with 75% of staged cancers diagnosed at Stage 1 and 2 | **BOB STP**: Implementation of the new Suspected CANcer (SCAN) Multidisciplinary Centre (MDC) pathway (for early diagnosis). | **FYFV**: Ensure that there are sufficient numbers of GPs working in larger practices with greater access to diagnostic and specialist advice.<br>* GPs and nurses working from community bases equipped to provide a much greater range of tests and treatment.<br>**AWCCO**: NHS England should mandate that GPs have direct access to key investigative tests for suspected cancer - blood tests, chest x-ray, ultrasound, MRI, CT and endoscopy. | Health and wellbeing gap; 70 years of life gained for 1,161 lung cancer patients.<br><br>care and quality gap; funding and efficiency gap (saving £764k by diagnosing ovarian cancer earlier; and £800k by diagnosing colorectal cancer earlier) | **Accountable**: Cancer Alliance Clinical Lead<br>**Delivery**: Cancer Alliance Manager | CCG agreement on locations of MDC - link to STP plans<br>* Develop PID.<br>* Develop MDC design, reflecting Oxfordshire learning/evaluation.<br>* MDC recruitment and mobilisation.<br>* MDC 'go live'-phased implementation.<br>* Implementation and evaluation. | * Work with Provider Operational Groups (PODGs) to review the key pathways against the new guidance to identify where practice needs to change and assess impact on demand and responsibility.<br>* Ensure revised referral proformas are adopted adopt and implemented, with any locally agreed amendments, and placed on EMIS/VISION.<br>* Quantify and put in place commissioning arrangements for identified change in demand.<br>* Ensure diagnostics commissioning for direct access tests to deliver the revised 2ww guidance, i.e. review and support CCGs to negotiate current Any Qualified Provider contracts.<br>* Implementation of vague symptom pathway. | July 2017<br>October 2017<br>January 2018 | |
| **Early diagnosis & cancer transformation bid** | Adequate diagnostic capacity in place to meet waiting times standards (including 28 Day Faster Diagnosis Standard from 2018/19) | **BOB STP**: Rapid access for non 2ww if a possible cancer.<br>**Frimley STP**: Rapid access to diagnostics and upstream diagnosis. | | Care and quality gap | **Accountable**: Cancer Alliance Clinical Lead<br>**Delivery**: Cancer Alliance Manager | * Support Provider Trust to book the 1st outpatient appointment for 2ww referral within 5 working days.<br>* Review findings from 5 pilot sites and implement recommendations/lessons learnt.<br>* Agree Alliance wide programme for year 1.<br>* Phased redesign across Alliance using PDS methodology. | Current performance against 28 day standard indicated poor performance against the following tumour sites: Gynaecology, upper and lower GI, lung, urology, head & neck.<br>* Work with systems to undertake a detailed demand and capacity review and agree trajectory for commissioning additional endoscopy capacity for lower gastrointestinal cancers ensuring only JAG accredited providers are used.<br>* Implement Thames Valley Cancer Access Policy and Inter-provider breach guidance:<br>- Diagnosis of current pathway delays and agreement of a programme of pathway redesign across the Alliance.<br>- Development and implementation of redesigned pathways, with implementation and testing at one Trust followed by evaluation and pathway modification (where required) prior to implementation across the Alliance.<br>- Concordance audits of pathways by provider and compliance reviews to ensure efficiencies of production and capacity and demand analysis to meet predicted needs and avoid any delays. | May 2017<br>July 2017<br>January 2018 | |
| **Early diagnosis & cancer transformation bid** | All GPs undertaking a Significant Event Analysis for any patient diagnosed with cancer as a result of an emergency admission | | **AWCCO**: All GPs should be required to undertake a Significant Event Analysis for any patient diagnosed with cancer as a result of emergency admission. | Health and wellbeing gap; care and quality gap | **Accountable**: Cancer Alliance Lead<br>**Delivery**: Cancer Alliance Manager, CRUK Facilitators | * Develop action plan to implement recommendations across primary and secondary care.<br>* Implement Quality Improvement Scheme for GP practices.<br>* Agree approach with revalidation team to ensure GPs undertake SEA audit as part of their appraisal. | * Share recommendations from Emergency Presentations Audit project work. Develop quality improvement scheme for GPs to support improving use of 2ww pathway. | May 2017<br>August 2017 | |

**CANCER ALLIANCE**

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| **Early diagnosis** | GP practices have 'safety-netting' processes in place for patients sent for an investigative test | | **AWCCO**: NHS England should incentivise the establishment of processes by GP practices to ensure 'safety-netting' of patients, including adequate support for training. | Health and wellbeing gap; care and quality gap | **Accountable**: Cancer Alliance Clinical Lead<br>**Delivery**: Prevention & Early Diagnosis Clinical Lead | * Work with our primary care STP workstream colleagues to understand the issues relevant to capacity on primary care which impact on cancer care.<br>* Undertake workforce skills and confidence analysis, including role of extended primary and community workforce in identification and referral (NICE guidelines).<br>* Map curent training, SPD opportunities and resources. | * Agree headline issues to be covered in training, including adding testing prior to or in parallel with referral, eg urine and blood tests.<br>* Agree how training could be delivered, eg PLT or specific tailored course, webinars.<br>* Secure resources and delivery of training.<br>* Evaluate impact of training.<br>* Agree ongoing training requirement and delivery plan.<br>* Develop programme of action required from Macmillan GPFs to work with individual GPs or practices to improve their input for best patient outcomes.<br>* Link the work and support local CRUK facilitators to the education needs of GPs and practices in most need.<br>* Develop new resources including an online platform, video and podcasts.<br>* Assess current use of prediction software in primary care and explore options to maximise. | June 2017<br>September 2017<br>November 2017 | |
| **Treatment and care** | Alignment with radiotherapy provider networks as they are established, to modernise equitable radiotherapy provision and support the roll out of new and updated radiotherapy equipment | **BOB STP**: Collaborative working on clinical support services, particularly pathology and radiology. | **AWCCO**: NHS England should commence a rolling programme of replacements for LINACs as they reach 10 year life, as well as technology upgrades to all LINACs in their 5th year. All LINACs that are already 10 years old should be replaced.<br>* NHS England should support the provision of dedicated MR and PET imaging facilities for radiotherapy planning in major treatment centres. | Care and quality gap; | **Accountable**: Cancer Alliance Clinical Lead<br>**Delivery**: Cancer Alliance Manager | * Work with Spec Comm and neighbouring Alliance/STP footprints to explore scope for configuration and efficiency gains (and new models of delivery) eg chemotherapy, radiotherapy or specialised surgery using data to drive improvements in clinical outcomes. | Radiotherapy service review ongoing-proposed new clinical and service model; service specification currently under development. | Jul-17 | |
| **Treatment and care** | Chemotherapy available in community settings | | **FYFV**: Combined with consolidation of specialised care, we will make supporting care available much closer to people's homes; a greater role for smaller hospitals and expanded primary care will allow more chemotherapy to be provided in community.<br>**AWCCO**: NHS England should encourage the delivery of chemotherapy in community settings by sharing examples of good practice nationally. The chemotherapy Clinical Research Group should publish a list of drugs which are safe to give in community settings. | Care and quality gap | **Accountable**: CCGs<br>**Delivery**: Provider Trusts | * Develop forum to discuss approach and actions for implementation. | * Chemotherapy CRG to produce a list of drugs which are safe to give in community settings.<br>* PODG to review list of drugs once published. | Roll out from 2018/19 | |
| **Treatment and care** | All providers providing a directory of local services and facilitating local cancer support groups | | **AWCCO**: NHS England should encourage all hospital providers to provide a directory of local services (electronic and on paper) and facilitate local cancer support groups, which can provide peer and signposting support to cancer patients being treated there. This should complement directories provided in general practice. | Care and quality gap | **Accountable**: CCGs<br>**Delivery**: Provider Trusts | | Alliance Patient Engagement Lead to work with stakeholders and patient groups to establish baseline of current directories available with a view to amalgamating into a web portal. | Mar-18 | |
| **Treatment and care** | Improved access to clinical trials (particularly for teenagers and young adults) | | **AWCCO**: NHS England should ask National Institute for Health Research and cancer research charities to consider ways in which access to clinical trials for teenagers and young adults with cancer could be significantly increased. | Health and wellbeing gap; care and quality gap | **Accountable**: Cancer Alliance Clinical Lead<br>**Delivery**: Cancer Alliance Manager | * Analysis of trials to be raised at Expert Advisory Group for advice on increasing access to patients particularly teenagers and young adults. | * Research sub-speciality leads to ensure they are kept appraised of research developments and trials both locally and nationally and inform their respective delivery groups and members. | Mar-18 | |

**CANCER ALLIANCE**

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| Treatment and care | MDTs review a monthly audit report of patients who have died within 30 days of active treatment | | **AWCCO**: NHS England should require MDTs to review a monthly audit report of patients who have died within 30 days of active treatment, to determine whether lessons can be learned about patient safety or avoiding superfluous treatment. | Care and quality gap | **Accountable**: CCGs<br>**Delivery**: Provider Trusts | * PODGs Leads to discuss within group and agree trajectory for implementation and comparison metrics for measure. | * Analysis report to be provided to Alliance Delivery Group to include lessons learned. | Mar-19 | |
| **Treatment and care** | MDTs consider appropriate pathways of care for metastatic cancer patients | | **AWCCO**: The Trust Development Authority, Monitor and NHS England should encourage Multi-Disciplinary Teams to consider appropriate pathways of care for metastatic cancer patients. Clinical Reference Groups will need to play a key role in supporting these MDTs. | Care and quality gap | **Accountable**: Cancer Alliance Clinical Lead<br>**Delivery**: Cancer Alliance Manager | * PODGs Leads to discuss within group and agreed trajectory for implementation. | * Report to be provided to Alliance Delivery Group. | Sep-17 | |
| Treatment and care | Effective MDT working is in place | **Frimley STP**: Leadership and team development programmes for MDTs.<br>* Clinical and care leaders sharing expertise and supporting generalists/specialists to work together, sharing responsibility and accountability across MDTs. | **AWCCO**: NHS England should encourage providers to streamline MDT processes such that specialist time is focused on those cancer cases that don't follow well-established clinical pathways, with other patients being discussed more briefly. | Care and quality gap; funding and efficiency gap | **Accountable**: CCGs<br>**Delivery**: Provider Trusts | * Undertake a desktop review of current MDT workings and identify opportunities for improvement and reform. | * Await outcomes of national audit on effective MDTs.<br>* Discuss and compare findings of national and local audit with clinical groups to understand what practices need to change. | | |
| **Patient experience** | Delivering care closer to home for patients with head and neck cancer | **• BOB STP:** Acute Trusts collaboration to deliver equality and efficiency<br>**• Frimley STP:** Reducing variation and health inequalities across pathways | **FYFV:** Care closer to home<br>**AWCCO:** NHS England should accelerate the commissioning of services for patients living with and beyond cancer, with a view to ensuring that every person with cancer has access to elements of the Recovery Package by 2020. | Care and Quality Gap | **Accountable**: Cancer Alliance Clinical Lead<br>**Delivery**: Macmillan H&N Project Manager | Clinical Engagement, development of business case, rollout in Berkshire, Bucks and Milton Keynes. | * 2 year pilot project<br>* Current state and gap analysis of requirements for patient numbers and appointments and staff requirements<br>* SCN to recruit post for 2 years<br><br>* Swindon/Oxford business case development | April-2017<br>Dec-2017 | |
| **Recovery package & cancer transformation bid** | All elements of the Recovery Package are available to all patients, including:<br>* All patients have a holistic needs assessment and care plan at the point of diagnosis and at the end of treatment<br>* A treatment summary is sent to the patient's GP at the end of treatment<br>* A cancer care review is completed by the GP within six months of a cancer diagnosis.<br>Lifestyle advice is part of the Recovery Package and return to work is included in assessment and care planning | **BOB STP**: OUH to carry out electronic holistic needs assessments and treatment summaries for each tumour site, which is fed back to GPs. | **FYFV**: Promote the provision of the Cancer Recovery Package, to ensure care is coordinated between primary and acute care, so that patients are assessed and care planned appropriately.<br>**AWCCO**: NHS England should accelerate the commissioning of services for patients living with and beyond cancer, with a view to ensuring that every person with cancer has access to elements of the Recovery Package by 2020.<br>* NHS England should pilot, through new or existing vanguard sites, assessment of holistic needs for cancer patients at the point of diagnosis, evaluating the benefit of earlier palliative care and/or intervention from Allied Health Professionals.<br>**AWCCO**: NHS England should work with partners to ensure that supporting people with cancer to return to work is a key focus. This should include ensuring that return to work is fully integrated into assessment and care planning and should encourage the commissioning of vocational rehabilitation services. | Care and quality gap | **Accountable**: Cancer Alliance Clinical Lead<br>**Delivery**: Cancer Alliance Manager | * Undertake audit of current position across the region - funded by Macmillan.<br>* Share findings and agree with primary care and Trusts a local plan which identifies which tool or method will be used for each element of RP, who will complete or process it and by when.<br>* Agree a phased implementation by tumour site to achieve full implementation by 2020.<br>* Agree metrics to measure outcomes.<br>* Agree a training plan for Holistic Needs Assessments including communication skills training for Clinical Nurse Specialists.<br>* Utilise patient partnership group members and wider to the design and running of education and support.<br>* Clarify who can conduct a Cancer Care Review (CCR), what it is, what it should comprise. Encourage uptake of the practice nurse course for CNSs.<br>* Encourage practices to use the Cancer Care Review templates on EMIS & VISION.<br>* Support Primary Care to improve the quality and delivery of the Cancer Care Review.<br>* Ensure return to work is included as part | Governance established<br>* Map community hubs.<br>* Build and test integrated cancer system. | April 2017<br>July 2017<br>January 2018 | |

**CANCER ALLIANCE**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Recovery package & cancer transformation bid** | Services are in place to respond to needs identified through assessment and care planning, including rehabilitation services to support return to work and the reduction and management of consequences of treatment | **BOB STP**: Improving services for survivorship patients. | **AWCCO**: For NHS England, supporting people to return to work is a key focus. This should ensure that return to work is fully integrated into assessment and care planning and encourage the commissioning of vocational rehabilitation services.<br>* NHS England should ask National Institute of Health Research and research charities to develop research protocols which would lead to a better understanding of the long-term consequences of different treatment options.<br>* CCGs and Health & Wellbeing Boards to work together to identify and promote best practice in approaches to support people living with and beyond cancer. They should involve individuals and organisations beyond the NHS.<br>* NHS England and Health Education England should support a national review of the cancer rehabilitation workforce and promote the role of Allied Health Professionals in multidisciplinary teams | Health and wellbeing gap; care and quality gap | **Accountable**: Cancer Alliance Clinical Lead<br>**Delivery**: Cancer Alliance Manager | * Undertake baseline assessment of rehab support services available to patients following end of acute treatment - funded by Macmillan.<br>* Develop recommendations and approach to take forward with CCGs. | * Review & share findings including those from the Berkshire Well Being programme.<br>* Develop proposals for Thames Valley with partners including developing metrics for outcome measures.<br>* Explore opportunities to ensure cancer support and follow up can be integrated with the ongoing management of other long term conditions.<br>* Consider how best to ensure that exercise programmes are available for all appropriate cancer patients.<br>* Ensure that all multidisciplinary teams have referral pathways in place for lymphoadema services, pelvic radiation disease, sexual dysfunction support and psychological support.<br>* Ensure all patients offered advice on vocational rehabilitation.<br>* Ensure all patients offered advice on physical activity, weight management and how to access appropriate programmes. | July 2017<br>November 2017 | |
| **Stratified follow up pathways & cancer transformation bid** | All breast cancer patients have access to stratified follow up pathways of care, and, dependent on evidence from pilots, from 2018/19 all prostate and colorectal cancer patients have access to stratified follow up pathways of care | | **AWCCO**: The Trust Development Authority and NHS England should ensure all providers are incentivised to start implementing stratified follow-up pathways of care for patients treated for breast cancer. NHS England should pilot stratified follow-up pathways of care for other tumour types, ideally including prostate and colorectal and some rarer cancer types, with an aim to roll out nationally for at least two other cancer types by 2020. | Care and quality gap | **Accountable**: Cancer Alliance Clinical Lead<br>**Delivery**: Cancer Alliance Manager | * Develop and agree prostate stratified pathway design detail.<br>* Complete rollout of breast stratified follow up programme. | * Review and share learnings from pilots and breast programme.<br>* Complete rollout of breast risk stratified pathway to eligible patients at RBHFT/GWHFT.<br>* Rollout of prostate risk stratified pathway at all 5 trusts, short term staffing increase to support required. | July 2017<br>October 2017 | |
| **Recovery package** | Appropriate integrated services for palliative and end of life care are in place | **BOB STP**: Increasing the number of patients supported to die in their place of choice. | **FYFV**: Support and aftercare and end of life care will all increasingly be provided in community settings.<br>**AWCCO**: NHS England should ensure that CCGs commission appropriate integrated services for palliative and end of life care, in line with NICE quality standard (2011). | Care and quality gap | **Accountable**: Cancer Alliance Clinical Lead<br>**Delivery**: Cancer Alliance Manager/EoLC Clinical Lead | * Undertake baseline assessment.<br>* Risk stratify patients based on need-early identification.<br>* Utilise learnings and advice from EoLC programme.<br>* Assurance that integrated services for palliative and end of life care are in place. | * Review services for better coordination and communication between health and social care professionals, community services and family members' involvement as set out in What's Important To Me: A Review of Choice in End of Life care (The Choice Review).<br>* Promote an appropriate interface with end of life care services.<br>* Develop triggers for alerting palliative and end of life care services, and for considering entry into the end of life care register.<br>* Understanding at population level the concerns leading to re-referral. | September 2017<br>December 2017 | |
| **Patient experience** | | | NHS England should continue to commission CPES annually. It should also take steps to increase BME representation in CPES for a minimum of 1 to 2 years to understand drivers of poorer experience within these groups better. It should consider how SPES data canbe linked with other datasets to understand experience across the pathway. It should also develop a methodology to collect data on patient experience for under 16s. | Health and wellbeing gap; care and quality gap | **Accountable**: Cancer Alliance Manager<br>**Delivery**: Patient Engagement Lead | * Review the annual national Cancer Patient Experience Survey, ensuring transparency over variation across the STP geography and assure STP leadership of the action plans in place to reduce that variation.<br>* Champion parity between patient experience, clinical effectiveness and safety by enabling IT for a digitised cancer pathway.<br>* Develop and test new approaches for commissioning and providing CNS or key worker care. | * Action plan to reduce variation based on results of annual national Cancer Patient Experience Survey.<br>* Develop patient engagement programme across all activities. | June 2017<br>October 2017 | |

**STROKE AND VASCULAR**

| Ambition | STP priorities: local links and interdependencies | National priorities: policy links and interdependencies | Contribution to the three gaps | Accountable lead & delivery lead | High level actions | Major milestones/Planned trajectory | Timescale | Status update (RAG) |
|---|---|---|---|---|---|---|---|---|
| **Stroke** | | | | | | | | |
| All patients experiencing stroke symptoms will be taken to a HASU for the first 72 hours of their stay in hospital<br><br>All HASUs in the SSNAP to be performing at an A rating for their Team Centred Total KI score | **BOB STP**: Patients taken to a HASU to enable the best outcomes.<br><br>**BOB STP:** Reduction of unwarranted variation. | | Health and wellbeing gap; care and quality gap | Dr Matthew Burn/Network manager | Complete reconfiguration in East Berkshire (May 2017).<br><br>Review reconfiguration in E Berks and Oxford | SCN to support the reconfiguration process, to oversee that the pathways become embedded, and to monitor the outcomes post-reconfiguration to ensure that the changes translate to benefits for patients. | 2017 | |
| 7 day service delivery for stroke | | Royal College of Physicians Sentinel Stroke National Audit Programme. 7 Day Services (7DS) initiative. | Care and quality gap | Dr Matthew Burn/Network manager | SSNAP results per 4 month period over 2017/18.<br>Liaise with stroke clinical leads at HASUs and map out position<br>Promote best practice towards compliance | SCN to pursue 7DS initiative for Stroke and aim for compliance throughout TV . Highlight other areas of underperformance to the relevant CCGs. | Feb-18 | |
| Prevent 200 strokes in Thames Valley | **BOB STP**: Prevention: focus on areas such as stroke.<br>**Frimley STP**: Data deep dive into stroke. | FYFV: Targeted intervention to reduce avoidable illness. | Health and wellbeing gap; care and quality gap; funding and efficiency gap. Inpatient and rehab for stroke costs £23k. 200 strokes for TV would save £4.6m.<br>Total cost breakdown<br>NHS 50%<br>informal care 27%<br>indirect costs 24%. | Dr Matthew Burn/Network manager | QOF results for 16/17 and 17/18. | Work with AHSN to improve the number of people detected with Atrial Fibrillation, the proportion anticoagulated, and the quality of anticoagulation (eg the Time in Therapeutic range for patients on Warfarin). To support initiatives in prevention through the management of hypertension. | 2018 | |
| MK CCG to optimise stroke services locally, specifically to ensure that the local HASUs are fit for purpose and delivering best quality services to all local CCGs | **Frimley STP**: Hypertension and stroke pathway development.<br>* Set up hypertension and stroke pathway. | **National Stroke Strategy**: All patients with stroke should be admitted to HASU. 7DS intiative. | Care and quality gap | Dr Matthew Burn/Network manager | SSNAP results per 4 month period over 2017/18. | SCN to support CCG in the determination of the optimal configuration of services. | 2017 | |
| Consolidating stroke services at OUH | **BOB STP**: One HASU delivering the best outcomes.<br>* Establishment of an STP-wide planning and commissioning function for stroke services.<br>* Strengthening collaboration around the urgent care pathway and its associated clinical pathways with an initial focus on stroke. | **FYFV**: There is a compelling case for greater concentration of care. | Health and wellbeing gap; care and quality gap | Dr Matthew Burn/Network manager | Timescale to be determined through discussion with Oxfordshire CCG. | TV SCN to support the CCG and Acute Trust in the reconfiguration proposals and to evaluate improved outcomes for patients post-reconfiguration. | 2017 | |
| Development of access to thrombectomy services for the population of Thames Valley | **BOB STP**: Specialised commissioning | Royal College Guidelines<br>NICE Guidelines | Health and wellbeing gap; care and quality gap | Dr Matthew Burn/Network manager | Development of regional infrastructure to support thrombectomy during 2017/18 | SCN to work with local providers and commissioners to develop the imaging and transportation infrastructure to support a regional thrombectomy service. To support providers wishing to undertake thrombectomy with service development. | 2018 | |
| **Vascular** | | | | | | | | |
| Ensure safe transition of vascular clinical network into a operational delivery network, with robust governance arrangements and a work plan for delivery | | Ensuring compliance with the national service specification for Specialised Vascular service<br>Deliver 7 day services | Care and Quality gap | Network Associate Director | | | Anticipated conclusion June 2017 | |

**CLINICAL SENATE**

| Topic | Ambition | STP priorities: local links and interdependencies | National priorities: policy links and interdependencies | Contribution to the three gaps | Accountable lead & delivery lead | High level actions | Major milestones/Planned trajectory | Timescale | Status update (RAG) |
|---|---|---|---|---|---|---|---|---|---|
| **Independent Clinical Reviews** | Provide NHSE with clinical recommendations regarding the Phase 2 of the Oxfordshire transformation plans | **BOB STP:** Oxfordshire Transformation | To be updated once scope of work is known | Care & Quality Gap and Funding & Efficiency Gap | **Accountable:** Jane Barrett<br>**Delivery:** Wendy McClure | Engagement with NHS Stage 2 assurance process | | Awaiting timelines from OCCG - estimate Q3 2017/18 | |
| | Provide NHSE with clinical recommendations regarding the Buckinghamshire transformation plans for community services | **BOB STP:** redesign of community hospital provision | To be updated once scope of work is known | Care & Quality Gap and Funding & Efficiency Gap | **Accountable:** Jane Barrett<br>**Delivery:** Wendy McClure | Engagement with NHS Stage 2 assurance process | | scheme currently running as a pilot - estimate Q1 2018/19 | |
| | To continue to follow up the outstanding recommendations in the Phase 1 Oxfordshire Transformation report | **BOB STP:** Oxfordshire Transformation | | Care & Quality Gap and Funding & Efficiency Gap | **Accountable:** Jane Barrett<br>**Delivery:** Wendy McClure | Continued liaison with OCCG | | Some are dependent on outcome of Phase 1 consultation - est June/July '17 | |
| **Smoking Cessation** | Deliver the smoking cessation programme for secondary care clinicians (London Senate) | **BOB STP:** Making every contact count; Bucks 'stop before the op'<br>**FRIMLEY STP:** Prevention programme - making every contact count and quit support for patients before elective procedures | London Senate guidelines; Links to SCN work areas | Health & Wellbeing Gap | **Accountable:** Jane Barrett<br>**Delivery:** Wendy McClure | * Review with Council members - March '17<br>* Contact BOB and Frimley leads to ascertain level of interest | Subject to STP agreement.<br>Planned for discussion at March '17 Council meeting | March '17 | |
| **Community Hospitals / Community services** | What is the appropriate population size for a diagnostic hub – particularly for imaging. A proactive piece of work to develop guidelines | **BOB STP:** BW - redsign of of system wide use of diagnostics;<br>Bucks redesign of community hospital provision;<br>Oxon - increase diagnostics in the community<br>**FRIMLEY STP:** develop integrated care - aligned crisis response, rehab and re-ablement | tbc | Care & Quality Gap and Funding & Efficiency Gap | **Accountable:** Jane Barrett<br>**Delivery:** Wendy McClure | * Currently seeking STP mandate and clarification of required outputs.<br>* Identify clinical expertise to inform the work | tbc | Commence March 2017 | |
| | What is the benefit of co-location of GP practices with community hubs.<br>A proactive piece of work to develop guidelines | **BOB STP:** Bucks - development of community hubs in each locality<br>**Frimley STP:** new model for GPs at scale | tbc | Care & Quality Gap and Funding & Efficiency Gap | | Review scope with STPs | Subject to STP agreement | Contact with STPs Feb'17 to assess need and scope | |
| | Community/physio rehab services – what is the need by population.<br>A proactive piece of work to develop guidelines | **BOB STP:** Bucks - development of community hubs in each locality<br>**FRIMLEY STP:** develop integrated care - aligned crisis response, rehab and re-ablement | tbc | Care & quality gap; funding & efficiency gap | | Review scope with STPs | Subject to STP agreement | Contact with STPs Feb'17 to assess need and scope | |
| | Community Hospital Report - report on current status of community hospitals across TV and opportunities for the future (linked to 3 topics above) | **BOB STP:** BW - review of community hospitals;<br>Oxon - review of community services;<br>Bucks - review of community hospitals | tbc | Care & quality gap; funding & efficiency gap | **Accountable:** Jane Barrett<br>**Delivery:** Wendy McClure | | | Subject to previous lines | |
| **Urgent & Emergen** | New model for crisis care - Senate acting as critical friend or formal review of proposal | **BOB STP:** BW - new model for crisis care - independent review | tbc | tbc | | • Liaison with UEC Network re involvement and potential for Senate role<br>• Contact with BW to understand timescales and level of interest | Subject to STP agreement | | |
| | Delivering urgent and emergency care services in the right place at the right time - Senate acting as critical friend to STP and/or U&EC network to review proposal | **BOB STP:** NMC<br>**FRIMLEY STP:** redesign of urgent and emergency care services | tbc | tbc | | Liaise with UEC Network | Subject to STP agreement | Liaison with Network Feb/Mch '17 | |
| **Acute Hospital** | Reduce acute hospital utilisation - Senate review of SEC work and its recommendations to evaluate for local adoption | **BOB STP** | SEC guidelines | Care & quality gap; funding & efficiency gap | | Initial scoping.<br>Discussion with STP | | | |

| Topic | Ambition | STP priorities: local links and interdependencies | National priorities: policy links and interdependencies | Contribution to the three gaps | Accountable lead & delivery lead | High level actions | Major milestones/Planned trajectory | Timescale | Status update (RAG) |
|---|---|---|---|---|---|---|---|---|---|
| **CLINICAL SENATE** | | | | | | | | | |
| **Acute Hospital** | Reduce unwarranted variation | **BOB STP:** reduce variation in access to clinical care and in outcomes **FRIMLEY STP**: reduce clinical varaition in 5 pathways and establish an agreed process for identifying future pathways | | Care & quality gap | | | | | |
| | Standardisation of clinical pathways - Senate acting as critical friend, formal review of proposals or working in a proactive way to develop pathways | **BOB STP and FRIMLEY STP** (as above) | | Care & quality gap; funding & efficiency gap | | | Subject to discussion with STPs | | |
| **Workforce** | Workforce: To seek assurance that the various organisations responsible for workforce planning for the Thames Valley have adequate plans to provide the required workforce | Major issue for both STPs | | | | | Subject to discussion with STPs | | |
| **Specialised commissioning** | PPCI - delivery of 4 key standards across TV | | | | | | | | |
| **Review of earlier Senate recommendations for the purposes of learning** | PPCI at Wexham | | | | **Accountable:** Jane Barrett **Delivery:** Wendy McClure | | | | |
| | Specialised Vascular Services | | | | **Accountable:** Jane Barrett **Delivery:** Wendy McClure | | | March '17 | |
| | Stroke in Oxfordshire | | | | **Accountable:** Jane Barrett **Delivery:** Wendy McClure | | | June/July '17 | |
| | Stroke in East Berkshire | | | | **Accountable:** Jane Barrett **Delivery:** Wendy McClure | | | | |
| | Maternity Capacity | | | | **Accountable:** Jane Barrett **Delivery:** Wendy McClure | | | | |

**DEMENTIA**

| Ambition | STP priorities: local links and interdependencies | National priorities: policy links and interdependencies | Contribution to the three gaps | Accountable lead & delivery lead | High level actions | Major milestones/Planned trajectory | Timescale | Status update (RAG) |
|---|---|---|---|---|---|---|---|---|
| Increase rate of formal diagnosis of dementia patients to at least 67% | **BOB STP**: Improvement in dementia care/diagnosis.<br>* Further raising awareness of recording dementia diagnosis.<br>* Achieve a dementia initial assessment within 6 weeks of GP referrals.<br>* Target and promote support and training to practices, with the aim of achieving 100% Dementia Friendly practices in West Berks.<br>* Improving diagnosis rates to 67% by 31 March 2017. | **FYFV**: The NHS is making a national effort to increase the proportion of people with dementia who are able to get a formal diagnosis from under half to two thirds of people affected or more.<br>**FYFV MH**: Develop referral to treatment pathways for dementia. | Care and quality gap | Accountable: Dr Sian Roberts<br>Delivery: Sylvie Thorn | 1. Work closely with CCGs to deliver 2 year dementia programmes. (1.02)<br>2. Providing expert clinical advice to assurance processes. (1.01)*<br>3.Work closely with CCGs to support achievement of Dementia Diagnosis Rate of > 67%.<br>4. Support CCGs to develop sustainable dementia clinical leadership through the delivery of an enhanced Dementia Friendly Practice Scheme so there is at least one Dementia Friendly Practice per CCG.<br>5.Support CCGs in promoting the development and implementation of C&SP for those with dementia (1.09)<br>6.Support CCGs to develop and improve the provision of post-diagnostic support in their areas. | 1. Hold quarterly meeting for Dementia commisioners to provide leadership and support.<br>2. Hold 1:1s with CCGs, and the South Central MH Leads monthly phone conference to aid improvement of diagnosis rates (1.3)<br>3. SCN to identify low-performing CCGs, engage with Ops & Delivery relationship managers; and ensure improvement activity is captured for regional performance. (1.2)<br>4.1 Launch a second wave of Dementia Friendly Practices,. (1.07)<br>4.2 Deliver leadership development programme for Dementia as part of scheme.<br>4.3 Project complete and final outcome reports from practices received.<br>4.4 Project evaluation completed.<br>5.1 Work closely with CCGs to implement national care planning template for dementia. (1.08)<br>5.2 Develop exemplars of Dementia care and support planning in each CCG area by providing targeted support to specific GP practices (1.1)<br>6.1 Design a clinical network best practice forum event to share best practice/explore challenges to delivery. (1.05)<br>6.2 Develop resource of best practice in post-diagnostic suppor to disseminate best practice with CCGs.<br>7. Complete South Central dementia programme to scope/audit CCGs against performance, carers and involvement, post diagnostic support, and clinical leadership metrics (1.5) | Quarterly<br>Quarterly<br>Quarterly<br>April 2017<br>Quarterly<br>March 2018<br>August 2017<br>March 2018<br>October 2017<br>December 2017 | |
| Increase the number of people being diagnosed with dementia and starting treatment within 6 weeks from referral, with a suggested improvement of 5% compared to 2015/16 | | **FYFV MH**: Develop referral to treatment pathways for dementia. | Care and quality gap | Accountable: Dr Sian Roberts<br>Delivery: Sylvie Thorn | * Provide clinical leadership and support commissioners in understanding and preparedness for the forthcoming standard. (1.06)<br>* Ensure CCGs have Service Deivery Improvement Plans in place to ensure preparedness for compliance with the Referral To Treatment standard. (1.6) | * Analyse: dementia diagnosis rates using QOF data, referral to treatment times using Mental Health Minimum Dataset data, self-report data from CCQI tool, annual monitoring of care plan reviews using QOF data; use this analysis to drive improvements at IAF meetings. (1.4) | 2017-18 | |

**DIABETES**

| Ambition | STP priorities: local links and interdependencies | National priorities: policy links and interdependencies | Contribution to the three gaps | Accountable lead & delivery lead | High level actions | Major milestones/Planned trajectory | Timescale | Status update (RAG) |
|---|---|---|---|---|---|---|---|---|
| Treatment Targets:<br>At least 43,474 additional patients with diabetes in Thames Valley will receive the three treatment targets on a regular basis. | **BOB STP**: Improving diabetes diagnosis and care.<br>**Frimley STP**: Establish pathway on diabetes control. | To support implementation of successsful diabetes transformation funding bids, in line with the bid specific actions and timescales. | Health and wellbeing gap; care and quality gap | Network manager/clinical lead | * Annual analysis of NDA and QOF data, identifying high performing practices and CCGs, undertake review both within TV and nationally.<br>* Model cost and quality gain for TV CCGs.<br>* Identify best performers to enable sharing of best practice and learning.<br>* Support CCGs in the implementation of successful transformation bids.<br>* Ensure maintainence of timescales and targets, provide remedial input as required.<br>* Report to DRG and regional board. | * Attaining target of 40% by CCG within 2017/18.<br>* Reduce practice variation with a focus on improving performance of the poorest performing practices in each CCG.<br>* Achieve a % improvement across all practices. | 2018<br>2018<br>2019 | |
| Structured patient education:<br>3,520 more people to receive structured patient education.<br>*20% by 2017/18<br>*50% by 2020/21 (National ambition = an additional 10% per year attending to 2021) | **BOB STP**: Improving diabetes diagnosis and care.<br>**Frimley STP**: Establish pathway on diabetes control.<br>* Prioritised identifying people with diabetes earlier and improving their self care & management. | To support implementation of successful diabetes transformation funding bids, in line with the bid specific actions and timescales. | Health and wellbeing gap; care and quality gap<br>Delivery of structured education for the prevalent population of patients with TYPE 1 diabetes could deliver savings of an estimated £880 average per person after 5 years and £3,600 after 10 years<br>Delivery of structured education for newly diagnosed patients with TYPE 1 diabetes could deliver savings of an estimated £440 average per person after 5 years and £1,800 after 10 years<br><br>Delivery of structured education for the prevalent population of patients with TYPE 2 diabetes could deliver savings of an estimated £160 average per person | Network manager/clinical lead | Using the structured education review carried out in 2015:<br>* Work with CCGs to ensure use of report and its resources is maximised.<br>* Identify, and aim to provide, any specific assistance/support required across CCGs.<br>* Facilitate opportunities for collaboration across CCGs re the procurement of new providers and the learning from new courses.<br>* Work with CCGs to ensure they commission a mixed menu of education provision based on local population needs.<br>* Support CCGs in their implementation of successful patient education transformation bids.<br>* Ensuring achievement of timescales and targets, provide remedial input as required.<br>* Reporting to DRG and regional board.<br>* Work with CCGs to ensure they are well positioned to maximise opportunities for securing future funding for online courses. | * 3,520 more people to receive structured patient education.<br>* 20% by 2017/18. | 2017/18 | |

**DIABETES**

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| 360 fewer people undergoing amputations.<br>*Reduce to level of best performing area in England by 2020 ('Average to Excellent') | **BOB STP**: Improving diabetes diagnosis and care.<br>**Frimley STP**: Establish pathway on diabetes control. | **National programme**-via transformation bids- improved availability of MDFTs and diabetes inpatient specialist nurses. | Health and wellbeing gap; care and quality gap; funding and efficiency gap (£1.9m)<br>A report published in 2017 by Diabetes UK found healthcare related foot ulceration and amputation in diabetes in 2014-15 cost<br>0.72-0.83% of the entire NHS budget. Initiatives in Brent, Somerset and Ipswich have reduced incidence of ulceration, reduced amputations by 43% and reduced bed days saving up to £926,000. | Network manager/clinical lead | Building on Foot Conference (February 2017) and TV Footcare Pathway (2016):<br>* Develop cost and quality case for change based on TV pathway.<br>* Undertake analysis and identify learning for TV from National Diabetes Audit foot audit (due to be published in March 2017).<br>* Model the impact of best practice initiatives ie BHT in patient foot care.<br>* Work with CCGs in the adoption of best practice pathway.<br>* Support implementation of successful transformation bids for MDFT.<br>* Ensuring achievement of timescales and targets, provide remedial input as required.<br>* Reporting to DRG and regional board. | [potential cost benefit of reduced amputations] | 2019 | |
| An increased proportion of practices participating in the National Diabetes Audit | | Requirement within transformation bids | Care and quality gap | Network manager/clinical lead | * Provide advice and guidance re GMS contract changes.<br>* Work with CCGs to understand impact and challenges of changes to NDA achievement.<br>* Identify and promote actions to aid achievement. | All CCGs to achieve 100% for 16-17 data | May/June 2017) | |
| Roll out Diabetes Prevention Programme by supporting readiness to implement the programme/Support delivery of the NHS Diabetes Prevention Programme for people with type 2 diabetes.<br>By 2020 all local health economies will have comprehensive prevention programme in place referring 500 people per 100,000 population annually. | **BOB STP**: Rollout of the diabetes prevention programme across BOB from its current implementation in Berks West.<br>**Frimley STP**: Rollout of national diabetes prevention programme.<br>* Development of a project. | **FYFV**: Our ambition is to change this over the next five years so that we become the first country to implement at scale a national evidence-based diabetes prevention programme modelled on proven UK and international models. | Health and wellbeing gap | Network manager/clinical lead | * Support wave 1 sites to maintain trajectory of referrals.<br>* Support wave 2 sites to complete mobilisation and achieve referrals as per trajectory.<br>* Provide oversight of performance and remedial input as required.<br>* Ensure CCGs are well placed to engage in future funding opportunities re different models of delivery.<br>* Reporting to DRG and regional board. | Wave 1 sites to maintain trajectory of achievement with a target of 3,800 referrals<br><br>Wave 2 sites to complete mobilisation<br><br>Wave 2 sites to deliver to trajectory Y1 3323<br>Y2 9549 | <br><br>April 2017<br><br>2017/18<br>2018/19 | |
| Support CCGs identified via the CCG Assessment Framework as having poor outcomes in relation to diabetes | | | Care and quality gap | Network manager/clinical lead | * Carry out review in individual localities using RightCare tools.<br>* Ensure all CCGs have used RightCare methodology for diabetes improvement.<br>* Support CCGs in review of current and proposed pathways to ensure optimal [xxx].<br>* Provide local and national best practice guidance and learning to CCGs. | All CCGs to identify and maximise opportunities from RightCare methodology. | 2017/18 | |

**DIABETES**

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| For the TV CCGs to set ambitious targets of improvement across all aspects of diabetes care, based on evidence and adoption of best practice prevention and treatment. | | Diabetes Transformation Programme: To support implementation of successful diabetes transformation funding bids, in line with the bid-specific actions and timescales. | Care and quality gap; funding and efficiency gap<br><br>This is being calculated | Network manager/Clinical lead | * Development of case for change.<br>* Identify local initiatives such as medicines optimisation (Slough) and in patient foot care (BHT), model the potential cost and quality gain for the population of TV.<br>* Use national and international data comparators to identify best practice, model cost/quality gain for TV population.<br>* Work with CCGs to adopt best practice initiatives into their model of care.<br>* In conjunction with CCG colleagues, articulate the case for change to CCG boards.<br>* Provide leadership to facilitate local understanding of effective service delivery through sharing of best practice in diabetes. | * Production of comprehensive case for change for CCG and Health and Wellbeing boards.<br>* Identification and modelling of key initiatives; local, national and international.<br>* CCGs to adopt best practice initiatives within local plans.<br>* TV CCGs to be in top decile of performance in diabetes care. | 2021 | |
| Inpatient care: Improving access to specialist diabetes teams for inpatients. | | Inpatient care: Improving access to specialist diabetes teams for inpatients. All secondary care providers have specialist teams to assess and manage inpatients with diabetes effectively. | Care and quality gap; funding and efficiency gap<br><br>Clinical studies suggest that specialist diabetes inpatient teams can reduce prescribing errors, improve patient outcomes and reduce length of stay. | Network manager/Clinical lead | * Produce case for change to identify cost/quality impact and potential for CCGs of improving inpatient care.<br>* Analysis of NDA in patient audit (due March 2017) to identify areas of best practice in TV and nationally.<br>* Identify local and national best practice, and model impact of local adoption across TV.<br>* Work with CCGs to drive improvement in inpatient care.<br>* Support implementation of successful transformation bids.<br>* Ensure maintainance to timescales and targets, provide remedial input as required.<br>* Reporting to DRG and regional board. | * All acute trusts to comply with national best practice for inpatient care.<br>* Improvement across key indicators (length of stay/bed days). | 2020 | |

**END OF LIFE**

| Ambition | STP priorities: local links and interdependencies | National priorities: policy links and interdependencies | Contribution to the three gaps | Accountable lead & delivery lead | High level actions | Major milestones/Planned trajectory | Timescale | Status update (RAG) |
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| Support for STPs and operational plans for End of Life Care (EoLC), including maximising opportunities to integrate EoLC into other work programmes eg<br>- Urgent and emergency care (U&EC)<br>- Long term conditions (LTC)<br>- New models of care<br>- Transforming primary care<br>- Personalisation 24/7 services<br>- Cancer<br>- Dementia<br>- LD | **Frimley STP:** Redesigning urgent and emergency care, including integrated working and primary care models providing timely care in the most appropriate place.<br>* Action to improve long term condition outcomes including greater self management and proactive management across all providers for people with single long term conditions.<br>* Frailty Management: Proactive management of frail patients with multiple complex physical and mental health long term conditions, reducing crises and prolonged hospital stays.<br><br>**BOB STP:** Working with general practice to make sure it is central to delivering and developing new ways of providing services in local areas.<br>* Organising urgent and emergency care so that people are directed to the right services for treatment, such as the local pharmacy or a hospital accident and emergency department | **Network Deliverables 2017-18:**<br>* To facilitate end of life care to be embedded as part of transformation of services across STP footprints and through operational plans, especially in the priority areas of cancer, dementia, LD, UEC and primary care<br>* To particularly support STPs where there is no mention of EoLC to understand the opportunities and benefits.<br>* To work with other regional leads to align and join up plans and delivery mechanisms e.g. Cancer Alliances, UEC board etc. | Care and Quality Gap, Finance and Efficiency Gap. An estimated £8.2m can be saved in TV by 2700 deaths taking place in the community as opposed to in a hsopital. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215107/dh_133105.pdf | Network manager and clinical leads | * Work with CCG leads to map progress across their local system in the adoption of One Chance to Get It Right and Ambitions for Palliative and End of Life Care.<br>* Establishing links with Better Care Fund leads to promote EoLC within integration plans.<br>* Deliver EoL opportunities to STP programme meetings. Work with STP leads to embrace EoL within their programmes. Host themed STP/EoL events ie urgent and emergency care and end of life.<br>* Build on the Urgent and Emergency Care work to develop compelling cases for the contribution of EoL to other key programmes. Utilise national data and local variance to demonstrate potential cost and qualiy gain of adoption of EoL initiatives. | * STPs to have robust EoLC strategies, based on Ambitions for Palliative and End of Life Care.<br>* Health and Wellbeing Boards to recognise EoL as a major theme in their integration strategies. | CCG leads mapping: 2017<br><br>Delivering EoL opportunities: 3-6 months (May 2017-August 2017)<br><br>Build on U&EC work: Ongoing<br><br>Provide cases for alignment: 2017 | |
| Provision of 24/7 end of life care across Thames Valley | **BOB STP**: Implementing a 24/7 palliative care advice line for patients<br>* Increasing the number of patients supported to die in their place of choice.<br>* Increased digital interoperability.<br>* All GPs, A&E and parts of community service have access to Electronic Palliative Care Coordination Systems (EPaCCs).<br><br>**Frimley STP:** Redesigning urgent and emergency care, including integrated working and primary care models providing timely care in the most appropriate place. | **The Government Response to the Review of Choice in EoLC:** Each person who consents must have their choices recorded in EPaCCs<br>* EPaCCs (or its equivalent) is 100% available across all areas by April 2018<br><br>**The Government Response to the Review of Choice in EoLC:** That by the end of 2019, every local area should establish 24/7 end of life care for people being cared for outside hospital, in line with the NICE quality standard for end of life care, which supports people's choices and preferences. | Care and quality gap;<br><br>Localities that have commissioned 24/7 services have seen an increase from 23% to 40% of people dying at home, which improves care quality and reduces unwarranted hospital admissions. | Network manager and clinical leads | **EPaCCs**<br>* Model the potential cost and quality gain for TV CCGs of EPaCCs. Drawing on national guidance and exemplar sites.<br>* Scope current EPaCCs plans and review progress.<br>* Work with CCGs to have comprehensive EPaCCs plans.<br><br>National EPaCCs guidance to be reviewed and key learning along with a guidance on tools and resources to be provided to CCGs.<br>Provide expert advice to CCGs re best practice, compliance with national specification and measures of success.<br><br>**24/7**: Identify national examples of 24/7 services, with a focus on measureable impact.<br>Develop compelling case for 24/7 provision, providing potential cost and quality gain for CCGs. | **EPaCCS:** For all CCGs to have implemented EPaCCs to meet the 2018 target. All CCGs are assurance on the quality and effectiveness of their EPaCCs system: aligns to metrics project.<br><br>**24/7:** By 2019 all CCGs to provide 24/7 palliative care services Ensuring robust measures for assurance: aligns to metric project.<br><br>**ReSPECT:** To promote and enable a comprehensive adoption of ReSPECT across all providers to enable the expression of wishes and choices to enhance end of life care for the TV population. | EPaCCS:<br>Scope<br>(3 months - May 17)<br><br>Review plans<br>(6 months - Aug 17)<br><br>Review progress<br>(9 months - Nov 17)<br><br>Achieve target<br>April 2018<br><br>Scope current provision<br>July 2017<br><br>Review progress<br>March 2018<br><br>Achieve target<br>2019 | |

**END OF LIFE**

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| Assurance on delivering high quality end of life services.<br><br>**Thames Valley Strategic Clinical Networks: The Road to 2020:** 10% increase across Thames Valley of death in place of usual residence. | **BOB STP**: Increasing the number of patients supported to die in their place of choice<br>* Increased digital interoperability.<br>* All GPs, A&E and parts of community service have access to EPaCCs.<br><br>**FRIMLEY STP:** Reducing variation and health inequalities across pathways to improve outcomes and maximise value for citizens across the population, supported by evidence. | **The Government Response to the Review of Choice in EoLC:** That the work on individual-level outcome and experience measures for palliative care, being led by NHS England and Public Health England, should incorporate real time feedback and also measure the extent to which a person had been offered choice and whether their choices had been met. These measures should also provide meaningful data to monitor the impact of a national choice offer on health inequalities. | Care and quality gap; funding and efficiency gap<br><br>Nearly half of all deaths occur in hospital. Three quarters of deaths are expected, providing an opportunity to plan and express wishes. Where patients have a shared record of their wishes an achievement of 82% dying in place of choice is possible. | Project Lead accountable to Thames Valley SCN EoL team<br><br>Network manager and clinical leads | **Phase 1 Scoping and development**<br>* Establish/confirm opportunities for measurement within the EoL pathway.<br>* Review nationally available data and outcomes of work on metrics in other regions.<br>* Analyse work done for U&EC deep dive, local and national examples for evidence of EoL metrics with relevance to other areas of work.<br><br>**Phase 2 Implementation**<br>* To work with each CCG to support selection, implementation and embedding of the selected metrics as normal practice for ongoing data collection and assurance.<br><br>**Phase 3 Sustainability and sharing**<br>* To work with each CCG to address blocks to sustainability and explore opportunities for cross provider sharing. | For CCGs to have an agreed set of metrics that provide CCG board assurance to inform service improvement.<br><br>CCGs to develop local measures that include patient and carer real time experience e.g. VOICES survey.<br><br>For Health & Wellbeing Boards to have an agreed set of metrics that provide Health & Wellbeing Board assurance to inform service improvement.<br><br>To promote a TV EoL Dashboard that captures metrics from CCGs to highlight good practice and identify unwarranted variation across the region.<br><br>Use metrics to demonstrate the opportunity and impact of improvement. | Phase 1:<br>April 17-July 17<br><br>Phase 2:<br>July 17-Dec 17<br><br>Phase 3:<br>Dec 17-April 18<br><br>Drawing on RightCare methodology: July 17-Dec 17<br><br>Supporting CCGs: Dec | |
| Sharing intelligence and spreading good practice | **BOB STP**: Rolling programme of education for staff. Developing our workforce, improving recruitment and increasing staff retention by developing new roles for proposed service models.<br>* Integrating health and care services by bringing together health and social care staff in neighbourhoods to organise treatment and care for patients. | **Alignment with HEE mandate:**<br>HEE/Local Education and Training Boards to ensure that staff have training to enable choice in EoLC including the early identification of needs, advance care planning, communications skills, shared decision making, the use of coordination systems (eg EPaCCS) and working in partnership with people and other organisations to design and deliver person centred care.<br><br>**The Government Response to the Review of Choice in EoLC:** That health and social care commissioners include initiatives aimed at increasing community resilience and involvement in end of life care in their plans.<br><br>**5YFV:** To engage patients and communities including expansion of integrated personal health budgets and choice in end of life care. | Care and quality gap; | Thames Valley SCN EoL team | * In collaboration with HETV, provide a programme of clinical workshops to support local education and training initiatives for the clinical workforce.<br>* Promote EoL champions across all workplace settings and providers in both health and social care.<br>* TVSCN EoL team to act in a leadership/coordinator role on behalf of the 4 Southern region networks.<br><br>Bring the 4 networks across the South together for sharing and dissemination of best practice, to work on initiatives that cross boundaries ie adoption of ReSPECT which enables the development of personalised patient held records.<br><br>Facilitate cross provider working groups to implement adoption of ReSPECT Community initiatives to increase awareness of EoLC and enhance public understanding.<br><br>Identify, promote and work with community focused initiatives and share good practice eg Dying Matters, Dr Ellen | To promote and support End of Life Care as everybody's business. | Collaboration with HETV:<br>2017<br><br>Bringing 4 networks together:<br>Ongoing<br><br>Facilitate cross provider working groups:<br>March 2017 onwards<br><br>Identifying/promoting community initiatives:<br>Ongoing | |

**MATERNITY**

| Topic | Ambition | STP priorities: local links and interdependencies | National priorities: policy links and interdependencies | Contribution to the three gaps | Accountable lead & delivery lead | High level actions | Major milestones/Planned trajectory | Timescale | Status update (RAG) |
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| **Workstream 1 (although will align to all workstreams): Better Births: To support the local maternity systems develop by STP across TVSCN** | Local Maternity systems are fully functional in BOB STP and Frimley Health STP. | **BOB STP**: Changing the model of care based on the national maternity review to better suit patients rather than just increasing capacity of current services. | **Better Births**: Providers and commissioners should come together in local maternity systems covering populations of 500,000 to 1 million with shared standards and protocols agreed by all. | Care and quality gap; | Accountable Lead:Jane Herve Delivery lead Rebecca Furlong | *Agree work plan and governance structure of LMS.<br>* Ensure recommendations from TVSCN Maternity and Capacity Report and TV Maternity Senate stakeholder forum inform work plan which will include:<br>* TVSCN to provide feasibility of 24/7 phoneline staffed by midwives to provide advice and support to women who think they are in labour.<br>* Workforce issues.<br>* Capacity issues.<br>* SCN to support LMS to ensure regionally available specialised services that LMSs can access and that they are accessed when needed.<br>* SCN to support the 2 LMS' to reduce unwarranted variation through development of their work plans and to align with TVSCN Maternity priorities which will include the priorities listed below as well as national updates, sharing best practice and benchmarking against each maternity service with the development of the regional maternity dashboard in order to ensure improvement in the quality of services | Governance arrangements of LMS agreed - Jul 17<br><br>TV Regional Matenrity Dashboard and reporting criteria to flow into LMS process agreed - Jul 17<br><br>Each Local Materntiy system has developed a work plan which aligns to "Better Births" - Oct 17 | Oct-17 | |
| **Workstream 1 (LMS) and 2 (Safer Care): CCG IAF Maternity indicators:<br>- Maternal smoking<br>- Stillbirth and neonatal death<br>- Experience of care** | Provide targeted improvement support and clinical advice to poorly performing CCGs according to the CCG Improvement and Assessment<br>**1 5% reduction in stillbirth rates by 2019** | | **Better Births**: Saving Babies' Lives is a national care bundle designed to tackle stillbirth and early neonatal death in a focused way. | Care and quality gap | Accountable Lead:Jane Herve Delivery lead Rebecca Furlong | * Agree TVSCN SOP with all trusts as Regional Maternity dashboard is in final stages of development<br>*TVSCN to continue to support Saving Babies' Lives care bundle implementation by completion of action plans and progress surveys for NHS E<br>*TVSCN to support commissioners & providers to implement focused interventions as new evidence emerges.<br>* Ensure Trusts align to AHSN Maternity Network on Growth scan pilot<br>*TVSCN to support National Maternity and Neonatal Safety collboborative -align to PSC /AHSN | Implementation of TVSCN Regional Maternity dashboard to identify improvement through regional benchmarkingto ensure data flow and review by providers - Jul 17 | Ongoing | |
| **Work stream 1 (LMS) and 2 (Safer Care) and 5 (workforce): Better Births : TVSCN Maternity Capacity** | That the recommendations from the TVSCN Maternity Capacity report and TV Maternity Senate stakeholder forum are progressed through the establishment of the LMS via each STP in TV and through the National Maternity tranformation programme. | **BOB STP**: Identifying additional capacity needed to meet changing needs of population.<br>* Oxon reviewing obstetric provision and supporting midwife-led units.<br>Frimley STP: Investment in Wexham Park maternity department. | **FYFV**: Make recommendations how best to sustain and develop maternity units across the NHS.<br><br>In line with requirements of National Maternity & Neonatal Safety Collaborative | Care and quality gap; funding and efficiency gap | Accountable Lead:Jane Herve Delivery lead Rebecca Furlong | *Ensure STPs are informed of work plan of each LMS<br>*Ensure all key partners and stakeholders are part of the LMS<br>* Engage with the Early adopter sites to understand possible outcomes from the National Maternity transformation programme :personalised budget, tariff.<br>* Work with HEE on development of the maternity workforce | TVSCN to triangluate the reocmmendations from the TVSCN Maternity capcity report /Senate stakeholder forum to help faciliate a work plan for both STPs in TV | Jun-17 | |

**MATERNITY**

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| **Workstream 4: Perinatal Mental Health: Better Births To improve access to Perinatal mental health care across TV** | 357 additional women to be seen in perinatal mental health services in Thames Valley by 2019. Succesful bids in wave 2 Community Development fund for Specialist Perinatal Mental health services | **BOB STP**: Agreeing and implementing Bucks perinatal mental health pathway. * Integrated perinatal mental health services. **BOB STP**: Comprehensive perinatal mental health services to ensure early intervention and better outcomes for mothers, their babies and families. | **Better Births**: Better postnatal and perinatal mental health care to address historic underfunding. | Health and wellbeing gap; care and quality gap | Accountable Lead: Jane Herve, Bryony Gibson/Michael Yousif Delivery lead: Rebecca Furlong | *Maintain the TVSCN Perinatal Mental Health steering group in order to: Provide support, advice, sharing best practice, networking through professional groups and leadership to locality networks to support timely delivery on identified work programme.<br>* Attendance at and active engagement with all 4Locality PNMH Networks providing the bridge between local direction and national priorities and guidance.<br>* To provide clinical advice to Assurance when reviewing STP and CCG plans, and funding bids.<br>* Implement the TVSCN perinatal mental health forum on the TVSCN website.<br><br>*Support to the Berkshire PNMH localities in the development of their specialist services including;<br>* Ensure TV MBU document in use<br>*Audit no of eligible women not admitted to MBU *Contribute to the Webbeds pilot in Wessex<br>*Complete Infant parent scoping in TV | * To have provided support and advice to Oxford and Buckinghamshire in putting forward an effective bid to the Community Development Fund to establish a new PNMH service in line with national guidance.<br>(Launch application process in Q2 2017/18 for wave 2 and notify successful applicants by end Q3) | Q3 17-18 | |
| **Workstream 4: To improve quality and access to Perinatal mental health care- Impementation of Perinatal Mental Health education programme 2017** | Education provided to over 240 clinicians in the Thames Valley working with women suffering with mental illnesses during the perinatal period<br>Specilaist Perinatal train the trainer session deliver by SLAM to SP Clinicians in TV to then be able to upskill local workforce in 4 regional events | **BOB STP**: Multiprofessional working. | **Better Births**: Better postnatal and perinatal mental health care to address historic underfunding.<br>* Training professionals to improve skills such as perinatal mental health care. | Care and quality gap | Accountable Lead: Jane Herve, Bryony Gibson/Michael Yousif Delivery lead: Rebecca Furlong | *To develop education sessions to align with National Perinatal competencies developed by HEE.<br>*Ensure staff are released to attend training or development related to PNMH as required * Liaise with HEE TV to collaborate on delivering PNMH workforce requirements. (1.1)<br>* Ensure users with lived experience of PNMH are integrated into education systems. (1.12) | 240 practioners and medical staff attending 4 x Regional general education events 4/5, 8/6, 11/9 and 25/9 in 2017.<br><br>24 x practitioners to attend Specialist Winchester 2 day conference for Specialist PNMH teams in TV in June 2017. | Dec 17<br><br>June 17 | |
| **Workstream 4 :Development of Perinatal Mental Health Matrix** | Matrix developed for services (maternity, mental health, health visiting, IAPT) in Thames Valley to be evaluated against NICE Quality Standards 115 on perinatal mental health. The aim is to provide a mechanism to benchmark performance against other services in the region and national priority standards. | | **Better Births**: Better postnatal and perinatal mental health care to address historic underfunding. | | Accountable Lead: Jane Herve, Bryony Gibson/Michael Yousif Delivery lead: Rebecca Furlong | * Build perinatal matrix as a demo and engage with all key stakeholders to ensure fitness for purpose<br>*Develop report templates to allow for regional reporting<br>*Identify and train clinicians to submit data;<br>*Phased implementation across the TV and South | Perinatal matrix developed in demo mode and shared with steering group.<br><br>Perinatal Matrix launched and utilised. | Apr-17<br><br>Sept 17 | |
| **Workstream 2 (Safer Care) and 9 (Prevention ): Better Births** | Improve the management of women with diabetes in pregnancy or improve the outcomes for women who develop gestational diabetes in pregnancy | | **Better Births**: Screening and identification of women to detect those at risk of developing conditions such as diabetes in pregnancy.<br><br>Aligned to National Maternity and Neonatal Safety Collaborative actions | Health and wellbeing gap; care and quality gap | | * Develop and undertake audit of women with diabetes in pregnancy and women who develop gestational diabetes in pregnancy in 2016.<br>* Provide a forum to share results of audit and share best practice and agree next steps to reduce any unwarranted varation.<br>* Ensure all key stakeholders are included in forum. *TVSCN to support National Maternity and Neonatal Safety collboborative -align to PSC /AHSN | Undertake audit by July 2017. | | |

**MATERNITY**

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| **Work stream 3 Choice and personalisation: Better Births: Postnatal Care** | Improve Postnatal Care | | **Better Births**: Better postnatal and perinatal mental health care to address historic underfunding. Personalised Care | Care and quality gap; funding and efficiency gap<br><br>Tested in RBH - discharge 80% of cases using this. Midwife time saved of 3200 hours equating to £94,000 | | * Map pathway for postnatal care collecting data on LOS, readmission and reason for admission, acuity of women as examples to understand issues.<br>* Work with services users through the SCN/AHSN maternity expert user group to understand the experiences of women.<br>* Use information gathered to share best practice and learning by benchmark against each other and drive improvement in the quality of services across the region.<br>*Work with RBFT to develop iBook to be used across TV for postnatal information needed by women developed with women to ensure standardised information given. | Produce a benchmarking report for BOB LMS on postnatal care.<br><br>Produce an interactive iBook for postnatal advice to mothers and family on discharge.<br><br>Test and roll out in RBH<br><br>Roll out in other TV Trusts | Sept-17<br><br>Jun 17<br><br>Mar 18<br><br>Mar 19 | |
| **Work streams 2 (Safer Care) and 9 (Prevention): Better Births** | **Improve Preconception care across Thames Valley SCN**: Health Mum/Health Baby. Focus on 4 key cohorts of women: women with diabetes, epilepsy (women on anti-epileptic medication), cardiac history and those on anticoagulants. | | **Better Births**: Screening and identification of women to detect those at risk of developing conditions such as diabetes in pregnancy.<br><br>Aligned to National Maternity and Neonatal Safety Collaborative actions | Health and wellbeing gap; care and quality gap | Accountable lead: Jane Herve<br>Delivery lead: Rebecca Furlong | * Continue to provide evidence to CCG Commissioners of the reason why preconceptual counselling is essential.<br>* GPs to identify women in the high risk group as defined and the SCN to work to develop a QUIPP toolkit to allow this to happen.<br>* Pharmacy: SCN to link with Trust and all other pharmacists to see the feasibility of them supporting part of preconception counselling where possible. Can include:<br>- Ensuring women who are planning pregnancy are on vitamin D, correct dose of folic acid<br>- Signpost back to GP, provide leaflers to give to women<br>- Website to signpost women and identify women in high risk groups, consider education needs of those women | | | |

**CHILDREN'S MENTAL HEALTH**

| Topic | Ambition | STP priorities: local links and interdependencies | National priorities: policy links and interdependencies | Contribution to the three gaps | Accountable lead & delivery lead | High level actions | Major milestones/Planned trajectory | Timescale | Status update (RAG) |
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| **Implementation of recommendations of future in mind: Transformation of CYP Mental Health services** | TVSCN to support Implementation of local transformation plans: to expand access to CYP services by 7% in real terms this requires a focus on improving data collection to ensure all CYP that are seen are reported. | **BOB STP**: Integrated all ages service.<br>* Increasing availability of evidence based interventions for children. | **FYFV**: We want to expand access standards to cover a comprehensive range of mental health services, including children's services.<br><br>**FYFV MH**: By 2020/21 at least 70,000 more children and young people should have access to high-quality mental health care when they need it. | Health and wellbeing gap; care and quality gap | Accountability Lead: Stephen Madgwick Delivery Lead Rebecca Furlong | * Support to STPs as required in developing and delivering their 2 year CYP MH programmes<br>* Provision of a Bimonthly Thames Valley CYP Mental Health Strategic Steering Group to maintain focus on improvement, share learning and best practice, act as a conduit for sharing national information, and provide support in developing funding bids<br>* Attendance at all LTP meetings across Thames Valley to provide bespoke support, advice, leadership, sharing of best practice and maintain focus on delivery<br>* Support to deliver CYP MH Commissioner Development Programme at local level in conjunction with the national team<br>* Provision of expert clinical advice to assurance processes set up by Assurance and Delivery colleagues, such as LTP refreshes, CCG and STP plans, and review of funding bids<br>* TVSCN will use the MH dashboard with CYP Metrics but will also ensure service user experience, waiting times , admission | Annual planning refresh for CCGs against delivery programmes<br><br>Bid process likely to commence, managed and run | 01/10/2017<br><br>Dec 17 to Mar 18 | |
| **DATA** | Trusts will be able to report all National requirements of the MH Minimum dataset. | **BOB STP**: Improving early identification and help for emerging emotional health & wellbeing problems. | **FYFV**: We want to expand access standards to cover a comprehensive range of mental health services, including children's services.<br>**FYFV MH**: By 2020/21 at least 70,000 more children and young people should have access to high-quality mental health care when they need it. | | Accountability Lead: Stephen Madgwick Delivery Lead Rebecca Furlong | * TVSCN to link providers and commisioners to understand the Referral to acceptance rates - to ensure children and young people are referred to the right service at the right time<br>* TVSCN will support all providers including LA/Vol Sector to report into the MHMDS as required<br>* TVSCN CYP MH programme will use the NHS E MH dashboard with CYP Metrics to inform support of transformation across TV and the results<br>* Waiting times -TVSCN will work with providers and commisioners to understand progress in reducing waiting times but also supporting trusts when demand goes up if pathway review needs to happen such as for autism - support this process through workshop to review what works well to reduce waiting times | Strategic quarterly meetings to review and further develop data capability across Thames Valley region | Ongoing 2017-18 | |

**CHILDREN'S MENTAL HEALTH**

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| **Eating disorders** | That 95% of children and young people are seen within 4 weeks (1 week for urgent cases) and that trusts can report the data Nationally | **BOB STP**: CAMHS Community Eating Disorders meeting access targets. | **FYFV**: We want to expand access standards to cover a comprehensive range of mental health services, including eating disorder services. | Health and wellbeing gap | Accountability Lead: Stephen Madgwick Delivery Lead Rebecca Furlong | *The TVSCN will maintain the TV Eating disorder best practice group - to share best practice , provide support and a forum to benchmark services across the region. *TVSCN to support Commissioners and providers to join the national quality improvement and accreditation network for community eating disorder services (QNCC ED)<br>* Develop proforma to support trusts to submit data as per AWT guidance.<br>*To work with Adult Eating disorder service to understand how transition works | Produce a TV benchmarking report of eating disorder services across TV<br><br>Best Practice events - quarterly to include continued focus on ED | 01/06/2017<br><br>Quarterly | |
| **CYP IAPT** | To support CYP IAPT programme | **BOB STP**: Increasing availability of evidence based interventions for children. | | Health and wellbeing gap; care and quality gap | Accountability Lead: Stephen Madgwick Delivery Lead Rebecca Furlong | * Work closely with Oxford AHSN to develop a mutual programme of work which avoids duplication and ensures maximum clinical effectiveness.<br>* Work with Health Education England to understand workforce gaps, facilitating meaningful support for providers<br>.*Ensure CYP IAPT is included in data project | Further clarity sought on scope and delivery of IAPT work programme | Jun-17 | |
| **Schools** | That schools feel that they have the right support and skills to manage the emotional well being of Children and young people or where needed are able to access support . That the Children and Young people feel supported at school and if unwell are able to access support. | **BOB STP**: Improving early identification and help for emerging emotional health & wellbeing problems. | | Health and wellbeing gap; care and quality gap | Accountability Lead: Stephen Madgwick Delivery Lead Rebecca Furlong | * Workshop to share best practice for CYP MH within schools<br>* Identify additional workstreams from workshop.<br>* Through existing groups of young people such as Youth parliaments we are able to understand children and young peoples experiences of support and accessing services<br>* Ensure Transition from children to adults and school to college is considered | Benchmarking report to be published to understand provision in school settings in TV | Sept-17<br><br>Ongoing | |
| **Specialised Commissioning** | Support of NHS E Specialised Commissioning and Health and Justice National programmes including CCG Collaborative commissioning to ensure pathways are seamless. | | | | | * Work with Health and Justice providers and commisioners to plan education of wider stakeholders and system to raise awareness and focussed training for specific members of the CYP teams.<br>* Support and facilitate CCGs and Specialised commisioners to work together on colloborative commisioned services<br>* Work with NHS E Spec Comm to get the data for admission to tier 4 to understand number of eating disorder admissions | Launch event of national programme CCG collaborative commissioned services<br><br>Quarterly workshops<br><br>E-module to be launched | Sept 17<br><br>2017-18<br><br>2018 | |
| **Vulnerable groups** | To ensure children and Young people who are suspected to have autism are seen within an agreed time but to also expand this to consider the management of autism across the lifespan. | **BOB STP**: Integrated all ages service.<br>* Improving early identification and help for emerging emotional health & wellbeing problems. | FYFV: We want to expand access standards to cover a comprehensive range of mental health services, including children's services. | Health and wellbeing gap; care and quality gap | Accountability Lead: Stephen Madgwick Delivery Lead Rebecca Furlong | * Evaluation from autism best practice event<br>* Work with NHS E to review waiting time reduction from additional resource given and agree a workshop to see what is working and share best practice and agree next steps<br>* Work with adult MH SCN and commsioners and providers to consider all age pathway with a focus on transition | *Autism waiting time workshop to develop strategic direction for management of autism<br><br>*All age Autism best practice event October 2017 | May 17<br><br>Oct 17 | |

**CHILDREN'S MENTAL HEALTH**

| **Vulnerable groups** | To ensure CYP who are LOOKED AFTER receive equitable access to mental health services where needed | **BOB STP**: Improving early identification and help for emerging emotional health & wellbeing problems. | | Health and wellbeing gap; care and quality gap | Accountability Lead: Stephen Madgwick Delivery Lead Rebecca Furlong | *Benchmark the numbers of Looked after children in Thames Valley, their placements, issues and gaps<br>*Triangluate with the best practice event for LAC in 2016 and understand common issues and gaps with providers and commisioners - understanding what happens when child moves to adult services<br>*Identify areas of good practice in order to improve care for this cohort when needed.<br>*Align to the National workstream | Benchmarking report to be published to understand provision in school settings in TV | 2019 | |
|---|---|---|---|---|---|---|---|---|---|
| **Crisis** | To ensure there is access to urgent and emergency mental health care for children and young people | **BOB STP**: Integrated all ages service. | **FYFV MH**: NHS England should invest to expand Crisis Resolution and Home Treatment Teams for children and young people. | Health and wellbeing gap; care and quality gap | Accountability Lead: Stephen Madgwick Delivery Lead Rebecca Furlong | *Provision of a CN event on the new standard<br>*Facilitate a ALL AGE workshop to understand gaps and how the SCN can support both providers and commissioners to meet the new AWT standard in consideration of transition as well<br>*Ensure link with Data teams from the start of project | *Deliver "all-age crisis" event in Thames Valley | May 17<br><br>Ongoing | |

**ADULT MENTAL HEALTH**

| Topic | Ambition | STP priorities: local links and interdependencies | National priorities: policy links and interdependencies | Contribution to the three gaps | Accountable lead & delivery lead | High level actions | Major milestones/Planned trajectory | Timescale | Status update (RAG) |
|---|---|---|---|---|---|---|---|---|---|
| **IAPT** | Commission additional psychological therapies so at least 16.8% of people with anxiety and depression access treatment, the majority of additional services to be integrated with physical healthcare, by April 19 | **BOB STP**: Psychological therapy and preventative wellbeing contract for mild to moderate anxiety and depression. | **FYFV MH**: NHS England should increase access to evidence-based psychological therapies to reach 25 per cent of need so that at least 600,000 more adults with anxiety and depression can access care.<br>* We need to ensure complete roll out of the children and young people's IAPT programme across England by 2018. | Health and wellbeing gap | Accountable: Dr Rob Bale<br>Delivery: Linda Hill | * Embed core elements from AHSN IAPT network<br>* In collaboration with NHSi Intensive Support Team provide clinical expertise, guidance and sharing of best practice to those CCGs identified as not achieving the targets, whilst also championing local excellence. (1.01)<br>* Support wave 2 early implementers bids, work with DCO to manage effective use of funding (1.03)<br>* Work with HEE to define workforce gaps (1.04)<br>* Work with CCGs to understand and map new areas of demand. (1.05)<br>* Liaise with national team to provide bespoke support and advice to commissioners and providers re: wave 1 and 2 early implementers of IAPT. (1.06) | * Funding for hidden waits issued February 2017 | | |
| **Physical Health** | Increasing the number of people living with severe mental health problems having their physical needs met [by at least 4,986 by 2020/21 in Thames Valley] | **Frimley STP**: Join up physical and mental health care for high-need groups, such as people with severe mental illness. | **FYFV**: Patients with mental illness need their physical health addressed at the same time as their mental health.<br>* The NHS must drive towards an equal response to mental and physical health, and towards the two being treated together.<br>**FYFV MH**: Physical health checks should be made available for everyone with a severe mental illness.<br>* [Patients with SMI] should be offered screening and secondary prevention reflecting their higher risk of poor physical health.<br>* People with SMI at highest risk of dying prematurely will be supported to access tests and screening to monitor their physical health in primary care. | Health and wellbeing gap; care and quality gap | Accountable: Dr Rob Bale<br>Delivery: Linda Hill | Scope South Central (TV) against FYFV recommendations for physical health needs in SMI; determine gaps and areas of focus (2.16) | * Publish an analysis of current levels of provision for meeting the physical health needs of those with SMI. | April 2017<br><br>ongoing to 2021 | |
| **Physical Health** | Deliver integrated physical and mental health provision for people with severe mental illness. Ensure that 30% SMI population has access to NICE recommended physical care checks and interventions by April 2019 | **Frimley STP:** Join up physical and mental health care for high-need groups, such as people with severe mental illness. | **FYFV**: Patients with mental illness need their physical health addressed at the same time.<br>**FYFV MH**: Physical health checks and smoking cessation programmes should be made available for everyone with a severe mental illness.<br>* People with severe mental illness at highest risk of dying prematurely will be supported to access tests and screening to monitor their physical health in primary care.<br>* There should be a new focus in primary care on the physical health care of people with severe mental health problems, including psychosis, bipolar disorder and personality disorder.<br>* Delivering extra training for primary care staff in supporting people with severe mental illness. | Health and wellbeing gap; care and quality gap | Accountable: Dr Rob Bale<br>Delivery: Linda Hill | * Define current availability of data and reporting (QOF/CQUIN)<br>* Monitor attainmenmt of 30% health checks on GP registers<br>* Develop actions from the published analysis of current levels of provision | | 2019 | |

**ADULT MENTAL HEALTH**

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|---|---|---|---|---|---|---|---|---|---|
| **Crisis** | Commission effective 24/7 mental health crisis response services in all areas; Crisis Response and Home Treatment Teams as an alternative to acute admissions, and eliminate of out of area placements (OAPs) for non-specialist acute care | **BOB STP**: Working with Thames Valley Police and South Central Ambulance Service to improve mental health triage in ambulance and police dispatch and diverting people in crisis to appropriate local services.<br>* New model for crisis care.<br>**Frimley STP**: Rapid access to support preventing escalation into crisis and avoidable hospital admission (including mental health liaison services and safe havens/crisis cafes). | **FYFV**: Proper funding and integration of mental health crisis services, including liaison psychiatry.<br>* We also intend to work with carers organisations to support new volunteer programmes that could provide emergency help when carers themselves face a crisis of some kind.<br>* Helping patients get the right care, at the right time, in the right place making more appropriate use of community mental health teams.<br>**FYFV MH**: NHS England should ensure that a 24/7 community-based mental health crsis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to acute inpatient admissions.<br>* NHS England should invest to expand Crisis Resolution and Home Treatment Teams (CRHTTs).<br>FYFV MH: Improve timely access to inpatient mental health services for those who present at A&E.<br>* At least 50 per cent of acute hospitals | Care and quality gap | Accountable: Dr Rob Bale<br>Delivery: Linda Hill | * Work closely with the national crisis care concordat programme to ensure South Central (TV) continues to perform against national standards. (3.01)<br>* Map areas of focus of the crisis care concordat programme across CCG plans/STP to ensure alignment (3.02)<br>* Scope South Central (TV) against FYFV recommendations to determine gaps and areas of required focus for future SCN action plans. (3.03)<br>* Support commissioners and providers to develop and improve community provision as an alternative to hospital care. (3.04)<br>* Host an age-inclusive crisis event (May 2017) | | Apr-18 | |
| **LP** | Ensuring all acute hospitals have all-age mental health liaison health services in emergency department and inpatient wards and that at least 50% of acute hospitals meet the Core24 service standards as a minimum | **BOB STP**: Integrated all-ages services and pathways for mental health and learning disability services. | FYFV MH: Improve timely access to inpatient mental health services for those who present at A&E.<br>* At least 50 per cent of acute hospitals should be meeting the Core24 service standard as a minimum.<br>* No acute hospital should be without all-age mental health liaison services in emergency departments and inpatient wards. | Health and wellbeing gap; care and quality gap | Accountable: Dr Rob Bale<br>Delivery: Linda Hill | * Provide rapid/relevant feedback where Core24 funding bids are unsuccessful. (3.07)<br>* Scope South Central (TV) against FYFV recommendations for liaison health services to determine gaps and areas of required focus for future SCN action plans (3.08).<br>* Champion those who are successful in their bid applications and support them to full delivery. (3.09)<br>* Host best practice event to showcase progress with LP A&E provision to Core24 | | Apr-18 | |
| **OAT** | Introducing standards for acute mental health care that are as flexible and close to home as possible; reducing the practice of sending people out of area for acute patient care | **BOB STP**: Increases in services will be tailored to local populations. | **FYFV MH**: Out of area placements for acute care should be reduced and eliminated as quickly as possible.<br>* Care is provided in the least restrictive way and as close to home as possible.<br>* The NHS should expand proven community-based services for people of all ages with severe mental health problems who need support to live safely as close to home as possible. | Care and quality gap | Accountable: Dr Rob Bale<br>Delivery: Linda Hill | * Define current data and address any anomolies (or potential for i.e. point of crisis out-of-area)<br>* Formalise reporting mechanisms and support commissioners to strengthen data to identify OATs<br>* Develop local best practice (avoidance) guidance | | Apr-18 | |
| **EIP** | At least 50% of people with first episode of psychosis starting treatment with a NICE-recommended package of care with a specialist Early Intervention in Psychosis (EIP) service within two weeks of referral by 2020/21 | **BOB STP**: All age EIP services meeting national targets.<br>* Service Development Improvement Plan (SDIP) in place for 2016/2017 to improve standards in key mental health services i.e. Early Intervention in Psychosis. | **FYFV**: 95% of those experiencing a first of psychosis start treatment within a fortnight.<br>**FYFV MH**: People experiencing a first episode of psychosis should have access to NICE-approved care package within 2 weeks of referral.<br>* The NHS should ensure that by April 2016 more than 50% of this group have access to EIP services by 2020/2021. | Health and wellbeing gap; care and quality gap; funding and efficiency gap<br><br>Patients receiving an intervention within 14 days of their first episode of psychosis saves the NHS £4031 per patient. | Accountable: Dr Rob Bale<br>Delivery: Linda Hill | * Work with Oxford AHSN to define future role in EIP; to develop best practice and ensure delivery of core quality standards<br>* Align with Oxford AHSN on system engagement activity to avoid duplication and communicate effectively. (2.02)<br>* Establish links with HEE for effective workforce planning and development | | 2019 | |

**ADULT MENTAL HEALTH**

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| **Suicide** | Reduce suicides by 10% | **BOB STP**: Improving outcomes in secure mental health units and prevent suicide. | **FYFV MH**: Reduce suicide by 10% by 2020/21.<br>* Every area must develop a multi-agency suicide prevention plan that demonstrates how they will implement interventions targeting high-risk locations and supporting high-risk groups within their population.<br>* NHSI and NHSE, with support from PHE, should identify steps services should take to ensure that all deaths by suicide across MHS-funded settings are learned from to prevent repeat events. | Care and quality gap | Accountable: Dr Rob Bale<br>Delivery: Linda Hill | * Establish an expert reference group with Public Health sucide prevention leads; liaise on multi-agency suicide plans to match with SCN programme. (2.08)<br>* Support the Suicide Prevention and Intervention Network (SPIN) in raising awareness, educating and disseminating best practice aimed at suicide reduction in Thames Valley. (2.12) | | 2019 | |
| **IPS** | Increase access to Individual Placement Support for people with severe mental illness by 25% | | **FYFV MH**: More people living with mental health problems should be supported to find or stay in work through IAPT for common mental health problems and expanding access to Individual Placement Support. (IPS) | Care and quality gap | Accountable: Dr Rob Bale<br>Delivery: Linda Hill | * Provision of support and advice on increasing access to IPS by 25% by 2018/19. (2.21) | | 2019 | |
| **Enabling** | Support and assure delivery of the 2017/18 Must Dos set out in the Share Planning Guidance and the trajectories set out in the Mental Health Five Year Forward View | | | Health and wellbeing gap; care and quality gap; funding and efficiency gap | | * Establish regional coordination function to assure delivery and facilitate reporting to the national mental health and dementia programme.<br>* Facilitate local understanding of effective service delivery through sharing of good practice.<br>* Support CCGs identified as having poor outcomes.<br>* Establish/maintain regional resources/networks for driving delivery and improvement. | | | |

**SUPPORTING TRANSFORMATION**

| Ambition | STP priorities: local links and interdependencies | National priorities: policy links and interdependencies | Contribution to the three gaps | Accountable lead & delivery lead | High level actions | Major milestones/Planned trajectory | Timescale | Status update (RAG) |
|---|---|---|---|---|---|---|---|---|
| **Care & Support Planning** | | | | | | | | |
| Adoption of Care and Support Planning across all CCGs in Thames Valley. With 80% of people with diabetes having a care and support planning consultation. | Frimley STP: Improve quality of care and outcomes through more consistent monitoring, improvement in long-term health & population outcomes, and support prevention agenda. Within local plan/already in place across all CCGs in TV for people with diabetes, as a minimum. | **FYFV**: LTCs are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term. Driving forward the "Person Centred Care" agenda- Delivering the 5YFV, by supporting the adoption of care and support planning (C&SP) based on the House of Care (HoC) model. Diabetes a significant LTC for the population of TV, also common in patients with multi-morbidity. Original UK study on C&SP undertaken with people with diabetes. | Care and quality gap<br><br>In Tower Hamlets introduction of C&SP resulted in 72% of people with diabetes received all 9 processes in National Diabetes Audit: best in England (average 49%) | Julia Coles | Working with individual CCGs to support delivery of their plans for C&SP in diabetes in the first instance<br>- further rollout of C&SP training for primary care and integrated teams.<br>- provision of workshops for secondary care<br>- provision of workshops for the wider practice teams<br>- advise and contribute to CCG working groups, with particular emphasis on robust measurement of impact and effectiveness of C&SP<br>- support to individual practices where required<br><br>Achieve CCG sustainability and normalization of C&SP for diabetes through -<br>- Provision of facilitator training<br>-Providing a programme of mentorship and support for CCG trainers and facilitators<br>- Provision of Train the Trainer programme | For all CCGs to have C&SP underpinning their diabetes model of care.<br><br>All CCGs to achieve their ambition of embedding C&SP, with robust outcome measures and sustainability plans.<br><br>For CCGs to recognise and capitalise on the potential afforded by the adoption of this approach across all LTCs, and settings - primary, community and integrated teams. | 2019 | |
| All patients with long term conditions to have CSP consultations as part of their routine care | **Frimley STP**: LTC outcomes including greater self-management and proactive management across all providers for people with single LTCs. | **FYFV**: We will make good on the NHS' longstanding promise to give patients choice over where and how they receive care. Supporting delivery of Realsing the Value 2016 | Care and quality gap<br>The Cochrane Review 2015 identified personalised care planning resulted in:-<br>• Better physical health (blood<br>glucose, blood pressure).<br>• Better emotional health (depression).<br>• No difference in subjective<br>health status (multiple measures).<br>• Better capabilities for selfmanagement<br>(self-efficacy). | Julia Coles | Quarterly trainers and coordinators meetings. Joint plan with HETV. Formalise contacts with relevant programmes.<br>Explore interest in TV wide LTC group.<br>Identify and build on potential of C&SP within other networks- dementia, neurology, cancer,<br>Explore potential and value of TV study re impact and key components of normalising C&SP. | Identify those CCGs who wish to adopt C&SP for LTCs over and above people with diabetes.<br>Provide expert input and resources to CCG's to support this change.<br>Work with HETV to provide a tailored programme of support drawing on national resources/experts.<br>Contribute to national work for the benefit of local systems i.e. RCGP, BHF and Year of Care.<br>Support CCGs and NHSE in capitalising on alignment of national programmes i.e. C&SP and diabetes transformation bids-treatment targets, C&SP and the GP forward view. C7SP and new models of care. | 2019 | |
| **Events/conferences** | | | | | | | | |
| [Local ambition] To create a dynamic calendar of events and conferences which harness best practice, quality speakers aligned to national and local priorities and use innovative methods of engagement | | National priority programmes | Care and quality gap<br>Health and wellbeing<br>Funding & Efficiency | A: Senior Network Managers<br>D: Network Managers | * Use of Eventbrite for capturing<br>* Consistent use of Mailchimp for communication and wider engagement<br>* Ensure engagement through use of voting system - Slido and event activities<br>* Further develop innovative approaches to working together e.g. hacking<br>* Post event access to resource to be housed at tvscn.nhs.uk | Quarterly and annual events across all programmes including wider Medical Directorate conference in June 17 | Ongoing | |

**SUPPORTING TRANSFORMATION**

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| To organise 2 x conferences in-year which position TVSCN as a wider over-arching improvement hub with best practice | Prevention/Transformation | Prevention at scale | Care and quality gap<br>Health and wellbeing<br>Funding & Efficiency | Shahed Ahmad<br>James Carter | * Create wide stakeholder interest<br>* Engage credible speaker and local chairs for sessions<br>* Develop engaging subject matters against a theme for the event<br>* Connect wider transformation programmes from internal NHS England | NHSE Medical Directorate conference<br><br>TVSCN conference | June 17<br><br>November 17 | |

**Commissioning guidance**

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| To produce a fourth iteration of the TVSCN commissioning guidance, taking on the lessons and opportunities that the web based platform produced in 16-17. Further opportunities to work across internal NHS England programmes (GPFV/UEC/Transformation) as well as Arms Length Bodies for inclusion into guidance | | | Care and quality gap<br>Health and wellbeing | Aarti Chapman<br>James Carter | * Feedback exercise from stakeholders<br>* Scope NHS England/TVSCN capability of offer<br>* Engage ALBs to understand scope of guidance offer<br>* Work with internal NHS England to understand use of a web resource | Engagement exercise<br><br>Scoping of functionality<br><br>ALB and Internal engagment<br><br>Content development/augmentation<br><br>Launch of next version of guidance | April 2017<br><br>May 2017<br><br>May 2017<br><br>June 2017 - Sept 2017<br><br>Sept 2017 | |

**Clinical engagement**

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| [Local ambition] To continue and widen the engaged clinical base from across CCG and STP's as well as wider nursing and HCP colleagues to create stronger involvement, well engaged stakeholders able to drive and share messages at local, CCG and STP level | | | | Network Managers<br>James Carter | * Transposing work and outputs from networks into easily digestable communications and via differing platforms | Susan Jebb webinar - Brief interventions in weight management | Apr-17 | |

**Neurology (East Berks)**

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| [Local ambition] To transfom community neurology services and champion new models of care which provide more effective and seemless services for the patient. | | RightCare Programme | Care and quality gap<br>Funding and efficiency gap | Accountable: Dr Zam Cader<br>Delivery: | | Secure external funding for continuation of the project | to March 2018 | |