HEALTH AND WELLBEING BOARD

Minutes of a meeting of the Health and Wellbeing Board held on Wednesday 14th May 2014 at 2.00pm in the Walker Room, Meeting Point House, and Telford TF3 3HS.

PRESENT: Cllr R Overton (Chair) (Telford and Wrekin Council), Cllr A England (Telford and Wrekin Council) and Cllr P Watling (Telford and Wrekin Council) D Evans (Clinical Commissioning Group), Cllr E Clare (Telford and Wrekin Council), P Taylor (Telford and Wrekin Council), Cllr G Green (Telford and Wrekin Council), L Johnston (Telford and Wrekin Council), Cllr J Seymour (Telford and Wrekin Council), Liz Noakes (Telford and Wrekin Council), D Wickham (NHS England Shropshire and Staffordshire Area Team), J Chaplin (Healthwatch Telford and Wrekin)

Also Present: K Roberts (Interim Service Delivery Manager, Commissioning)

Officers: M Cumberbatch (Legal Services) J Power (Delivery and Planning Manager) and J Clarke (Democratic Services Officer).

HWB-60 MINUTES

RESOLVED – that the Minutes of the meetings of the Health and Wellbeing Board held on 12th March 2014 be confirmed and signed by the Chair.

HWB-61 APOLOGIES FOR ABSENCE

Dr M Innes (Vice-Chair) (Clinical Commissioning Group) and D Harrison (Clinical Commissioning Group).

HWB-62 DECLARATIONS OF INTEREST

None

HWB-63 PUBLIC SPEAKING

No members of the public had registered to speak.

HWB-64 REVIEW OF THE HEALTH AND WELLBEING BOARD

J Power, L Noakes and M Cumberbatch presented a joint report which proposed a series of changes to the Health and Wellbeing Board which had been built on the discussions held at the development session on the 3rd April 2014.

The two key drivers for the proposed changes were:-

- The introduction of a Better Care Fund following the integration of Health and Social Care
- A review of the existing Partnership working arrangements led by the Council

It was proposed that the role of the Board be developed to become more strategic and focus on supporting and driving the integration and transformation of services in order to improve the health and wellbeing of our communities and to reduce health inequalities.

The focus of the commissioning and Transformation Partnership would be to bring greater consistency and better connection with partners as well as focusing on improving outcomes. In order to achieve this the "Telford £" would map resources currently used and may in the future involve the creation of pooled or aligned budgets which would focus on driving the integration of services and value for money.

A brief overview was given regarding refocusing the role of the Health and Wellbeing Board. It was proposed that the role of the Board be developed to become more strategic and focus on supporting and riving the integration and transformation of services to improve the health and wellbeing of our communities. This would also help to reduce health inequalities and ensure maximum value from the finite resources. It was proposed that the partnership landscape was amended and this was show in in Diagram 1 at 1.3 to the Report.

The Strategic Commissioning Group was officer and partner led and created a more joined up working relationship to give a better oversight with regard to the Telford £.

It was good practice for Committees and Boards to review their Terms of Reference at the commencement of the new municipal year but it was considered that it was more appropriate for them to be reviewed at this stage as it was more than twelve months since the Board had emerged from its "shadow" operation and a number of developments had taken place. There was now a provision for public speaking at Board Meetings and both Health and Wellbeing Board Strategic Commissioning Group and the Better Care Fund Project Management Group had been established.

There were a number of key changes as follows:

- Membership – the Chair of the Community Safety Partnership to become a member of the Health and Wellbeing Board

- Frequency of Meetings – a change from bi-monthly meetings to quarterly meetings with 2 development sessions per year

- Quorum for Meetings – the quorum be amended as follows "Quorum of one quarter is required, with a minimum of one Councillor Board Member from Telford and Wrekin Council and one Board member from the CCG required in attendance".

The detailed Terms of Reference were set out at Appendix 1 to the Report and the key changes highlighted in yellow. (except the changes at paragraph 2.11 which would remain without the proposed amendments following comments from David Evans)

A discussion took place including:

- Living Well Board and the need for public health focussed strategy to drive integration and commissioning. This would be brought back to the Health and Wellbeing Board for the Board's oversight and assurance

- Report to come back to HWB in early 2015 rather than January 2015 due to the changes to the meetings timetable

- There needed to be a focus on the whole agenda and not just on integration

- Concerns regarding the Health and Wellbeing Board becoming too “divorced” and another Board being created to sit underneath the HWB.

- Board Sponsors needed to be involved at the appropriate time

- The transformation role was now being put in place. It was also hoped that Board Members would feed into the process.

- The need for the Living Well Board to co-ordinate and deliver public health outcomes and in order to make an impact

- Remit of the Health and Wellbeing Board – to hold organisations to account

- In order that there was no duplication the Boards need to work together with Partners ie autism/alcohol and drugs

- Board Sponsors to keep a watch of the Working Groups which were more flexible than the HWB

- The recording of Agendas and Minutes from the Working Groups and access for HWB members – the need for effective communication

RESOLVED –

(a) that the recommendation for amendment of the Constitution be taken to Full Council as appropriate;

(b) the role of the Strategic Commissioning Group be developed to integrate the commissioning actions of all of the proposed Commissioning and Transformation Partnerships;

(c) that Commissioning and Transformation Partnerships be established to bring greater consistency and connectivity to partnership working;

(d) that a Living Well Board was created;

(e) a report be brought back to the Health and Wellbeing Board in early 2015 by the Strategic Commissioning Group on the Telford £;

(f) that subject to the approval of the changes to the membership by the Council the Chair of the Community Safety Partnership be invited to become a member of the Health and Wellbeing Board;

(g) that the number of scheduled Health and Wellbeing Board meetings be set at four per municipal year; and

(h) that the Terms of Reference set out in Appendix 1 to allow meetings to be quorate in the event that NHS England and Healthwatch representatives are unable to attend.

HWB-65 FOCUS ON HWB PRIORITIES

Support People to Live Independently

K Roberts gave an update on progress against the Health & Wellbeing Strategy priority "supporting people to live independently" and information regarding local performance against the related performance measures.

The report highlighted links between the priority and the whole Adult Social Care Outcomes Framework agenda and the wider whole system performance agenda.

There were 4 national priorities adopted for Adult Social Care set out in the Local Account for 2012/13 which were:

- Domain 1 – Enhancing the quality of life for people with care and support needs
- Domain 2 – Delaying and reducing the need for care and support
- Domain 3 – Ensuring that people have a positive experience of care and support
- Domain 4 – Safeguarding adults whose circumstances make them vulnerable and protecting them from harm

With regard to Domain 4, this was part of the bigger picture which involved 21 separate indicators which could be found at Appendix 2 to the report.

The performance indicators, statistics and outturns from the periods 10/11-12/13 where showing some growth. The first six months of this year indicated that performance was going well although there was much more to do including:

- the self-assessment of staff
- community based low support options
- direct payments - against the national indicators this was not particularly going well but it was improving.
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital - these figures were showing as worsening although the performance at 6 months 2013/14 was to be confirmed
- People receiving re-ablement services – this was a locally agreed indicator but further scrutiny was needed. There was a link to the Better Care Fund. Overall it was getting better
- Delayed transfers of care from hospital – this currently showed a decrease in classification
- Carers make a real contribution to enable people to remain living at home. Performance of carers was good
- Better Care Fund – the target focus for the Better Care Fund was to transform public services for adults needing high levels of health and social care support, particularly frail older people at risk of and/or suffering from falls; dementia; long term conditions/end of life; high risk of admission to hospital or care home; discharged from hospital with a need for rehabilitation and/or enablement; self-help and self-care for as long as possible, wherever possible; enabling those at increased risk of hospital, nursing or residential care admission to have systems in place to get help at an early stage; ensuring financial efficiency

Five nationally set performance measures would be used to monitor progress for the Better Care Fund with associated metrics:

- Reducing non-elective hospital admissions, re-admissions and length of stay

- Reducing permanent admissions to residential and nursing care (ASCOF indicator)
- Patient experience
- Reducing delayed transfers of care (an ASCOF indicator)
- Improving the effectiveness of re-ablement/rehabilitation service (an ASCOF indicator)

P Taylor thanked K Roberts for her report.

Updated figures for 2013/14 had now been received:

- Proportion of people using social care who received self-directed support – 60%
- Proportion of people using social care who received direct payments – 11% outturn
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital – 67%
- People receiving re-ablement service who need no support at the end of their service - no local indicator
- Delayed transfers of care from hospital - this was now confirmed at 8.22% a worsening of performance

The report was open and honest. The activity did not say anything about the quality of the services.

There was now a journey to embed personalisation and there was a need to clearly support people to live at home. The performance agenda needed to be looked at together with the indicators for the Adult Social Care Outcomes Framework and the NHS Health Performance Framework. The review of priorities would be integrated within the Better Care Fund priorities.

A discussion took place including:

- Whole priority change of direction for BCF
- Delays and difficulties with payments
- Telford £ to secure best for individuals
- More detailed figures to be brought back to the HWB
- More control of personal finance
- People find change difficult to manage
- Cross party working very important
- Importance of working more closely with partners
- Carers and the carers' survey
- Development of community capacity
- Whole System Score Card Approach

RESOLVED – that:

a) **the report be noted; and**

b) **the Health and Wellbeing Board be kept informed of progress in the future, through reference to work undertaken in relation to 'Better Care Fund Plan' and a whole system/balanced scorecard performance approach.**

HWB-66 NHS ENGLAND – SHROPSHIRE AND STAFFORDSHIRE AREA TEAM COMMISSIONING INTENTIONS FOR 2014/15

D Wickham presented a report on NHS England – Shropshire and Staffordshire Area Teams' Commissioning Intentions for 2014/15.

The report the impact of the commissioning intentions which were to further improve:

- quality and safety of care
- access to appropriate services for all our population, but especially the vulnerable
- performance of NHS services so that NHS England can deliver on NHS constitutional rights

Priorities aligned to national business rules and underpinned the planning criteria which included primary care, GP practices, pharmacy and dental services.

The delivery domains were linked to the outcome measures and had seven programmes which involved synergy and alignment:

- Programme 1 – reducing unwarranted clinical variation
- Programme 2 – primary care incentives and remunerations review
- Programme 3 – improved access
- Programme 4 – workforce
- Programme 5 – optimisation of professions allied to medicines
- Programme 6 – infrastructure – estates and IT
- Programme 7 – public empowerment

Work that would be undertaken around these areas would be:

- Partnerships with the CCG
- Alignment with the BCF and emergency admissions
- Self-care and expert advice to align with the BCF
- A mechanism to contribute to a long-term control map
- Access to out of hours dental services
- Avoidable admissions work

With regard to public health commissioning, it was aimed to work across all areas for maximum benefit in order to take this forward to a higher level.

Specialised services were not in place at the present time but this would be looked at centrally on a service by service basis in conjunction with the Commissioning Board, the CCG and NHS England Area Team.

A discussion took place including:

- Improving access to primary care and sustaining the workforce
- 7 day working
- Clustering of practices and IT issues
- Continuity of care
- Primary Care clinical vaccination services
- Synergies over a number of areas
- Primary care at scale
- Future Fit

- Important of communication of changes to service users
- Extensive period of engagement with regard to Primary Care and the need to talk to as wide a section of the community as possible
- Differences in contract payments

RESOLVED – that:

a) **the report be noted; and**

b) **the Board highlighted health visiting (particularly the Healthy Child Programme), screening and immunisation and primary care as areas for improved synergy between the Council/Public Health, the CCG and NHS England Area Team's commissioning intentions.**

HWB-67 NHS FUTURE FIT PROGRAMME REPORT

D Evans presented a report on the NHS Future Fit Programme which provided an update on the progress and forward plans of the Programme.

The programme focused on acute and community hospital services in Shropshire and Telford and Wrekin. This involved all communities who used the services across Shropshire, Telford and Wrekin and Mid-Wales.

The aim was to develop a clear vision for excellent and sustainable acute and community hospitals which were safe, accessible and offered the best clinical outcomes, attract developing, skilled and experienced staff, provide rapid access to expert clinicians, work closely with community services and focus on those specialist services that could only be provided in hospital.

The Mental Health Care Bill would have an impact on primary care services within Shropshire, Telford and Wrekin and Mid-Wales.

It was hoped that this model would provide an excellent and sustainable future with the right workforce.

The programme had been approved by 4 of the 5 sponsors:

- Shrewsbury and Telford Hospitals
- Shropshire and Telford and Wrekin NHS Trusts
- 2 CCGs

Powys were in the process of confirming but they were just in the process of changing their Chief Executive on their Board.

The programme was currently in Phase 2 of the development of a model of care and there would be a period of engagement and public consultation.

A report would be brought to the Telford and Wrekin CCG after the general election in May next year (2015).

Appendix A to the report set out the case for change. This would involve an increase in sub-specialisation and specialisation; maintain a skilled workforce; changes to the population profile; higher expectations; clinical standards and development in medical technology; economic challenges; opportunity costs in quality of service; impact on accessing services for

populations living in two urban centres and much more sparsely populated rural communities in order to deliver the best possible services across two sites.

Appendix B to the report related to the "Moral Compass" and the principles for joint working. It was recognised that there would be some complex and difficult decisions to be made. This would involve:

- The 'common good' (for all who look to services in this geography for their health care) versus the individual or locally specific good (the preferences of sub groups)
- The present versus the future
- Organisational interest versus public interest
- One priority versus another when resources are limited

The principle solution would hope to gain the greater good for the greatest number of people but that this would not be good for everyone. This would involve changes to emergency and acute care but it was hoped to mitigate against this by using a pathway where services could be accessed close to home with shared decision making.

Appendix C to the report related to the Emerging Clinical Models of Care. D Evans thanked Bill Gowers, Mike Innes and Edd Borman for all of their hard work on the model.

It was suggested that there may be 1 acute and emergency care centre in the whole of Shropshire and Telford and Wrekin. This was a clinical model only. However to achieve this it would mean moving peoples care closer to home. Current A&E services would be split into walk in and urgent care centres. Heart attack/stroke patients would be seen at emergency care centres. These were relatively small numbers and the service was not being removed. Local acute services, a small proportion of planned care and elective surgery could be seen at the same centre together with complex ITU cases. Other planned surgery would be given at treatment centres which would be able to cover 80% of surgery, investigative medicine and diagnostics. The aim would be to then have follow appointments closer to home.

Engagement and feedback would be taken from patients. This facility would fit with the BCF and it was hoped to downstream as much treatment as possible rather than having to admit patients to hospital.

Several comments were made regarding the recommendation "e" to the report "consider how alignment between the Programmes's Clinical Model and the Health and Wellbeing Strategy might be best demonstrated. Board Members were unhappy about endorsing this recommendation and suggestions were that this be amended to "acknowledge" or "note" the recommendation. The Borough was still growing with new housing in areas such as Newport, Albrighton and Shifnal and the members felt that they needed to consider the proposals more fully.

Following the discussions and the concerns raised David Evans agreed to withdraw recommendation "e" for further discussions to take place and that this report be brought back to the Board at a later date.

A discussion took place including:

- **Report to be brought back to the HWB after the general election 2015**
- **Case for change**
- **Need to look at community needs as Telford is a growing Borough**

- **"current way of delivering services not sustainable" need to do things differently**
- **1 site – this may not be Telford or Shrewsbury**
- **Need the right care at the right time by the right staff**
- **Not all achievable in the way the Board would like to see**
- **Integrated care records**
- **Partnership care**
- **Very little reference to mental health**
- **Integrated services**
- **IT issues**
- **Clustering of GP practices**
- **Acute and community hospitals were given up in order to have the Princess Royal Hospital**

It was suggested to the Board that the wording of recommendation E was not quite right and that this recommendation would be withdrawn and brought back to the Board at a future meeting.

RESOLVED – that

a) the Board note the Programme's Case for Change;

b) the Board note the Programme's Principles for Joint Working;

c) the Board note the current progress made by the Programme and its future plans; and

d) the Board note the Interim Clinical Report (including the extent of its alignment with the Council's Health and Wellbeing Strategy).

HWB-68 IMPLICATIONS OF THE CARE BILL: IMPLEMENTING THE CARE AND SUPPORT REFORMS – PROGRAMME START UP

P Taylor presented a report on the implications of the Care Bill: Implementing the Care and Support Reforms – Programme Start Up.

The report gave an update on the implications of the Care Bill and set out the requirements to effectively put in place a change management programme to deliver any necessary changes when the Bill becomes law.

The Bill is likely to place significant additional responsibilities on the Council and increase the cost of delivering community care services to those eligible for public support meaning that the Council would need to profile the additional costs into it budget planning process for 2015 and beyond. The Council would also need to continue with the transformation programme aimed at reducing care costs to the Council and exploring integration with partners. There would also be a need to find care outside of hospital settings due to the overall level of funding.

Policy and Best Practice Guidance emphasised the person-centred, asset based care as in the future people's care and support needs would be expected to be met by:-

- Harnessing existing capacity within neighbourhoods and families to provide support
- Addressing people's needs at an earlier stage and before the need for formal services
- The provision of high quality state support based on clear national entitlements

It also envisaged that cared and support would be more effectively joined up across all local services (particularly health and housing) and would work more collaboratively across local authorities, providers and other statutory organisations.

The Bill would be used as a legal framework to be put in place for the BCF.

The timelines for the passage of the Bill could be found at 4.2 to the report. Unfortunately there was not detail available at present and it was expected that the guidelines and regulations would be out for consultation at the end of May or early June.

The key proposed changes were:

- Clarification of entitlement to care and support
- Development of national eligibility criteria (based on existing criteria)
- Family carers to be treated equitably with the person they care for
- Reform of funding of care and support
- Focus on prevention and wellbeing rather than crisis intervention
- Guarantee of service continuity between local authorities and should a service provide fail
- Simplification of system and flexibility for greater integration to achieve better outcomes
- Adult safeguarding put on a statutory footing

Key changes to the funding of care and support were:

- Separation of accommodation and care costs
- Accommodation costs payable by individual up to £12k per year
- £72k cap (no current cap) on total amount an individual would have to pay for care across their life time
- £123k upper capital threshold for means tested care (currently £23.5k)
- Right to deferred payment arrangement

Eligible cases would start to increase from April 2015 and this was expected to be a significant amount of people.

The risks and implications included:

- Loss of income from current service users
- New duty to pay for self-funding people once they reach the cap
- Additional assessment activity for carers and self-funders
- Under estimation of full costs at a national level and formula distribution
- Capacity to complete assessments
- Process and IT system change and state of readiness
- Unintended consequences – eg additional complaints, disincentives to family care, impact on the market through self-funders etc
- Implementing the Care Bill at the same time as dealing with budget reductions and the integration agenda

A programme management approach to delivering the transformation had been established and the key priority programme work streams were identified as:

- Deferred Payments

- Funding Reform
- Assessment
- Advice & Information
- Commissioning
- Adult Safeguarding Board

It was important to communicate and engage with stakeholders, health colleagues, workforce and organisations in order to deliver the plan and to make sure that everyone was up to speed with the new law and new systems prior to the Bill being implemented.

A discussion took place including:

- £72k fees
- Accommodation costs / assessments / contributions/ individual personal allowance
- Carers attendance allowance

RESOLVED – that

a) **the Health and Wellbeing Board note the implications and risks of the Care Bill and Reforms and the plans being put in place to ensure implementation of the Act when it becomes law; and**

b) **The Care Bill and its implications would be the focus of the next Health and Wellbeing Development Session in October.**

The meeting ended at 4.14pm

Chairman:

Date:

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD

24th SEPTEMBER 2014

UPDATE FROM THE STRATEGIC COMMISSIONING GROUP

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

The purpose of this report is to provide an overview of the work of the Strategic Commissioning Group and the Commissioning and Transformation Partnerships (CATPs) since the last Health & Wellbeing Board.

2. RECOMMENDATIONS

The Board is requested to:

- Acknowledge the recent progress on HWB priorities made through the Commissioning and Transformation Partnerships (CATPs)
- Note the Disabled Children's Charter Update Report attached at Appendix 1

3. IMPACT OF ACTION

Each of the CATPs has responsibility for reporting progress against HWB priorities to the Strategic Commissioning Group to whom they are accountable.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	*All of the Health and Well-being Board priorities are allocated to the CATPs. This report gives an update against each of these priority areas.*
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	Yes	• *Putting our children and young people first* • *Protecting and supporting our vulnerable children and adults* • *Improving the health and wellbeing of our communities and addressing health inequalities*

COMMUNITY IMPACT (cont.)	Will the proposals impact on specific groups of people?	
	Yes	*As above, the updates within this report relate to the key HWB priorities which cover all client groups. There is a specific focus on reducing inequalities in community and groups where outcomes are the poorest.*
TARGET COMPLETION/DELIVERY DATE	*See specific updates at Section 2 of the report. Further updates will be provided at the next HWB on 10th December 2014.*	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	*There are no direct financial implications arising from the recommendations within this report. It is anticipated that all ongoing work will be funded through existing funding streams contained within current budget strategies. Any financial implications and risks arising from specific areas of work (e.g. BCF) will be identified and contained within future reports.* *A key role for the group is to establish the amount spent by various public sector bodies and voluntary sector partners to establish how the Telford £ is allocated across Health & Wellbeing priorities. This is work in progress.*
LEGAL ISSUES	Yes	*Whilst the CATP's have been allocated tasks by the Health and Wellbeing Board, the Board retains the responsibility for the delivery of their objectives and legal requirements. Accordingly it is important that the Board reviews carefully the work of the CATP's to ensure that their given tasks are going to be completed in time and to a satisfactory standard. If the Board is of the view that this is not the case it can either give directions to the respective CATP's (via the Strategic*

		Commissioning Group or otherwise) including changes to work timetables or withdraw the tasks and revert to delivering them directly.
EQUALITY & DIVERSITY	Yes	*Key goal of the Health & Wellbeing Board is to narrow the gap in terms of health and other socio-economic inequalities.*
IMPACT ON SPECIFIC WARDS	No	*None*
PATIENTS & PUBLIC ENGAGEMENT	Yes	*The work of CATP includes consultation and engagement work to shape the commissioning of services – see updates given at Section 1 for more detail.*
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	*None*

PART B) – ADDITIONAL INFORMATION

1. INTRODUCTION

The Strategic Commissioning Group has met twice since the last Health and Wellbeing Board. The purpose of the first meeting was to agree the terms of reference for the group (summarised below) and updates from the Commissioning and Transformation Partnerships (CATPs) were received at the second meeting.

The aim of the Strategic Commissioning Group is to ensure that our commissioning processes deliver performance improvements against the Health and Wellbeing Board priorities by:

- encouraging integrated working between local health, social care and public health commissioners
- using the JSNA to systematically inform partners commissioning intentions
- developing commissioning as a strategic function that uses system thinking and agreed commissioning models to understand the relationships between need, demand and outcomes for service users.

In order to ensure that the Health and Wellbeing Board priorities are taken forward, Commissioning & Transformation Partnerships (CATPs) were established to be responsible for ensuring delivery against the priority areas– the CATPS are accountable to the Strategic Commissioning Group and provide regular updates on their progress with a particular focus on commissioning activity against the key Health and Wellbeing Board priorities.

The key messages, priorities and progress updates from the CATPs are detailed within section 2 of this report.

2. UPDATE FROM THE CATPs

Key messages reported by CATPS to the Strategic Commissioning Group are outlined in the following sections:

2.1. Better Care Fund Programme Board

A key priority for the BCF Board is the integration of health and social care for adults. The immediate priority for this group is to complete the BCF re-submission to the Department of Health – currently updating on progress in readiness for submission on 19th September 2014 (a

separate report is being presented to the Health and Wellbeing Board on 24th September in relation to the Better Care Fund resubmission).

An update was provided on the accelerated pilot to reduce hospital admissions with key plans in September 2014 to focus on ambulatory assessments, diagnostics and discharge care with support.

Improving information provision online and via the 111 service to reduce admissions is a key area of future activity.

2.2. Community Safety Partnership

The Community Safety Partnership is responsible for the following Health and Wellbeing priority:

- ***Reduce the misuse of alcohol and drugs**.*

The four community safety priorities are:

- Overall crime is reduced in the Borough
- Anti-social behaviour is reduced – to include environmental crime
- Greater Community Cohesion in the Borough
- To reduce the fear of crime –keeping residents safer in Telford & Wrekin

These outcome-focussed priorities are all heavily influenced by the impact of the misuse of drugs and alcohol, due to their association with crime and anti social behaviour. The Drug and Alcohol Action Team (DAAT) Board multi-agency partnership board reports to the Community Safety Partnership (CSP) and oversees the implementation of the substance misuse strategy.

Key DAAT Board headlines

- The staffing issues in the clinical service provided by Shropshire Community Health Services NHS Trust, which supports the Council's in-house Drug & Alcohol Service (DARS), have now been resolved following recruitment of new nursing staff.
- Inpatient detoxification services (for alcohol misuse and opiate drug users) are being retendered and a set of approved providers will be agreed in October 2014.
- Key messages from a Moving Forward event held in June are being used to shape the future model for commissioning of treatment and recovery services. New contracts will be in place from June 2015.
- September is National Recovery Month and a series of local activities will take place, including a Celebration event at the Place on 24th September, organised by Telford Aftercare Team.

- Improving performance and outcomes monitoring is a key area of work required to support the implementation of the strategy. Clinical governance arrangements are also being developed.

2.3. Living Well Board

The Living Well Board is responsible for the following Health and Wellbeing priorities:

- ***Reducing the numbers of people who smoke***
- ***Reducing the numbers of adults and children with excess weight***
- ***Improving emotional health & wellbeing***

Establishing the Living Well Board

Work is underway to establish the Living Well Board. The focus of the Board's work programme will be to coordinate and maximise collective action to promote positive wellbeing, healthy lifestyles and root causes of poor health. Workshops with key stakeholders took place in August and the first meeting of the Board is scheduled for October. In addition to the existing priority plans, stakeholders have identified an interim programme of work to include the following:

(1) Development of a 'health and wellbeing offer' to complement the Council's wider offer to local businesses

(2) Development and delivery of a population based campaign to promote the key messages for the Five Ways to Wellbeing and to raise awareness of local activities and available support

(3) Delivery of a Making Every Contact Count training programme for staff to increase staff confidence to raise lifestyle issues and signpost to available support services

(4) A summary of public health guidance to support officers to make planning decisions that support the creation of healthy environments

Other Key Living Well developments

- Stop Smoking Services – options appraisal, based on lessons learned from the process in 2013, has been undertaken for the re-tender of smoking cessation services. SMT have recommended the preferred option to Cabinet, which will be a tender consisting of two lots: Stop Smoking (core and out of hours service) and Stop Smoking (in pregnancy). Wide engagement with partners and

providers on the proposed model for services is now taking place and new service contracts will in place in April 2015.

- The smoking quit rate has improved, with over 60% of smokers setting a quit date still quit after 4 weeks during October 2013 – March 2014. This is significantly higher than the national average quit rate of 52%. Although the quit rate has improved there has been a drop in the number of quitters. This drop is reflected across the country and is thought to be caused by the increase in the use of e-cigarettes.
- Healthy Lifestyles Hub and Health Trainer Service contribute to improved outcomes for excess weight, improved emotional health and wellbeing and increasing physical activity. Service improvements and efficiencies following in-sourcing to the Council in April 2014 are already evident.

2.4. Children, Young People and Families Board

The Children, Young People and Families Board is responsible for the following Health and Wellbeing priority:

- ***Reduce Teenage Pregnancy***

The following progress has been made by the group:

- Vulnerable People Commissioning Team (all age) now formed and recruitment ongoing to new posts.
- Review and refresh of the Children in Care strategy is complete
- Review and Refresh of the Children with Disability (and SEN) strategy – jointly with health, this work is underway. In relation to this work, attached at Appendix 1 is a report prepared and agreed by this Board to provide an update on our progress against the Disabled Children's Charter.
- Development of the SEND Direct online marketplace
- Procurement underway for non accommodation support services for Children in Care
- Regional procurement activity to commence for residential care
- Regional procurement under consideration for foster care provision
- Procurement underway for a domiciliary care framework contract
- Procurement being considered for carers services
- Development service specification for tier two CAMHS provision in collaboration with health colleagues and consideration of an

integrated service model between CAMHS and the educational psychology service

- exploring alternative models of supported accomodation provision where this will improve quality and sufficiency by developing in house provision
- Developing opportunities with micro markets (such as care farms) for children with disabiliies
- Ongoing development of the West Mercia Adoption Project
- Development of the SEND Local Offer to be published by September 2014
- Developing systems locally so that young carers are able to live a full life and are protected from excessive or inappropriate caring responsibilities and preparing for the implementation of the Care Act.
- Development of Summer Arts college for children in care
- Regional mediation procurement underway for mediation services for SEN

2.5. Early Help

The development of the Early Help Strategy and action plan is one of the priorities of the Children, Young People & Families Board. The document and action plan has used a whole systems approach with a strong focus on prevention. The strategy is underpinned by evidence, population data and combines the Healthy Child Framework with the Children's Centre programme; emphasising a pathway approach. It uses a life course approach covering children and young people aged 0-25 years recognising the special educational needs and disabilities reforms.

Implementation of the Early Help Strategy and action plan will deliver improvements in the following outcomes:

- the health and wellbeing of children, young people, families and carers
- the educational attainment of children and young people
- the emotional health and wellbeing of children, young people, families and carers
- the prospects of children and young people in Telford & Wrekin
- the engagement of children, young people, families and carers in services.

Delivery of the Strategy and action plan will be overseen by the Early Help Partnership Board. The programme of work will maximise the collective action of our Early Help partners to contribute to improving

outcomes for children, young people and our families as well as driving change and challenging how services are being delivered.

Our strategic approach will also maximise the opportunities afforded by new working arrangements following the transfer of commissioning responsibilities for some areas of public health to local authorities including School Nursing, school health improvement, the Family Nurse Partnership and Health Visiting.

The strategy re-focuses our efforts in a more upstream way, with a strong theme of prevention.

The programme of work will include action to maximise joint working with our local schools and the voluntary sector to develop their universal prevention roles as they often have well established links with local families and communities.

3. NEXT STEPS

The Strategic Commissioning Group continues to work with CATPs to further develop the governance arrangements and information flows to and from the CATPs and the Strategic Commissioning Group. Membership of the Boards are also being reviewed to ensure all CATPs are represented on the Strategic Commissioning Group in readiness for the next meeting on 23rd September 2014.

4. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

Please see section 2 for detailed information on impacts associated with CATP work.

5. PREVIOUS MINUTES

There are no previous minutes – this is the first Strategic Commissioning Group report to the HWBB but this will be a standing item at future meetings.

6. BACKGROUND PAPERS

None.

Report prepared by Jo Winborn, Partnership & Planning Officer: Delivery & Planning Telephone: 01952 380672

Appendix 1: Disabled Children's Charter Update

Report prepared for the Children, Young People and Families Board

July 14

Report Authors: Katrina McCormick & Rebecca Johnson

1. We have detailed accurate information on the disabled children and young people living in our area, and provide public information on how we plan to meet their needs.
All local authorities have a statutory responsibility to maintain a record of children with disabilities in the area ("the record"). Systems are in place across the Local Authority (LA) and Health to collate this information through parental and professional reporting. We are aware that this is under reported in the Telford and Wrekin; however, this is not uncommon to all local authorities. The record is voluntary and parents for a variety of reasons may choose not to be included in the record. We have up to date information via the Joint Strategic Needs Assessment (JSNA) around estimates according to the census as well as projections for the future. In addition to this we have information in relation to short breaks data returns. We also have a record of children with Special Educational Needs (SEN). The Special Educational Needs and Disabilities (SEND) reforms will provide us with an opportunity to develop this information further and we are refining developing new systems to support this. Responsibilities around the dissemination of information exist across a number of posts through a variety of methods, e.g. groups meetings, regular newsletters and website. Information is being published in the SEND Local Offer in September 2014 including commissioned services that are available to meet the needs of disabled children. The SEND Local Offer will evolve an improve over time. We have a joint commissioning strategy for disabled children that contains details of data, trends and commissioning plans. We are updating this as a joint Market Position Statement between the Clinical Commissioning Group (CCG) and the LA.
2. We engage directly with disabled children and young people and their participation is embedded in the work of our Health & Wellbeing Board.
We recognise that this is an area of work to focus and prioritise and we intend to progress via an overall Communication and Consultation Plan which is in development and being monitored by the Aiming High Board. The introduction of the Independent Supporters service provided by CVS will enable a greater voice for disabled children and young people (up to 25). We are working with our local parent/carer forum (Parents Opening Doors) to seek participation by disabled children and young people to inform joint commissioning arrangements for the future.

We include individual children and young people in activities such as tender evaluation and our local disabled children's user forum is consulted on the development of projects and initiatives.

3. We engage directly with parent carers of disabled children and young people and their participation is embedded in the work of our Health & Wellbeing Board.

We regularly engage with parent carers of disabled children and young people through a wide variety of methods. These include representation at Aiming High Board, all SEND reforms working groups, commissioning meetings, school meetings etc.

The introduction of the Independent Supporters Service should support this area of work.

We regularly engage with Parent/Carers through Parents Opening Doors (PODS) forum.

The CCG is looking to extend this to include Listen Not Label.

Local Providers are actively engaged in the SEND reforms and are committed to working in coproduction with parents and carers as they review and look to improve services with commissioners.

Service users also directly participate in the Health Family and Friends test.

4. We set clear strategic outcomes for our partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account.

Aiming High Board monitors progress of our key partners against key actions including the SEND action plan.

Monitoring progress towards outcomes takes place via regular contract monitoring reviews with internal and external providers.

The Disabled Children's Strategy is due for a refresh and will be led by the LA with CCG input.

Health Community Provider monitors learning disabilities as a matter of routine, many of the services commissioned are provided to this cohort.

5. We promote early intervention and support for smooth transitions between children and adult services for disabled children and young people.

This is an area that we have previously identified as needing to be redesigned and the recent introduction of the Transition Working Group should support this work.

We commission and promote early interventions for children via the Stepping Stones Centre which includes the child development centre.

Smooth transition from children to adult services is supported, for example the Continence

Service has a Steering Group with PODS representation.

We work with our Providers to ensure smooth transitions between services and act upon intelligence from parents/carers.

6. We work with key partners to strengthen integration between health, social care and education services, and with services provided by wider partners.

The Team Around the Child process supports this work and the new Education, Health & Care Planning process will further enhance via integrated teams.

Aiming High Board, Children, Young People & Families Board and the Health & Wellbeing Board are all integrated Boards with wide representation to ensure that the work is considered by all partners.

Good working relationships between health and LA commissioners are being built upon including identifying areas for joint training across services in support of implementing change.

We engage with wider partners in the third sector in support of strengthening integration.

7. We provide cohesive governance and leadership across the disabled children and young people's agenda by linking effectively with key partners.

Aiming High Board (for children with SEN and Disabilities) is a multi agency board chaired by an Assistant Director for Children's Safeguarding and Specialist Services (LA) who provides the link around cohesive governance and leadership. The Aiming High Board is accountable to the Children, Young People & Families Board.

Links are established with key partners and attendance at meetings in support of implementing change. This has occurred within the available staffing resource.

HEALTH & WELLBEING BOARD
24 SEPTEMBER 2015
HEALTH & WELLBEING BOARD STRATEGY OUTCOME MEASURES: PERFORMANCE 2013/14
REPORT OF DELIVERY & PLANNING MANAGER, TEFORD & WREKIN COUNCIL

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

1.1. The purpose of this report is brief the Board on the latest available performance data against the Health & Wellbeing Board priority outcome measures as at end of 2013/14.

2. RECOMMENDATIONS

2.1. That the Board reviews end of year 2013/14 performance against the priority outcome measures. Where acceptable progress and improvement is not being made the Board needs to consider what directions should be given to officers to address these issues.

3. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to specific Health & Wellbeing Board Strategy Priorities	
	Yes	*All Priorities*
	Will the proposals impact on specific groups of people?	
	Yes	*The priorities impact across all communities*
TARGET COMPLETION/DELIVERY DATE	*This is part of the on-going monitoring of delivery of the Board's priorities.*	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	Although there are not any immediately obvious direct financial consequences arising from the recommendation contained in this report, there may be cause for further statistical and financial analysis arising from the results reported. Further analysis and benchmarking can be used to determine the value being obtained from resources being used to deliver the outcomes and the potential for improved performance.
LEGAL ISSUES	Yes	Receiving and reviewing the information contained within this report assists the Health and Wellbeing Board in undertaking its role of guiding and overseeing public health

		responsibilities and arrangements in the local authority (as set out in the Board's terms of reference at paragraph 1.5). That, in turn, contributes towards the Council meeting its statutory responsibilities such as those contained in The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013. Where acceptable progress and improvement is not being made the Board needs to consider what directions should be given to officers to address these issues.
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	The report identifies key risks to the delivery of the Council's priorities
IMPACT ON SPECIFIC WARDS	No	Borough-wide impact

4. PART B) – ADDITIONAL INFORMATION

4.1. Against each of its priorities, the Health & Wellbeing Strategy identified a series outcome measures with the purpose of tracking progress and improvement. Appendix One of this report sets out progress against each of these measures – presenting the available data as at 30 March 2014 (end of year 2013/14).

4.2. It is important to highlight that:

- performance against these measures is typically challenging – one of the central reasons why Health & Wellbeing Board priorities were chosen was because they were areas which required improvement.

- many of these measures are slow moving – because they are entrenched challenges but often because the number of cases are relatively small (on a population basis) so that any change takes a number of years to show real, statistical change.

Moving Forward/Next Steps

4.3. As the new relationship between the Commissioning and Transformation Partnerships (CATP), Strategic Commissioning Board and Health & Wellbeing Board are established, CATPs will be responsible for driving forward performance against these outcome measures. Future reports from CATPs will provide and comment on performance issues to improve the linkage between performance and the actions taken by the CATPs to drive improvement.

5. PREVIOUS MINUTES

- Health and Wellbeing Board 22 January 2014

6. BACKGROUND PAPERS

- Health & Wellbeing Board Strategy

Report prepared by Jon Power, Delivery & Planning Manager. Tel 01952 (3)80141

Key

Improving (high is good) | Improving (low is good)
Worsening (high is good) | Worsening (low is good)

HEALTH & WELLBEING BOARD: 12 MONTH PERFORMANCE MONITORING

ID	Title	2010/11 Outturn	2011/12 Outturn	2012/13 Outturn	National Comparator 2012-13	Comparison to national position 2012-13	Performance at 6 months 2013-14	Performance at 9 months 2013-14	Performance at 12 months 2013-14	Estimate/ Outturn 2013-14	Direction of travel compared to 2012-13	Target 2013/14	Progress against target
Reduce excess weight in children and adults													
CYP001	Breast feeding (% of infants breastfeeding at 6 to 8 weeks)	33.2%	32.9% ↘	33.2% ↗	47.2% (2012/13)	Significantly worse	N/A	N/A	34.3%	34.3% (Estimate)	No change	▲	
Commentary on performance: This figure remains in the May.14 publication of PHOF.									Full year data covers 2013/14				
CM318	% excess weight (reception children)	N/A	N/A	23.9%	22.6% (2011/12)	No significant difference				24.1% (Outturn)	No change	▼	
Commentary on performance:									Full year data covers 2012/13 Academic year				
CM319	% excess weight (Year 6 children)	N/A	N/A	35.8%	33.9% (2011/12)	No significant difference				34.9% (Outturn)	No change	▼	
Commentary on performance:									Full year data covers 2012/13 Academic year				
Reduce teenage pregnancy													
CM067	Teenage conceptions (rate per 1,000 females aged 15-17 years)	52.7	47.5 ↘	37.5 ↘	30.7 (2011)	Significantly worse	38.0	N/A	36.8	36.8 (Outturn)	No change	▼	
Commentary on performance: Teenage pregnancy rates continue to fall locally, but remain significantly worse than England as a whole.									Full year data covers 2012				
Improve emotional health and wellbeing													
CYP003	Hospital admissions as a result of self-harm (rate per 1,000 population, all ages)	238.0	203.4 ↘	243.8 ↗	207.9 (2011/12)	Significantly worse	N/A	N/A	243.8	243.8 (Outturn)	Getting worse	▼	☹
Commentary on performance: No new data in 2013/14. Next data revision possible Aug 2014. This translates to 398 admissions.									Full year data covers 2011/12				
CM325	Suicide rate - Age standardised mortality rate from suicide and injury of undetermined intent (per 100,000 population)	7.0	9.2 ↗	9.1 ↘	8.5 (2009/11)	No significant difference	N/A	N/A	10.6	10.6 (Outturn)	Getting worse	▼	☹
Commentary on performance: Revised and historic data published in PHOF February 2014. For the three year period there were 52 recorded suicides. 37 males and 15 females.									Full year data covers 2010/12				

Key

Improving (high is good) | Improving (low is good)
Worsening (high is good) | Worsening (low is good)

HEALTH & WELLBEING BOARD: 12 MONTH PERFORMANCE MONITORING

ID	Title	2010/11 Outturn	2011/12 Outturn	2012/13 Outturn	National Comparator 2012-13	Comparison to national position 2012-13	Performance at 6 months 2013-14	Performance at 9 months 2013-14	Performance at 12 months 2013-14	Estimate/ Outturn 2013-14	Direction of travel compared to 2012-13	Target 2013/14	Progress against target
Reduce the number of people who smoke													
CM026	Smoking in pregnancy (% of mothers smoking at delivery)	23.6%	22.7% ↘	22.4% ↘	0.127 (2012/13)	Significantly worse	20.9% (107/511)	N/A	22.4%	22.4% (Outturn)	No change	⮟	
Commentary on performance:									Full year data covers 2013/14				
CM096	Reduce the number of babies born with a low birth weight (live births at term (>=37 wks, <2500g)r	3.1	2.7 ↘	4.6 ↗	2.8 (2010)	Significantly worse	N/A	N/A	3.3	3.3 (Outturn)	Getting better	⮟	☺
Commentary on performance:									Full year data covers 2011				
This figure has historically been similar to the England average until 2010 when it was worse. Fortunately, the most recent period shows a return to being similar to the English average.													
CM066	Smoking cessation (rate of successful quitters, per 100,000 pop)	1,452	1,482 ↗	1389 ↘	868 (2012/13)	Significantly better	N/A	N/A	1389	1389 (Outturn)	No change	⮝	
Commentary on performance:									Full year data covers 2012/13				
Latest data is 2012-13. New data available October 2014													
CM025	Hospital admissions attributable to smoking (rate per 100,000 population aged 35+)	1,381	1,606 ↗	1,612 ↗	1420 (2010/11)	Significantly worse	N/A	N/A	1612	1612 (Outturn)	No change	⮟	
Commentary on performance:									Full year data covers 2010/11				
In the latest Feb.14 PHOF, the 2010/11 figure was revised upward slightly from 1581 to 1612.													
CM024	Smoking related deaths (rate per 100,000 population)	379	369.8 ↘	371.2 ↗	297 (2009/10)	Significantly worse	N/A	N/A	349.3	349.3 (Outturn)	Getting better	⮟	☺
Commentary on performance:									Full year data covers 2010/12				
Revised figures published by PHE in May 2014 for years 2007 onwards													
Reduce the misuse of alcohol or drugs													
CM097	Reduce the number of people admitted to hospital due to alcohol-attributable conditions DSR per 100,000 population)	1386	1,520 ↗	1,808 ↗	1974 (2008/10)	Significantly better	N/A	N/A		N/A (Estimate)		⮟	
Commentary on performance:									Full year data covers 2013/14 financial year.				
No comment received													

Key

Improving (high is good) | Improving (low is good)
Worsening (high is good) | Worsening (low is good)

HEALTH & WELLBEING BOARD: 12 MONTH PERFORMANCE MONITORING

ID	Title	2010/11 Outturn	2011/12 Outturn	2012/13 Outturn	National Comparator 2012-13	Comparison to national position 2012-13	Performance at 6 months 2013-14	Performance at 9 months 2013-14	Performance at 12 months 2013-14	Estimate/ Outturn 2013-14	Direction of travel compared to 2012-13	Target 2013/14	Progress against target
CM113	Rate (per 1000) of violence against the person with injury where alcohol was recorded as a factor	3.4	3.2	2.8	N/A			2 (332/166600)	2.7 (438/166641)	2.7 (Estimate)	Getting better		
Commentary on performance: As per CM112 violence with injury offences continue to decline									Full year data covers 2013/14 financial year.				
CM364	Proportion of all in drug treatment, who successfully completed treatment and did not re-present within 6 months (non opiate clients)	N/A	19.7%	37.7%	40.2% (Jan - Dec)	Worse		47.5%		47.5% (Estimate)	Getting better		
Commentary on performance: There have significant improvement in completions for non opiate clients during the past two years									Full year data covers October - September 2013				
CM365	Proportion of all in drug treatment, who successfully completed treatment and did not re-present within 6 months (opiate clients)	N/A	8.8%	8.3%	8.2% (Jan - Dec)	Better		8.5% (103/208)		8.5% (Estimate)	Getting better		
Commentary on performance: No comment received									Full year data covers January - December				
CM322	Number of people admitted to hospital with alcohol-specific conditions - Males (DSR per 100,000 pop)	375.3	373	407.2	524 (2010/11)	Significantly better	N/A	N/A	421.6	421.6 (Outturn)	Getting worse		
Commentary on performance: Next data revision in May 2015									Full year data covers 2012/13				
CM323	Number of people admitted to hospital with alcohol-specific conditions - Females (DSR per 100,000 pop)	198.2	184.1	184.2	240 (2010/11)	Significantly better	N/A	N/A	181.7	181.7 (Outturn)	Getting better		
Commentary on performance: Next data revision in May 2015									Full year data covers 2012/13				
CM324	Mortality from Chronic Liver Disease (DSR per 100,000 pop 3-year rolling)		13.7	14.3	10.1 (2009/11)	Significantly worse	N/A	N/A	13.4	13.4 (Outturn)	Getting better		
Commentary on performance: Next Version due Dec 2014									Full year data covers 2010-12				

Key

Improving (high is good) | Improving (low is good)
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HEALTH & WELLBEING BOARD: 12 MONTH PERFORMANCE MONITORING

ID	Title	2010/11 Outturn	2011/12 Outturn	2012/13 Outturn	National Comparator 2012-13	Comparison to national position 2012-13	Performance at 6 months 2013-14	Performance at 9 months 2013-14	Performance at 12 months 2013-14	Estimate/ Outturn 2013-14	Direction of travel compared to 2012-13	Target 2013/14	Progress against target
Improve adult &childrens carers' health & wellbeing													
CM079	Carer-reported quality of life			8.0	8.1	Worse	N/A	N/A	N/A	N/A (Outturn)		▲	
Commentary on performance: This is from the Carers survey which is due to be carried out in 2014-15.									Full year data covers 2013/14 financial year.				
CM080	The proportion of carers who report that they have been included or consulted in discussion about the person they care for			72.8%	72.9%	Comparable	N/A	N/A	N/A	N/A (Outturn)		▲	
Commentary on performance: This is from the Carers survey which is due to be carried out in 2014-15.									Full year data covers 2013/14 financial year.				
Improve life expectancy and reduce health inequalities													
CM013	Male life expectancy at birth (years)	77.3	77.4 ↗	77.9 ↗	79.2 (2010/12)	Significantly worse	N/A	N/A	77.9	77.9 (Outturn)	Getting Better	▲	☺
Commentary on performance: In the Feb.14 PHOF, the 2010-12 figure was revised upward from 77.5 to 77.9. Next data revision Aug 2014.									Full year data covers 2010/12				
CM101	Life expectancy - Slope of index (Males)	7.1	6.2 ↘	6.9 ↗	N/A		N/A	N/A	6.7	6.7 (Outturn)	Getting better	▼	☺
Commentary on performance: New data released for 2010-12 in PHOF May.2014 included here, with some revisions to past data									Full year data covers 2010/12				
CM326	Life expectancy - Slope of index (Females)	3.1	3.4 ↗	2.6 ↘	N/A		N/A	N/A	2.5	2.5 (Outturn)	Getting better	▼	☺
Commentary on performance: New data released for 2010-12 in PHOF May.2014 included here, with some revisions to past data									Full year data covers 2010/12				
CM011	Mortality from all circulatory diseases (CVD) (rate per 100,000 population under 75, 3yr rolling average)	110.4	107.4 ↘	102.4 ↘	84.4 (2008/10)	Significantly worse	N/A	N/A	95.6	95.6 (Outturn)	Getting better	▼	☺
Commentary on performance: Figure published in PHOF (4.04i) May 2014. Next release after Dec 2014									Full year data covers 2010/12				
CM012	Premature mortality from all cancers (rate per 100,000 population under 75 years) 3-year rolling average	122.9	122.6 ↘	122.8 ↗	108.4 (2009-11)	Significantly worse	N/A	N/A	123	123 (Outturn)	Getting worse	▼	☹
Commentary on performance: Next update due Dec 2015									Full year data covers 2010/12				
CM104	Increase the numbers of people immunised against flu (% 65 years and over)	69.1	72.1% ↘	73.5% ↗	73.4% (2012/13)	No significant difference	68.7%	N/A	73.5%	73.5% (Outturn)		75%	

a co-operative council

Telford & Wrekin COUNCIL

Key

Improving (high is good) | Improving (low is good)
Worsening (high is good) | Worsening (low is good)

HEALTH & WELLBEING BOARD: 12 MONTH PERFORMANCE MONITORING

ID	Title	2010/11 Outturn	2011/12 Outturn	2012/13 Outturn	National Comparator 2012-13	Comparison to national position 2012-13	Performance at 6 months 2013-14	Performance at 9 months 2013-14	Performance at 12 months 2013-14	Estimate/ Outturn 2013-14	Direction of travel compared to 2012-13	Target 2013/14	Progress against target
Commentary on performance: This figure remains in the May.14 publication of PHOF. Next data revision will be Aug 2014.									Full year data covers 2012/13				
Support people to live independently													
CM073	Proportion of people using social care who receive self-directed support	30.2%	36.2% ↗	58.8% ↗	55.5%	Better	63.8% (1795/2812)	60% (1865/3109)	60.5% (2239/3694)	60.5% (Outturn)	Getting better	▲	☺
Commentary on performance: This measure has improved greatly over the last 3 years but we are now at saturation point where 100% of eligible clients are receiving services via 'Self Direct Support'.									Full year data covers 2013/14 financial year.				
CM074	Proportion of people using social care who receive direct payments	5.4%	5.8% ↗	8.1% ↗	16.5%	Worse	8.8% (248/2812)	8.2% (255/3109)	11% (432/3694)	11% (Outturn)	Getting better	▲	☺
Commentary on performance: A high level project group has been established which is looking right across the Direct Payment process in order to improve uptake and quality of Direct Payments. This is running alongside a regional project looking to address the same issues.									Full year data covers 2013/14 financial year.				
CM075	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services (Those offered Intermediate Care)	77.9%	74.3% ↘	53.7% ↘	81.4%	Worse	N/A	N/A	64.9% (61/94)	64.9% (Outturn)	Getting better	▲	☺
Commentary on performance: No comment received									Full year data covers 2013/14 financial year.				
CM076	People receiving re-ablement service who need no support at the end of their service		37.0%	34.9% ↘			39.1% (104/266)	42.7% (230/539)	N/A	40% (Estimate)	Getting better	▲	☺
Commentary on performance: This is a local indicator only. Work is ongoing to improve recording around enablement and report much clearer outcomes. The collection of this data has therefore changed with quarter 4 not comparable to the first 3 quarters.									Full year data covers 2013/14 financial year.				
CM077	Delayed transfers of care from hospital		8.6	5.3 ↘	9.5	Better	5.74	7.96	8.22	8.22 (Outturn)	Getting worse	▼	☹
Commentary on performance: Although this has increased over the last 3 months, this measure remains lower than previous year's national averages.									Full year data covers 2013/14 financial year.				

Key

Improving (high is good) | Improving (low is good)
Worsening (high is good) | Worsening (low is good)

ID	Title	2010/11 Outturn	2011/12 Outturn	2012/13 Outturn	National Comparator 2012-13	Comparison to national position 2012-13	Performance at 6 months 2013-14	Performance at 9 months 2013-14	Performance at 12 months 2013-14	Estimate/ Outturn 2013-14	Direction of travel compared to 2012-13	Target 2013/14	Progress against target
Support people with dementia													
CM105	Dementia diagnosis rates	N/A	N/A	N/A	42.8% (2011/12)		N/A	N/A	45.7%	45.7% (Outturn)		▲	

Commentary on performance: Full year data covers 2012/13
The national figure has improved and Telford & Wrekin's latest rate of 45.6% is similar to the national. The Alzheimer's Society has produced the data and is campaigning for these rates to improve.

Summary

Total Measures	**32**
☺ **Better than Target**	**15**
☹ **Worse than target**	**5**
No Target	**9**
Not Available	**3**
No data	**0**

TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD – 24th SEPTEMBER 2014

THE BETTER CARE FUND HEALTH & SOCIAL CARE INTEGRATION

REPORT OF: CLIVE JONES: ASSISTANT DIRECTOR FAMILY, COHESION & COMMISSIONING & FRAN BECK EXECUTIVE DIRECTOR COMMISSIONING TELFORD & WREKIN CCG

LEAD CABINET MEMBER – CLLR ARNOLD ENGLAND

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

The purpose of this report is to update members of The Health & Wellbeing Board regards proposals for resubmitting its plans for the integration of health and social care under proposals for creating The Better Care Fund.

2. RECOMMENDATIONS

2.1 The following recommendations are made:

That the Health and Wellbeing Board:-

- note revised requirements to put in place a Better Care Fund
- approves the BCF plan (submitted to NHS England on 19th September 2014).
- delegate power to the Chairman of the Health and Wellbeing Board to sign any further documentation relating to the revised BCF plan document that may be required
- delegate power to the Chairman of the Health and Wellbeing Board, in consultation with the Chief Operating Officer (CCG), to approve any further minor amendments or minor additions to the BCF plan as required by both the National Audit and Cabinet Office.

3. IMPACT OF ACTION

3.1 Our initial plan was submitted for approval in February 2014. Following reviews by both the National Audit and Cabinet Office, CCGs and local authorities are now being asked to review their plans assuming a 3.5% reduction in emergency admissions. We must resubmit our plan by the 19th September 2014. National conditions are unchanged, the following key changes must be demonstrated within revised BCF plans:

- A more detailed case for change and plan of action must be set out
- A more detailed analysis or risk (including mitigation) and risk sharing agreement must be defined and included in our resubmission
- The plan must demonstrate an alignment with other NHS and Council plans
- Each plan proposal must be described in more detail
- We must detail protection being given to social care services through BCF
- We must show evidence of engagement with stakeholders
- We must show how we have involved providers
- Specific requirement to show how we will reduce admissions by 3.5% with detailed modelling and phased activity assumptions to be included

3.2 Given that national conditions remain largely unchanged and the main purpose of the resubmission is to provide additional detail against an amended target for reducing admissions, the decision has been taken to use delegated powers approved by the Health & Wellbeing Board on the 12th February to approve submission of the amended plan prior to the meeting in order to meet the required dates for submission.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	*Improve emotional health and wellbeing of Borough residents.* *Support people with specific health needs to live independently for as long as possible.* *Support people with dementia.* *Support people with autism.*
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	Yes	*Vulnerable children and adults*
	Will the proposals impact on specific groups of people?	
	Yes	*Will impact on people who are ill or disabled, who need support and on their family carers.*
TARGET COMPLETION/DELIVERY DATE	*From April 2015*	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	In Telford, it is anticipated that the net contribution to the Better Care Fund in 2015/16 will be revised to £12.068m since our last submission. Significantly more detail showing how the fund will be spent and the expected value of benefits must be included in the resubmission. The project team are currently working on the detail which will be sent out to Health and Wellbeing Board members ahead of the meeting. This submission will also need to consider risk in more detail describing the process for developing a risk sharing model. The final risk sharing model will need to be approved by all parties as part of the finalisation of the Section 75 legal agreement. Whilst all metrics included within the plan will be monitored, only the reduction in admissions target will have any impact on funding to the Pooled Budget. The required minimum 3.5% reduction is linked to £840k of performance pay which will be held back out of the Pooled Budget and only released as and when admission reductions are achieved. If they are not achieved then this money will flow to the acute sector to

		fund admission activity. This is currently the only quantifiable financial risk known. Potential areas of financial risk are being identified but further work will be needed to ensure the value of these risks can be identified.
LEGAL ISSUES	Yes	The NHS England planning guidance sets out the recommended process and format for developing a plan for the Better Care Fund. If the guidance is not followed at any point there needs to be a justifiable reason for doing so as this may jeopardise the award of funding (as outlined in the guidance). Following the initial submission both the Audit and Cabinet Office have stipulated further requirements to the BCF Plan and further consideration by the HWBB. Accordingly, whilst the first BCF submission was considered by both the HWBB (12th February 2014, minute number HWB – 49) and the Cabinet (30th January 2014, minute number CB - 82) it is appropriate for the HWBB to review the revisions and confirm their approval or otherwise. There will be standards for the plan which are national requirements. However, there will also be the Council's and CCG's own requirements which should be in place to ensure good governance, effective contract management and the protection of sensitive data. Further, if the plan results in any possible changes to existing service provision to people, consideration needs to be given as to whether further equalities impact and consultation work needs to be undertaken. The new integration provisions will bring significant changes to the commissioning of some Council and Clinical Commissioning Group (CCG) services. As the plan moves from being a strategic to a more operational process, officers will identify specific areas where changes to existing commissioning processes will be needed to incorporate the integration required. If the changes may affect the Council's and CCG's commissioning plans and may require separate reports elsewhere such as Cabinet and CCG Governance Board. For example, changes to existing delegated powers may need to be made to undertake the new joint commissioning. There is reference to potential legislative

		changes which, if implemented, will need to be complied with as part of this process. It should be noted that in addition to the delegations requested as part of this report, Cabinet have previously delegated powers to the Interim Director of Health, Wellbeing & Care, in consultation with the Cabinet Member: Adult Social Care, to submit the Better Care Fund plan on behalf of the Council, subject to the required assurances being received from the Clinical Commissioning Group (Cabinet meeting 30th January 2014 – CB – 82).
IMPACT ON SPECIFIC WARDS	No	
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	*The timeframe for submitting a revised plan by 19th September has been challenging and required rapid joint effort by the Council and CCG working with its partners.*

PART B) – ADDITIONAL INFORMATION

1. INFORMATION

1.1 The Health and Social Care Act 2012 set out expectations around greater integration of health and social care services to provide more effective pathways and better outcomes and value for patients/service users. The spending review at the end of June 2013 set out the requirement to set up an Integration Transformation Fund, renamed the Better Care Fund (BCF) by April 2015, with at least a minimum value of CCG and Council funding included in the Better Care Fund.

1.2 The fund will be allocated to local areas where it will be put into a pooled budget under joint governance between the CCG and Council, with a condition that they must have a jointly agreed plan which meets certain requirements set nationally. There are six national conditions:

- Plans to be jointly agreed
- Protection for social care services (not spending)
- Seven day services in health and social care to support patient discharge from hospital and prevent unnecessary admissions at weekends
- Better data sharing between health and social care based on the NHS number
- Joint approach to assessments and care planning, funding used for integrated packages and a named accountable professional in all cases
- Agreement on the consequential impact of changes in the acute sector.

1.3 Elements of the BCF will be performance related.

1.4 The Health & Wellbeing Board approved the draft plan for submission to NHS England at their meeting on the 12th February 2014.

1.5 A Better Care Commissioning and Transformation Group, reporting to the Health & Wellbeing Board has been established to oversee the implementation of Better Care arrangements.

PROGRESS TO DATE

1.6 The following progress has been made since the initial submission of our plan in February 2014:

- The Better Care Commissioning & Transformation Group, supported by a number of sub groups is in place
- An Accelerated Pilot has been introduced, with the main aim of reducing hospital admissions
- A pilot befriending service is currently being commissioned
- Consideration is being given to creating an integrated front door and response for accessing adult care and health services

- Engagement activity has taken place with the social care and health workforce, voluntary sector and providers.

1.7 NHS England planning documents noted that emergency admissions would need to fall by 15% to finance the fund. Following reviews by both the National Audit and Cabinet Office, CCGs and local authorities are now being asked to review their plans assuming a 3.5% reduction in emergency admissions.

1.8 We must resubmit our plan by the 19th September 2014. National conditions are unchanged; the following key changes must be demonstrated within revised BCF plans:

- A more detailed case for change and plan of action must be set out
- A more detailed analysis or risk (including mitigation) and risk sharing agreement must be defined and included in our resubmission
- The plan must demonstrate an alignment with other NHS and Council plans
- Each plan proposal must be described in more detail
- We must detail protection being given to social care services through BCF
- We must show evidence of engagement with stakeholders
- We must show how we have involved providers
- Specific requirement to show how we will reduce admissions by 3.5% with detailed modelling and phased activity assumptions to be included.

1.9 The Department of Health have put in place a Better Care Task Force headed by Andrew Ridley (BCF Programme Director). The Task Force will be part of the Department for Communities and Local Government.

1.10 The Task Force have introduced/taken a number of temperature checks from each area to assess progress, have or are in the process of providing considerable additional guidance and have offered additional consultancy support to each CCG/Council.

1.11 The Task Force has also put in place a comprehensive assurance process/phase involving NHS England, CCGs, LGA and Local Authorities which will assess plans in detail once submitted on the 19th September.

1.12 The amended plan must be signed off by the Chair of the Health & Welling Being Board, Chief Operating Officer (CCG) and the Chief Executive of The Shrewsbury and Telford Hospital NHS Trust.

1.13 The project team will be working on the required revisions to our initial plan. This will be shared with members of the Board as soon as it is ready. Given the extremely tight timescale set by NHS England and the amount of work required The Chair of the Health & Wellbeing Board in consultation with The Chief Operating Officer have approved the plan for submission.

Key Dates

1.14 The following key dates apply to our plan resubmission

Activity	Date
New BCF Task Force in place led by Andrew Ridley (DCLG)	July 2014
New Templates & Guidance Issued	25th July
1:1 West Midlands Task Force Clinic	10th September
Revised Plan Submitted	19th September
All Plans assessed using common methodology	19th Sept to 3rd Oct
Telford Health & Wellbeing Board	24th Sept 2014
Moderation of Assurance Process	6th – 10th October
Plans reviewed by Simon Stevens & Bob Kerslake	6th – 10th October
Plans reviewed by ministers	13th – 17th October

2. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

N/A

3. PREVIOUS MINUTES

Health & Wellbeing Board – 12th February 2014 (HWB – 49)
Cabinet – 30th January 2014 (CB – 82)

4. BACKGROUND PAPERS

Report prepared by Clive Jones, Assistant Director Family, Cohesion and Commissioning Telephone: 01952 380900

Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Telford and Wrekin Council**
Clinical Commissioning Groups	**Telford and Wrekin Clinical Commissioning Group**
Boundary Differences	**Co-terminous boundaries**
Date agreed at Health and Well-Being Board:	**17 September 2014 by delegated authority**
Date submitted:	**19 September 2014**
Minimum required value of BCF pooled budget: 2014/15	**£645,000**
2015/16	**£11,690,000**
Total agreed value of pooled budget: 2014/15	**£12,908,000**
2015/16	**£12,068,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Telford and Wrekin Clinical Commissioning Group
By	David Evans
Position	Chief Officer
Date	17/09/2014

Signed on behalf of the Council	Telford and Wrekin Council
By	Paul Taylor
Position	Interim Director of Health Well-being and Care
Date	17/09/2014

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	Telford and Wrekin Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Richard Overton
Date	04/04/2014

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Joint Strategic Needs Assessment	The Joint Strategic Needs Assessment (JSNA) informs the development of priorities across the economy. The process brings together and explores a wide range of data, performance information and intelligence to identify those issues where the Borough is doing well and also those which remain a challenge and where more needs to be done. The JSNA is not one single document - individual parts of the JSNA can be found on our facts and figures page. The latest analysis from the JSNA process has been used to help identify local health and wellbeing needs,
Health & Wellbeing Strategy	This strategy sets out our commitment to working in partnership to improve the health and wellbeing of

	people living in Telford and Wrekin. The Telford and Wrekin HWBB is responsible for delivering the strategy and addressing health inequalities. http://www.telford.gov.uk/downloads/file/4123/hwb_priorities_consultation_may_2012
Urgent Care High Level project Optimising Capacity proposal supported by Chief Officers Group, approved by CCG Board.	The project reviewed issues faced by the economy in managing urgent care demands. It showed that the current network of bed capacity, resources, care pathways, teams and skills were not optimised, thus creating inefficiencies. The project set out an integrated health and social care model of working to support discharge. Key features included: Discharge home to assess as the norm; a Single point of access and referrals mechanisms; integrated triage, co-ordination and management; a shared record; rapid access to advice and 7 day working. http://www.telfordccg.nhs.uk/board-papers-9-july-2013
Multi-agency strategy for Carers 2013- 2016	This multi-agency strategy sets out the ambition for local Carer services as well as, new national priorities identified by Government. The strategy's priorities will be supported by an action plan which will inform how these priorities will be met. The monitoring of the plan will be undertaken by the Carers Partnership Board where carers actively contribute to discussions and debates. From a grass roots level, continued engagement with the Carers Forum will ensure carers have the opportunity to influence and shape future services, which affect both carers and the person for whom they care for. http://www.telford.gov.uk/downloads/file/5201/carers_strategy-draft
Older Adults strategy 2006-2016	This Joint Strategy sets out the health and social care commitment to working with older adults in Telford & Wrekin, and our partners, to ensure that every older adult can access information when they need it, is valued as a citizen and as a member of their local community, always has opportunities to improve his or her health and wellbeing, receives the care and support he or she needs to live as independently as possible and has personal choice and control over how the care and support they need is organised and provided. http://www.telford.gov.uk/downloads/file/2686/older_adults_strategy_refreshed_2010-2014
Multi-Agency Living Well with Dementia Strategy	This Joint Commissioning Strategy seeks to change the shape and quality of existing services to address

	the objectives in the National Dementia Strategy, 2009 (NDS). The purpose of the document is to drive the development of an equitable, seamless and coordinated dementia service of a good quality, using an agreed pathway served by agreed protocols and staffed by a trained, competent workforce. Implementation of the Strategy is through and Health and Social Care Economy Group for Dementia and accountable to the Health and Wellbeing Board.  Dementia Pathway - Living with Dementia !
Rehabilitation and Reablement strategy 2010-13	This strategy sets out the proposed developments and changes to rehabilitation and re-ablement services in Telford & Wrekin. The overall aim is to provide a range of services that improve the quality of life for people and enable them to live as independently as possible. To achieve this, services must be timely, accessible and organised to meet individual needs.   Rehabilitation and Reablement Strategy Rehab Action Plan 2012.doc
Integrated Community Enablement model	This paper sets out an approach to supporting frail elderly people with complex care needs through an Integrated Community Enablement model. It seeks to reduce admissions and length of stay through increased community capacity. The paper was supported by the CCG Governance Board http://www.telfordccg.nhs.uk/board-papers-12-november-2013
2-5 year Plan	http://www.telfordccg.nhs.uk/strategies
Strategic Clinical Review of hospital care and vice versa locally branded as 'Future Fit'	http://www.telfordccg.nhs.uk/future-fit
Adult Social Services Service Plan 2014/15	This plan that sets out what Adult Social Services does and the teams that currently sits in each area. Also included are the service's priorities, challenges, opportunities and key work streams for the year.  Adult Social Services 14 15 final.pdf
Council Medium Term Plan 2013/14 to 15/16	This Plan provides an opportunity to reflect on the Council's achievements over the past year as well as focusing on our future goals

	Council Plan - Council Plan - Downloads - Telford & Wrekin Council
Accelerated Pilot implementation plan	The development of the Accelerated Pilot is phase of the development of the Integrated Community Enablement Team. The Pilot was implemented from July 2014  Implementation Plan for the Accelerated P
BCF implementation Plan	The Implementation Plan in place and updated since March 2014  Better Care Fund Implementation Plan \

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

In five years time social care and health services will be fully integrated in the delivery of community based services care. The development and implementation of integrated health and care structures which will be contributing to a better patient experience/ improvement in outcomes but at a significant lower cost.

The BCF will be used to transform the health and social care system in Telford and Wrekin, promoting greater independence for patients and service users and improving on current areas of integrated care.

The aims are:

- Delivering the best possible health and social care outcomes for individuals in a personalised way.
- Promote and encourage self-help and self-care wherever and for as long as possible
- Enabling those at increased risk of hospital, nursing or residential care admission to have easy access to systems in place, to get appropriate help at an early stage.
- Ensuring financial efficiency and reducing duplication.

Six performance measures will be used to monitor progress through the Programme Management Board:

- Reducing non-elective hospital admissions, re-admissions and length of stay.
- Reducing permanent admissions to residential and nursing care.
- Improved patient experience
- Reducing delayed transfers of care.
- Improving the effectiveness of reablement/rehabilitation services.
- Reducing emergency admissions in 65 years + age group.

The current focus for the BCF is to transform public services for adults needing high levels of health and/or social care support, particularly frail older people at risk of and/or suffering as a result of:

- Falls
- Dementia
- Long term conditions /End of Life
- High risk of admission to hospital or care home
- Discharged from hospital with a need for rehabilitation and/or enablement

This is based on JSNA evidence of demographic changes. Local residents aged 65 and over are an increasing proportion with the fastest increase since 2001 in the 85+ age group (27.3%). The 65+ population is expected to increase by 9,200, an increase of 37%. This age group currently represents 14.5% of the total population. By 2026 this will 17.3%.

However integrated services will incrementally extend the target population in line with JSNA evidence including substance misuse, cancer, obesity, smoking and diabetes. JSNA key facts and figures (above) highlights:

- Inequalities in life expectancy between our most affluent and most deprived communities are predominately due to cancers and cardiovascular diseases
- Early death rates (under 75) from bowel cancer are higher than average and the incidence of lung and mouth cancers is worse than average
- In terms of waiting and treatment times for patients with cancer, the national standard times are not consistently delivered for the main tumour sites
- The prevalence of diabetes has doubled in the last decade increasing to 6.3% in 2012/13 from 3.4% in 2004/05, this equates to 8,669 people currently with diabetes
- Smoking-related hospital admissions are higher than the national average, approx 1,500 per year
- The high levels of excess weight and increasing prevalence of diabetes coupled with our ageing population will have a significant impact on the future local demand for health services. This includes: primary care, diabetes eye screening, diabetes care services and vascular services etc
- There are variations in the quality of treatment for patients with hypertension (high blood pressure) across our GP practices

The 2-5 year plan identifies that the priorities build on the local intelligence contained with the JSNAs. Strategic thinking in relation to health and wellbeing incorporates the Health and Wellbeing priorities, as part of the work on the Better Care Fund.

An Integrated Commissioning Strategy 2015 – 2020 will incorporate all elements of activity, growing beyond the areas of focus outlined in Themes 1 and 2 of the first operational year of BCF (2015-16).

Governance arrangements will be overseen by the Better Care Programme Management Board who reports to the Health and Well-Being Board via the an overarching Strategic Commissioning and Transformation Group.Individual organisation also report into their own governance structure. A detailed Action Plan will cover the first two years of activity in detail and provide broad strategic intentions for the remaining three year period. Annual review will allow the Action Plan to remain 'live' and be flexible to respond to local trends and priorities.

Efficiencies (net of agreed QIPP/saving targets) will be achieved by a reduction in management and administration; streamlining access to services; greater integration of services. Centralisation of identified functions will support further reinvestment in the local health and social care economy. The main focus of work will remain on prevention and Enablement.

Patient and service users will be reporting high levels of satisfaction with services. Building on existing patient experience surveys, feedback engagement and co-production they will be fully engaged in the design and consultation in relation to the development of services. Evidence of user engagement is set out below.

Local people will receive care and support from Integrated services. This means that providers from the Local Authority, the acute sector (including mental health and learning

disability services), community health services will deliver care in an integrated way and in collaboration with the voluntary sector and in partnership with providers of residential care (private and voluntary sector).

Patients and service users will have been supported to develop a range of self help systems including developing community capacity to support each other. They will have been supported to become more aware of individual responsibility to address potential and anticipated health issues, thereby reducing the need for admission into public sector funded services. The main vehicle to support this programme of cultural and behavioural change will be driven by Public Health. The focus will broaden beyond conditions associated with people over the age of 65 to include other major conditions including obesity and substance misuse including smoking and alcohol, as well as other long term conditions including mental health, autism and learning disability

Patients and service users will have a greater confidence in the range of early help and preventative support services available to them and appropriately use them as opposed to acute services. Where there is a need to use acute services these will be provided in a timely manner.

Much more work will take place in collaboration with local schools to provide the early educate in relation to healthy lifestyles as part of the long term strategy of health promotion and personal responsibility.

In partnership with local media and existing and established communication networks, the general public will have increased awareness of ‘what to do’ and ‘where to go’ to gain information, advice and support relating to their own health and well-being.

The voluntary sector will have established itself as a key partner in progressing this agenda for change. Specifically, there will be greater alignment within and across the voluntary sector and an increased investment over the five year period, funded by efficiencies achieved through increased integration. This will build on the work that is currently taking place with the voluntary sector and we will seek to achieve a co-production approach to change. This is intended to ensure that the voluntary sector, as a whole, reduced the demand for health and social care services through their development.

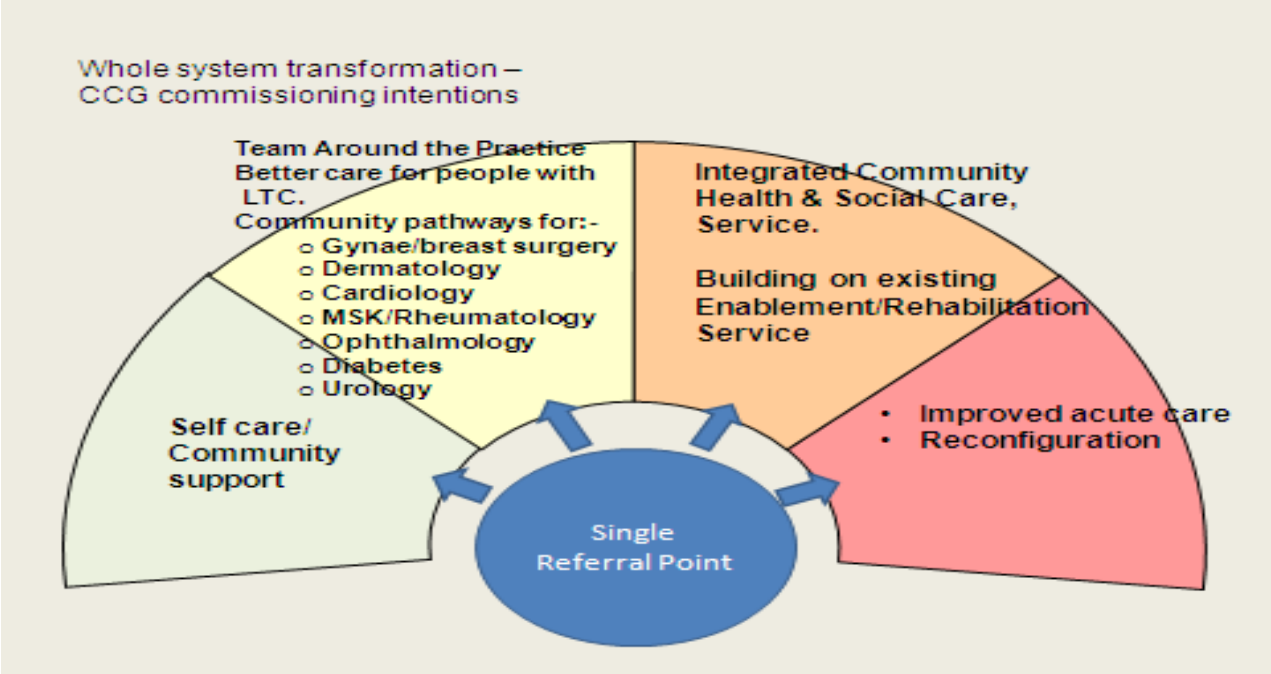
Health and social care services have been committed to transforming the health and social care system in Telford and Wrekin, promoting greater independence for patients and service users and improving on current areas of integrated care.

Council transformation has been driven by the national personalisation agenda in Adult Social Care which recognises that the traditional ways of delivering community care services are unsustainable against a background of budget constraints and increasing numbers of frail older people needing support. There is evidence that the historic approach can disable people, create dependency, is risk averse and leads to an over prescription of support, whilst discouraging innovative, personalised and more cost effective interventions including self-help and support.

Therefore the Council’s commissioning intentions are based around a more personalised approach with the person and their family taking greater control themselves through access to:

- Universal Information, Advice & Living Well
- Community Support to facilitate self-help
- Single point of access for specialist advice & support
- Prevention & Enablement to maximise independence and avoid or reduce the need for ongoing care and support
- Personal budgets to give greater choice & control for those who need ongoing support
- A network of support brokers who can offer knowledge, expertise, guidance and planning to service users leading to the creation of a Care and Support Action Plan

Similarly the CCG demonstrates its 'high level' commissioning intentions through the model below:



The four elements in the CCG commissioning strategy include:

- Stronger communities – to strengthen communities; develop greater capacity for patients to 'self-care', and to offer support to families and carers.
- A Team around the GP Practice – strengthen primary care with a multi-disciplinary approach to proactive support patients with Long Term Conditions, particularly those who are vulnerable.
- Enhanced Integrated Enablement Team – to build on the existing Home from Hospital and Enablement Services and to broaden the remit to include a community based Falls Service, all admission avoidance; all discharge of Rehabilitation and Enablement and End of Life Care.
- Improved Hospital care– ensuring acute hospital services has effective processes from ED attendance, admission, treatment pathway to discharge to ensure quality and efficiency.

The greatest synergies between the discrete Council and CCG plans is in the shared aspirations for:

- Prevention, self-help/self-care and building Community Capital
- Maximising Independence through the Integration of Out of Hospital and Enablement Services.

To deliver these aims two thematic areas and objectives have been developed. These are the two BCF schemes:

Theme (Scheme) 1 - Building Community Capacity in Telford and Wrekin

- To review current spend by both organisations on the voluntary sector services to help improve understanding of how to improve the effectiveness of the sector
- To support improvements in the infrastructure of the voluntary sector
- To jointly design and procure a range of support services that can be delivered by voluntary and community organisations
- To work through a robust engagement process with self-help organisations to clarify how best to strengthen them, and how to improve signposting for people to the help and support on offer
- To expand engagement with communities to understand how best to extend volunteering, neighbour support schemes and generate community capital.
- Achieving efficiency and reducing duplication

Theme (Scheme) 2 – Enhanced community services for Telford and Wrekin as an alternative to hospital provision

- To review how existing services funded by the resources being pooled in the BCF can be maximised to improve and enhance quality, value for money, and outcomes.
- To complete modelling to confirm how many people can be supported in Out of Hospital care, what staff are required (clinical and care) and what the costs will be.
- To establish an enhanced and expanded integrated and multi-disciplinary 'Out of Hospital Service'. This will provide a comprehensive continuum of services from admissions avoidance to end of life care.
- To utilise non-recurring Transformation monies in the CCG allocation for 14/15 to 'Invest to save' in staff and processes, evaluate Pilots and innovations to reduce admissions in readiness for 2015/16.
- To establish processes for referrals/access/assessment and support by the enhanced integrated service including the establishment of a Single Referral Point.

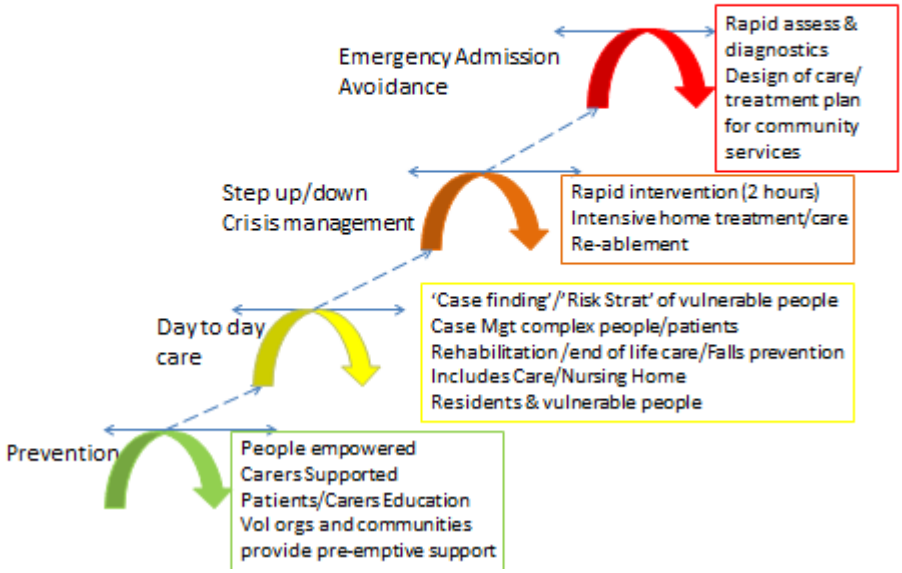
An additional area identified that will align to BCF is Team Around the GP Practice. This area connects Themes I and 2 and is also a major transformational programme within the economy. Team Around the Practice will develop a model to support primary care in reducing urgent and planned care admissions; case management of patients who are at high risk of admission or high users of NHS and / or social care services; further develop effective management of long term conditions where primary, community and/or social care interventions are needed

The two Themes/ schemes aligned with the Team Around the GP practice will enable transformation of all community services across community, primary and voluntary sector. By 2018/19 the local provision will be:

- Enhanced self- help, self-care and local community networks giving low level support minimising the need for health and social care services.
- The Team Around the Practice will providing enhanced 7 day services including planned care treatments, diagnostics and shared care with acute clinicians.
- Enhanced Community services comprising acute and community staff working together across the acute and community services to maintain people at home to reduce admissions.
- A hyper-acute provision that works with community services to admit only those who need that level of care.

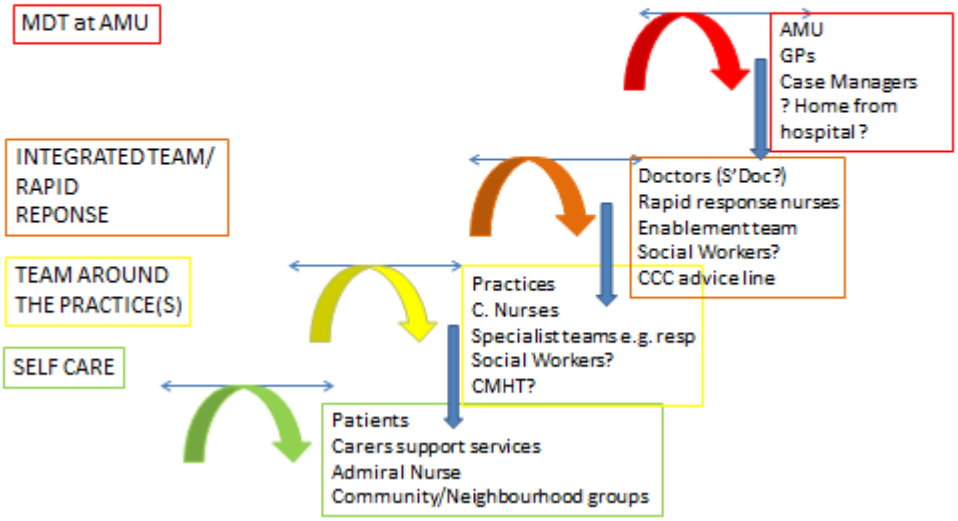
To support the implementation of the BCF schemes, a tiered approach has been developed. This sets out how services area aligned to levels of need

What would happen at each 'safety net'



Who works where?

NB model expects each 'tier' to support those below



The BCF will be developed in line with this tiered approach; identifying how services will operate and developing early intervention/preventative services for diverting service users away from high cost hospital or community care placements. By 2018/19 this approach will be fully in place.

Care and support will be delivered from community settings. A community based multi-disciplinary Enablement team is already in place which comprising nurses, occupational therapists, physiotherapists, social workers and care staff. Discussion is already under way as part of the Phase 2 development of the integrated provision

to identify accommodation for a larger integrated team. The team will have a central location, with hubs located across the Borough including named local GP surgeries. Care will be delivered along care closer to home: occurring directly in individuals homes as well as bases and places. This is to support local integration, aligning people within local support services to reduce isolation and reduce the long term need for higher level health and social care services.

Over the next five years there will be increased access to integrated care on a 24 hour, seven day week basis. The intention is to ensure the 24 hour, seven day week is a comprehensive service and includes all supporting functions to ensure ongoing delivery over weekends, evenings and bank holidays. There will be incrementally development of existing services that work out of normal office hours. Current services include:

Rapid Response is a 7day 8am -10pm provision;
Enablement is a 7 day service for care and support;
Shropdoc provides medical assessment out of hours to ensure a 24 hour medical response is available in the community.

Care and support being delivered though the development of the two schemes:

- Transformation of voluntary services to deliver more and more joined up voluntary support within communities;
- An Integrated Community Enablement team that will use evidence based interventions to avoid hospital attendance and admissions as well as support early discharge from hospital. This is set out within the Integrated model attached below.

Part of the cultural change will include increased use of Personal health and / or budgets, giving greater choice and control to individuals. The local economy will also implement a support broker model whereby a trained independent person will offer knowledge, expertise, guidance and planning which will be used to support the service user in developing a quality care and Support Action Plan which is personal to the service user.

Specific changes intended to be delivered using the Better Care Fund are:

- Achieving sustainable change
- Integrated delivery of all aspects of health and social care, so the approach will be comprehensive- currently developing plans for implementing this model (below)
- Established and adopted a multi- tiered model of care delivery and aligned capacity to meet demand in those tiers.
- Removed overlaps and duplication and to ensure timely response is given to patients requiring services. The accelerated pilot is currently testing out a new way of working. Early indications suggest the need for greater integration of services and proposals are currently being worked up to put this in place.
- Clear governance structures by creating a Better Care Programme Management Board, Strategic Commissioning Group and clear reporting lines into the Health & Wellbeing Board

Evidence of service user and public engagement is set out in the section below. In

summary: Healthwatch and voluntary organisations (through the CVS) are standing members of the Programme Management Board and each work-stream (see Terms of Reference); a service user and carer representation has also been identified, users and carers have been engaged through the Urgent Care Transformation Board, Health Roundtable and a public engagement event. A further event takes place on 24th September.

Service users and public participation was evidence within the BCF launch event. That is summarised below.

The BCF approach is based on the demographic changes, local Health and Well-Being priorities and local public health needs. The focus on the 65 years + population is in line with the broader demographic, and socio-economic changes locally. People aged 65 and over are an increasing proportion with the fastest increase since 2001 in the 85+ age group (27.3%). The 65+ population is expected to increase by 9,200, an increase of 37%. This age group will grow from 14.5% currently to 17.3% of the total population by 2026 with the very significant associated costs unless addressed.

The Integrated model attached below highlights the evidence base for the local approach. The specific change will be the co-location of the current Rapid Response team, Enablement service, community services and acute hospital staff, through a phased development, into a single integrated team. This will be managed with overall responsibility for the performance. Care and support will be community based, through a single point of access and integrated assessment.

Local people will receive care and support from a single Integrated service within their own home or in local bases and places to promote socialisation and access to local services. This means that providers from the Council, the acute sector (including mental health and learning disability services) and Community heath be aligned to deliver services in an integrated way. The integrated service will include the voluntary sector and in partnership with providers of residential care (private and voluntary sector).

Individual patients or service users will benefit from having a bespoke, personalised service which is tailored to their needs and remains in place for the required duration. Individuals will have the right, and be supported to have access to a personal budget and be in control of decisions affecting their lives.

The decision to move towards increased integration will provide a transformational approach to local practice and be one of the key critical component parts of changes linked to BCF. Without BCF, it is likely that we would have retained separate provider services with various levels of duplication and a pathway which focussed on the needs of the organisation rather than the patient/ service user.

While planning was taking place for more integration of services to BCF has accelerated thinking and timescales for development

Integrated model v4 11 8 14.docx

b) What difference will this make to patient and service user outcomes?

Patients and service users will have been supported to become more aware of individual responsibility to address potential and anticipated health issues, thereby reducing the need for admission into public sector funded services. The main vehicle to support this programme of cultural and behavioural change will be driven by Public Health. The focus will broaden beyond conditions associated with people over the age of 65 to include other major conditions including obesity and substance misuse including smoking and alcohol, as well as other long term conditions including mental health, autism and learning disability

Far more work will take place in collaboration with local schools so as to prevent addictions beginning during the formative years of our younger population.

The voluntary sector will have established itself as a key partner in progressing this agenda for change. Specifically, there will be greater alignment within and across the voluntary sector and encouragement to maximise the use of resources across the sector - efficiencies achieved through increased integration. This will build on the work that is currently taking place with the voluntary sector and we will seek to achieve a co-production approach to change

In partnership with local media and existing and established communication networks, the general public will have increased awareness of 'what to do' and 'where to go' to gain information, advice and support relating to their own health and well being.

The BCF will be used to transform the health and social care system in Telford and Wrekin, promoting greater independence for patients and service users and improving on current areas of integrated care.

The measures of benefits in terms of health gain and/ or personalisation and independence can be summarised in two categories – non-financial and financial benefits

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contributes to this?

Telford & Wrekin Health & Wellbeing Board has developed a 3 year Health & Wellbeing Strategy to improve the health and wellbeing of our communities and address health inequalities.

The Board recognises that effective commissioning and design of services is central to delivering against priorities and has agreed that the key principles of equity, accessibility, quality, financial sustainability, positive experience, safeguarding, engagement and early intervention & prevention will underpin our approach to improving health and wellbeing.

The Telford & Wrekin Vision for the BCF reflects the views of others expressed during consultations and is:

'To empower people in Telford & Wrekin to take control of their own health; to support them in caring roles, and to keep everyone as healthy and as independent for as long as

possible'.

To achieve this we will work in partnership with our communities to commission and deliver high quality integrated health and care services. In the first year the service model must address the growing demand of an aging population and people living with long term conditions (a summary of needs analysis from the JSNA)

The focus for the BCF is to transform public services for adults needing high levels of health and/or social care support, particularly frail older people at risk of and/or suffering as a result of:

- Falls
- Dementia
- Long term conditions /End of Life
- High risk of admission to hospital or care home
- Discharged from hospital with a need for rehabilitation and/or enablement

The Fund provides an opportunity to do something radically different given 'doing more of the same' is not in line with stakeholder views nor affordable. Our proposals must make better use of combined resources for service users, communities and tax payers.

Local user feedback constantly reinforces messages about the need for:

- better information to enable people to manage their own long term conditions as far as possible
- better support for carers
- services that promote independence.

An audit completed in 2013 which was commissioned as part of our Urgent Care Project Group 'Optimising Capacity on Discharge' highlighted that 15% of those admitted could have been treated in the community if the appropriate provision was in place. It also highlighted that 48% of patients in a hospital non-elective bed could have been supported with 'lower levels' of care in a community setting.

Reducing reliance on use of acute hospital beds, with increased investment in community services, is in line with feedback from our public, service users and clinicians. If the economy can design a service model that both strengthens community capital and delivers public services that are integrated, efficient, and 'skill mixed', it will achieve a more cost effective, sustainable option for delivering care in the future.

The initial approach will focus on the themes outlined below. Both organisations and all providers recognise that greater integration of commissioning, management and administrative support and ‘all age’ service provision is possible in the future, where the economy can demonstrate that this would be in the interests of the population of the economy and both statutory organisations.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

T&W CCG and TWC confirm the shared commitment to establishing the BCF and the two identified themes/ schemes:

- A national agenda which supports increased integration of provider health and social care services
- Shared co-terminous boundaries provides a context which supports increased integration
- A shared appetite by both authorities to achieve local changes in culture, behaviour and practice thereby addressing the limitations of the current configuration of services
- Demographic changes as highlighted in the JSNA and local strategic priorities as identified in the H&WB Strategy
- Cost pressures associated with demographic changes and the continued commitment to achieving sustainable efficiencies across the public sector
- Local reviews of services and the local recognised need to transform services

National reports highlight the need for further integration of care due to clinical benefits, efficiencies or improved outcomes eg:

- The Health and Social Care Act (DH 2012
- Everyone counts: planning for patients (DH 2013/14)
- Transforming Our Health Care System (Kings Fund 2013)
- Integrated care and support: our shared commitment (LGA/ NHS England 2013)
- Integrated Personal Commissioning Prospectus (NHS England, September 2014)

The report 'Integrated Care and Support: Our Shared Commitment' (August 2013) set out their planning 'vision' for how the pooling of funding would ensure a transformation in integrated health and social care and highlights the success of many professionals who have enabled us to cure or manage long term, often fatal conditions. However, the consequence of this success is increased challenges due to people living longer and often requiring 'continuous care and support, and the right systems and resources to enable that) The report also references the consequences of poor systems and care, for example citing Stafford hospital and Winterbourne View.

Therefore, the report argues for 'major change' based on a single premise of 'intergraded care for every person in England'. Overall, this approach achieves two major outcomes: better care for the individual and less pressure on the system.

This approach was endorsed locally. It provides a firm foundation to our proposals as outlined in the submission and will inform the development of a comprehensive Integrated Commissioning Strategy for 2015 – 2020. Overall, the local approach will deliver radical change which ensure services do not begin to decline, costs remain within available resources and vulnerable people are enabled and supported to maintain independence, with greater choice and control for a longer period of time

The 2011 census showed demographic changes, highlighted previously. T&W had a population of 164,400, with a younger age profile than nationally. The population is forecast to increase to 196,300 by 2026 (over 15%). However, it also highlighted that the population is ageing.

Based on this information, in the first instance (2015-16) the BCF will address the needs of local residents aged 65 and over are an increasing proportion with the fastest increase since 2001 in the 85+ age group (27.3%). The 65+ population is expected to increase by 9,200, an increase of 37%. This age group currently represents 14.5% of the total population. By 2026 this will 17.3%.

This rise in the population indicates a significant increase of people who will be frail elderly with complex needs; at risk of falls; have dementia and LTCs. Delivering services within the current configuration is not sustainable to manage the predicted increase in the population and subsequent demand on services. Analysis of the predicted increase of costs due to falls shows a £350,000 increase by 2020 and £935,000 by 2035 unless the model of delivery is changed.

In terms of local strategic direction a cross economy, three year Unscheduled Care Strategy was developed in 2011. One of the key principles was that patient journeys were simpler, shorter, safer and more effective. It was also built on key patient statements:

- Be 'joined up' and responsible for my care
- Help me understand my (urgent care) needs
- Assess and treat me promptly and in the right place
- Admit me to hospital only when necessary
- Try to care for me at home, even when I am ill

More recently, local discussions around 'Future Fit' have endorsed this message. The following key priorities have been identified and will inform the longer term strategic thinking about the BCF:

- Home is normal; matching people's needs with the correct level of care, preferably without changing their care setting
- Empowerment of;
    - Citizens to be co-responsible for managing their lives and social environment, whatever the health status
    - Clinicians working as member of fully staffed, innovative and energised teams in environment where they are valued and supported in a system that prioritises relationships, trust, co-responsibility and continuous learning.
    - Communities to influence the wider determinants of health at a local level
- Sustainability; prevention and wellbeing agenda success or failure over the next 20 years will determine will be the primary determinant of the 'disease burden'
    - Financial sustainability; financial austerity is one of the key drivers for radical change and is identified clearly as part of the 'case for change' in this programme.
    - Workforce sustainability;
        - consolidate some services
        - Utilise the available workforce

        - Prototype and implement rotating(and split) posts through different care settings
        - Improve recruitment and retention through more effective succession planning
        - Gain academic status
    - Sustainability of services; New models of care, workforce and commissioning must reflect whole patient journeys.

As part of local strategic direction, five Urgent Care High Level Projects were identified and overseen by Chief Officers of the CCG, Councils, acute and community providers Group. The projects were identified as essential in helping the local health and social care economy to better manage urgent care and improve performance: The Problem identified within the Project Charter for the groups were that the network of bed capacity, resources, care pathways, teams and skills is not optimised and/or we are unsure of the required demand. Locally, there is an economy level over-reliance on bed based services.

The Optimising Capacity to Support Discharge Project Group (Project Group) carried out some analysis of the 'Current State' (bed capacity and usage and community resources). The audit of 299 patients carried out for the Project Group during August 2013. It highlighted:

- 70% of these patients were over 70 years of age.
- 88% had significant risk factors, the most prevalent being co-occurring conditions and poor mobility.
- 16% of patients were non-qualified on admission (could be in a lower level of care ie not admitted)
- 77% of the reasons for non-qualified days (could have been discharged into lower levels of care such as residential care or home) were recorded in the audit as being within the control of SaTH.

The audit showed the high level of need of older people. It also indicated the opportunity to use lower levels of care in the community to manage those needs rather than acute beds.

The Project Group also reviewed national guidance before developing an Integrated Community Team model. This included the current Reablement Team, Home from Hospital Team, SATH resources and existing SCT teams within one integrated team. This became the basis of the Frail and Complex development and later to development of the Integrated model of the BCF (included within section 2)

The development of the integrated approach to care was determined prior to the BCF development and fundamental part of local commissioning plans from August 2013.

Limitations of the current configuration of services have been identified. It has been shown to be fragmented and not sufficiently co-ordinated. Unnecessary admissions and delays in discharge are evident. A review of the Frailty team pilot in June 2013 highlighted:

- Lack of knowledge by GPs and ambulance services of available community provisions and their responsiveness leading to unnecessary admissions and

delayed discharges.

- Lack of standardised referral and assessment processes across all providers
- Duplication of work, in particular, assessments with information remaining unshared and frustration for family carers
- Lack of timely response to facilitate early supported discharge and the delays leading to increased likelihood of dependency on public sector interventions
- Lack of capacity compounded by not making the best use of resources within and across providers
- Risk averse behaviour by staff regarding discharge leading to longer periods of time in acute services
- Inconsistent integration of health and social care
- Lack of clear roles and responsibilities for discharge planning

Service Mapping of current capacity identified inconsistency in working hours of different teams and therefore wide variation in service availability and access.

In line with the local case for change, the economy will continue to introduce change across other areas of the social and health care to address other pressing local needs. During 2015-16 the Programme Management Board will establish a process which supports learning from the work undertaken in relation to the BCF (2015-16) to inform and improve further innovation and development.

Specifically, during 2014-15 the local economy have developed robust plans, building on the submitted Implementation Plan, to support establishment of a fully integrated team co-located with clear systems and processes in place to address wider issues of shared health and social care.

While the BCF target metric relates to all admissions, there is an additional local metric focusing on 65+ years and above. This recognises the need to have a specific focus on this population:

A&E Attendances for T&W have increased by 3.9% for Quarter 1 2014/15;

	13/14	14/15	**Variance**	**% Inc/Dec**
Aged 0 - 16	2862	2919	57	1.99
Aged 17 - 64	6423	6818	395	6.15
Aged 65-74	803	855	52	6.48
Aged 75-84	680	667	-13	-1.91
Aged 85 and over	435	383	-52	-11.95
total	**11203**	**11642**	**439**	**3.92%**
Aged 16-59	6125	6509	384	6.27%

Emergency Admissions figures for T&WCCG show a rise of 3.72% (145) for Quarter 1 2014/15. The largest increase of 12.28% in the 65-74 year olds.

0-16yrs -7.80% (-63)
17-29yrs +3.02% (12)
30-64yrs + 10.11% (131)
65-74yrs +12.28% (64)

75yrs and over +0.11% (1)
Total +3.72% (145)

Specifically, during 2015- 16, this also will address the widening of the target population of the BCF in line with JSNA and local intelligence and data. This will include a wider group of people under the age of 65, substance misuse leading to longer term conditions associated with drugs, alcohol and smoking. This will be supported by moving to a single, multi-disciplinary access and assessment function ensuring vulnerable adults of all ages receive appropriate information, advice and guidance and assessments by appropriately trained professionals within appropriate response times.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

An Implementation for BCF has been in place since March 2014. Progress on Implementation Plan is included in Related Documents. Actions have been taken across all work-streams. Following a review of progress against actions the Programme Management Board has agreed to focus on key areas:

- Development of a single Single Point of Access
- Implement a single assessment and care plan process
- Implement each phase of the Integrated model
- Implement single record across health and social care
- Develop the voluntary sector

Each area will have key product outcomes and timescales and will be reviewed within the monthly Programme Management Board and work-stream meetings. These areas now have an identified Council Senior Officer lead or CCG Executive Lead to sponsor identified Project Leads. The BCF Lead retains oversight of the Programme as a whole.

The two Themes which are, in effect, the two BCF Schemes set out in Annex 1. Each Theme will have a separate work-stream and will be set out within revised Terms of Reference for the BCF:

- Building Community Capacity
- Developing the Integrated Community Enablement Service

Key actions and milestones for Building Community Capacity (Scheme 1) are set out below:

<u>October – December 2014</u>

- Profiling of the voluntary sector – range of interventions, capacity, strengths, areas for development as a sector.

<u>January – March 2015</u>

- Agree metrics, measures and data capture methodology for Theme

<u>April – June 2015</u>

- Implementation of Grants allocation to voluntary sector for CCG funded services
- Council funding of voluntary sector services

<u>July – September 2015</u>

- Develop joint process of Council and CCG to develop the commissioning of

the voluntary sector to support transformation
- Increase in Befriending schemes and volunteering evident
- Council development of community networks with the inclusion of the voluntary sector
- Development of advice and guidance and self help information

October 2015- March 2016

- Develop pooled budget for the voluntary sector
- Development of community based self- help groups

Key milestones for developing the Integrated Community Enablement Service as an alternative to hospital admission (Scheme 2) are summarised below:

October – December 2014

- Evaluation of the Accelerated Pilot
- Phase 2 implementation of the Integrated Community Enablement Service
- Development of the single assessment and care planning
- Move to single base for the Integrated Community Enablement Service
- Review of action plan to reduce care home admissions

January – March 2015

- Development of the model for community-based rehabilitation
- Development of a single Single Point of Access to services
- Development of Virtual ward model for most high risk patients
- Alignment of voluntary sector services to support the Integrated Community Enablement Service.
- Agreement of the s75 for 2015/16

April – June 2015

- Phase 3 implementation of the Integrated Community Enablement Service
- Implementation of community based rehabilitation provision – preparation for closure of acute rehabilitation unit
- Review impact on target population and revise based on local evidence
- Further development of 7 day working

July – September 2015

- Phase 4 implementation of the Integrated Community Enablement Service – integration of community rehabilitation
- Identification of additional innovations to reduce admissions
- Implement single record across health and social care
-

October 2015- March 2016

- Planning for further development of 7 day working
- Formal review of BCF performance – against metrics, local data and

evidence

Interdependencies
There are a number of interdependencies that need to be considered in developing and implemented BCF:

Other admission avoidance initiatives
A specific admission avoidance scheme is taking place currently. The 'Perfect Fortnight', placing a GP and nurse at the Front of ED seems to have reduced admissions.

As part of the Integrated model improved ambulatory care processes are essential to avoid admissions or ensure patients have a short a stay as possible.

Stakeholders can identify evidence of best practice of admission avoidance initiatives for proposed implementation.

Team Around the GP Practice
The Team Around the GP Practice connects Themes I and 2 and is also a major transformational programme within the economy. Team Around the Practice will develop a model to support primary care in reducing urgent and planned care admissions; case management of patients who are at high risk of admission or high users of NHS and / or social care services; further develop effective management of long term conditions where primary, community and/or social care interventions are needed

Mental health modernisation
Modernisation of mental health services took place in 2011- enhancing community services and development of a new, modern mental health in-patient facility, the Redwoods Centre. Reviews of the impact of modernisation have indicated improvements in community services. However, to ensure efficiencies are maintained, further reviews are taking place including the need for a nurse –led unit; cost effectiveness of RAID; use of PICU beds; alignment of mental health staff with other services including the Integrated Community Enablement Service.

Future Fit
This Shropshire-wide engagement process ffocusing particularly on the reconfiguration of local hospital services for the next 5 years. Potential benefits include:

- Better clinical outcomes through bringing specialists together, treating a higher volume of cases routinely
- Reduced morbidity and mortality through ensuring a greater degree of consultant-delivered clinical decision-making
- A pattern of services that by better meeting population needs, by delivering quality comparable with the best anywhere
- Better adjacencies between services through redesign and bringing them together
- Improved environments for care
- A better match between need and levels of care through a systematic shift towards greater care in the community and in the home

- A reduced dependence on hospitals
- A more coordinated and integrated pattern of care, across the NHS and across other sectors such as social care and the voluntary sector

Recruitment

The Shropshire economy has historically had difficulties in recruiting. Currently there is a national shortage of Geriatricians, at a time when community services have identified a specific need. Options for medical staff within the Integrated Community Enablement Service are being considered.

Resilience and Surge planning

Funding from resilience planning will support development of BCF initiatives during the winter.

b) Please articulate the overarching governance arrangements for integrated care locally

A Programme Management Board for the BCF is in place. This includes all provider organisations, representation from the voluntary and independent sector, cabinet member, Healthwatch and user representation. Terms of Reference have been agreed and include work-streams, key product outcomes and membership from organisations. Weekly meetings commenced in early March 2014. Since June the formal arrangement has been a monthly Programme Management Board and 2-weekly work-stream meetings.

Dedicated staffing has been in place since March to ensure robust Programme Management occurs, thereby supporting the two organisations in developing a firm foundation to the BCF. The Programme Management Board is chaired by co-chaired by the Executive Lead for Commissioning in the CCG and Assistant Director for Commissioning form the Council.

Identified work-streams for Service Redesign, Performance, Finance and Modelling and Communication and Engagement also meet on a 2-weekly basis and report to the Programme Management Board. Actions from the BCF Implementation Plan aligned to work-streams are progressed, reviewed and reported to the Programme Management Board

The Programme Management Board reports to the HWB Board through the Strategic Commissioning Group, which comprises officer representation from the Clinical Commissioning Group, Telford & Wrekin Council and NHS England. The group meets on a bi-monthly basis to ensure that our commissioning process delivers the Health and Wellbeing priorities whilst ensuring an integrated approach between local Health, Social Care and health related commissioners.

The Strategic Commissioning Group also aims to use the JSNA to inform commissioning intentions, ensure a strategic approach to commissioning to understand the relationship between need, demand and outcomes for service users and agree the scope of collaborative commissioning projects (prioritised by the Health and Wellbeing Board) which includes the implementation of the Better Care Fund.

The Strategic Commissioning Group reports directly to the HWB Board and receives

performance updates from each of the Commissioning and Transformation Partnerships (CATPs) for each 2-monthly meeting. There are four CATPs who are responsible for delivering against the Health and Wellbeing priorities and accountable to the Health and Wellbeing Board – the Chair of each CATP also sits on the Strategic Commissioning Group. One of the CATPs is the Better Care Fund Programme Board who provides a regular update to the Strategic Commissioning Group which in turn is reported to the Health and Wellbeing Board to whom it is accountable.

The HWB Board will confirm the outcomes of revising local priorities for 2014-19. The development of BCF will reflect and align to these priorities, introducing further innovation and collaboration to all sectors of the economy.

The CCG is accountable to NHS England for performance, and the Council to the local population through elected members and the Cabinet. The BCF will report formally into the Planning Performance and Quality Committee (sub-group of the CCG Governance Board) to ensure clear monitoring from the CCG perspective. Plans for BCF and Future Fit have been and will continue to be scrutinised by the Councils Joint scrutiny Committee. The cabinet member for Social Care also receives a monthly briefing regarding progress against plans.

BCF Governance structure 12.3.14.ppt

c) Please provide details of the management and oversight of the delivery of the Better Care Fund plan, including management of any remedial actions should plans go off track

A Programme Management Board for the BCF is in place. This includes all provider organisations, representation from the voluntary and independent sector and regular meetings are in place as set out in section 4b above.

As well as the Programme Management Board and formal reporting through to the HWB Board, there is a Strategic meeting of Council and CCG senior managers with BCF leads and the HWB Officer. This meeting reviews actions and progress and acts as a troubleshooting process to ensure progress in on track; identify actions if they are not.

Following a review of BCF progress within the Programme Management Board a number of further changes have been made:

- The CCG Chief Officer and Council Director will maintain oversight of the direction/ performance through regular one-to-one meetings with senior officers / Executives representing respective organisations
- Key priority BCF actions have CCG Executive or Council senior officer sponsors. They, alongside the Programme lead for each action will be held to account for actions, timescales and progress.
- The implementation Plan will be revised to include more detailed actions and milestones

ToR for programme managment board wit

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Building Community Capacity in Telford and Wrekin
2	Enhanced community services for Telford and Wrekin as an alternative to hospital provision

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise ?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Failure to 'win hearts and minds' will result in failure by patients to engage with care provided under the BCF programme. Some of those that BCF is targeted towards may not fully appreciate the intentions of BCF. Further, failure to implement the BCF will challenge the CCG's ability to address the common messages of consultative exercises.	Possible 3	Major 5	High 15	Patient and public engagement in the BFC programme. Meaningful communication and engagement, including the use of social media, to inform the Strategic Clinical Review and BCF. Establish community networks within the Telford 'Extended Family' and self-help groups for people with Long Term Conditions. Reduce negative impacts of care on people by meetings needs in and appropriate manner in the right environment and thereby improve the 'stories' that people tell afterwards. Use existing forums, patient representative groups, support groups to actively engage with user groups. Develop

				communication and engagement with other groups which can support the BCF, for example, Local Parish Councils, the Carers Partnership Board.
Failure to reduce reliance on acute care, in particular non-elective admissions and A&E attendances, may mean that all or part of the £3 million funding required for investment in sustainable community services may not be released. Also failure to reduce A&E attendances will exacerbate the risk of the 4 hour waiting target being missed. Failure to sufficiently incentivise SaTH to participate in transformation will exacerbate this risk. Further, failure to change the culture of risk aversion within both clinical and patient populations may lead to a failure to reduce admissions.	Possible 3	Major 5	High 15	Clear communication of expectation of the changes will commence within SaTH to enable the release of money as required to support BCF. Financial cash flow spreadsheet negotiated and agreed by Directors of Finance within CCG, SaTH and the council for the release and transfer of cash on a planned, monthly basis. Development and in year activity of the BCF Programme Board. Further innovations as part of the action plan within year to further reduce admissions and LoS. Negotiate income retention based on a new model for staff outreaching into new integrated community services. Citing of the community integrated team on the PRH site.
Ineffective change management may mean that existing team may continue to work in familiar patterns within their own organisations. Cultural change will not be achieved and patients will not receive joined up,	Possible 3	Major 5	High 15	Skills audit of SaTH, SCHT, Council (Enablement) and Voluntary sector. Re-deployment of SaTH and SCHT staff into the virtual team as part of integrated model.

personalised care closer to home. This risk may be exacerbated by 'change fatigue'. There may be insufficient staffing capacity and/or capability within the community trust, the council and the voluntary sector to absorb increased demand as new pathway 'beds in'. This risk will, in part, be mitigated by the gain to Social Care of at least £490K to support implementation of Care Act, thereby reducing dependency on residential care and reducing unit costs.				Some redeployment of staff from SaTH to the Community Trust to TAP. Recruitment of additional staff. Ensure a full mapping exercise of current support available in the community by voluntary sector organisations – decreasing risk of repeating service provision. Further innovations to promote new ways of evidence-based interventions. Use of CHC stranded funds to support acute care issues. Agreement to be reached and included in section 75 agreement.
Lack of representation by SaTH on the Programme Management Board or work-stream meetings may lead to failure to achieve BCF service and financial objectives through engagement or service re-design.	Very likely 5	Major 5	Very high 25	Continued formal communication with SaTH regarding lack of communication, which has resulted in recent engagement in two services re-design meetings.
Failure by the council to effectively plan for use of transformation monies, including failure to reduce permanent admissions to residential care, may mean inhibit the development of admission avoidance interventions within the community.	Possible 3	Major 5	High 15	Continued active involvement by the council in the BCF programme.

Failure by partner organisations, including the voluntary sector, to embrace cultural change and work in a truly integrated way will challenge the quality and timeliness of services. This will lead to failure to develop and implement fully integrated care pathways that empower patients and address the needs of the local demographic.	Possible 3	Major 5	High 15	Joint working within the Programme Management Group to inform change in partner organisations. Act upon the findings of the 'Optimising Capacity on Discharge' audit. Implement 'Single Referral Point' and single triage and assessment. C&EWS to promote the benefit of engagement with BCF with named groups with the aim of promoting cultural change, including the CVS.
Insufficient capacity within the local community, principally the voluntary sector, to support self-help/ self-care may mean that self-care will not form an effective element of service redesign to provide care closer to home, self-help intervention, community support and move activity from specialist to prevention and self-help. (Current providers include: Red Cross, Age UK and Council for Voluntary Services (CVS), Senior Citizens Forum and T&W Council)	Possible 3	Major 5	High 15	Invest resources to provide support to the voluntary sector to develop the leadership, capacity and skills to fulfil their role in the delivery of the BCF. Explore opportunities to support the voluntary sector to bid for external funding grants to support the delivery of leadership, capacity and skills training. Initiate a mapping exercise of all voluntary sector organisations working within T&W, defining areas of interest (this will go beyond the current themes but support future expansion and development of BCF, post 2015. Establish voluntary sector links to 'Teams Around Practices' and all other appropriate work streams.

				Provide open dialogue and full engagement of the voluntary sector including communication between chief Officers group (COG) attendees. Implement communication and engagement strategy as identified within the Implementation plan.
Failure by all organisations to work cohesively may lead to failure to reduce delayed transfers of care; leading to cost pressures.	Possible 3	Major 5	High 15	Activity monitoring. Ensure fair representation for all participating organisations on the HWWB.
Under spending in the BCF pooled budget or ineffective use of resources may lead to: - increased demand for community services, resulting in higher waiting times for community care assessment - shifting of staff to community services, resulting in deteriorating performance against the 18-week referral-to-treatment target - increased demand for residential and domiciliary care - negative impacts on patient experience.	Possible 3	Major 5	High 15	Programme management.
Overspending or failure to secure recurrent funding or achieve QIPP savings year on year will weaken the potential for the programme to deliver significant improvements in patient experience within the planned timescale.	Possible 3	Major 5	High 15	Phased roll out. Effective financial, quality, risk and performance monitoring and action planning including: robust monthly Strategic Commissioning Group meetings with written reports that allow full and proper scrutiny of

Failure to deliver safe, high quality services, which meet programme objectives, within the financial envelope may lead to poor patient safety and exacerbation of the local health economy financial deficit.				£ and KPIs. Maintain the CCG contribution within the limited indicated in the guidance.
Lack of clearly defined project 'products' and insufficient programme management capacity or structure will exacerbate the likelihood of the risks outlined about coming to fruition. This risk is exacerbated by the lack of national evidence to inform sophisticated modelling for activity and resources.	Possible 3	Major 5	High 15	Employment of additional finance and project management support. Development of a PMO approach. Work up a detailed service specification for the new integrated service including activity levels, targets and KPIs and refinement of activity and resource modelling. Understanding of the available data and an evidence base of activity will develop over time. Therefore close data monitoring must be maintained. Consider the use of data intelligence-current outcomes measured and reported on by voluntary sector organisations. Collective ownership of the challenges by key named officers in each organisation and formulation of jointly agreed strategies to achieve desired outcomes.
Failure to ensure easy access to services, especially people with an increased risk of	Possible 3	Major 5	High 15	See risks 1-10 above.

hospitalisation, e.g. the frail and elderly, will make delivery of safe and effective care and a good patient experience difficult to deliver with BCF programmes.				
There will be inconsistency of interpretation between the Council and CCG relating to the levels of CHC funding. This may lead to failure to fund care equitably and unresolved financial pressures.	Possible 3	Moderate 3	Moderate 9	Continued negotiations related to the level of the BCF pooled budget with Council MD and CCG CEO.
Initial BCF financial modelling utilised £2,500 per admission avoided. 1260 admissions created value of pooled budget from reduced admissions. This submission uses £1,490 per admission avoided. This gives a potential gap of £1.2m in pooled fund.	Possible 3	Major 5	High 15	CCG to review level of funding at full cost and marginal cost from year end data to re-model likely value. Recognise that early evidence in the Pilot that patients are not needing the levels of contact and care modelled as is therefore potentially less expensive to reduce admissions.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The key principles of the BCF programme are the transformation of self-help/ self-care and transformation of integrated health and social care services. Reduction in admissions and other key performance areas

There are a number of risks in the development of the BCF in relation to key stakeholders - T&WCCG, TWC) and providers particularly the acute hospital. These are:

There are a number of specific financial risks associated with the BCF. These are:

Risk	Who does it impact?	Potential value of Risk	Probability of Risk	Risk Management actions

The schemes do not succeed reduce non-elective admissions	CCG Council and Providers	£1-3m	50%	Accelerated Pilot, as part of Scheme 2 is already implemented seeking to reduce admissions. This plan is to make savings to create the pool and resources to develop community services. Phase 2 of developing the Integrated model (integration of rapid Response and Council into a single base and team being developed- timescale Scheme is regularly monitored to ensure it performing appropriately. Further schemes are identified in strategies for rolling implementation to support the existing approach to reducing admissions eg Team Around the Practice, ED Front Door Schemes Acute provider engagement with development of the schemes to reduce admission eg phased development of the Integrated model Scheme is regularly monitored to ensure it performing appropriately Schemes maintain reduced admissions. Acute provider supported in planning in line with reduced admission to reduce fixed costs.
The schemes do not succeed in reduce admissions to residential care	Council	£2m-£3m	50%	Accelerated Pilot, as part of Scheme 2 is already implemented seeking to reduce admissions. This plan is to make savings to create the pool and resources to develop community services. Phase 2 of developing the Integrated model (integration of rapid Response and Council into a single base and team being developed- timescale Scheme is regularly monitored

				to ensure it performing appropriately. Further schemes are identified in strategies for rolling implementation to support the existing approach to reducing admissions eg Team Around the Practice, ED Front Door Schemes Further innovations are identified in strategies for rolling implementation to support the existing schemes.
That the schemes do not reduce delayed transfers of care	CCG Council and Providers	C£1m	75%	Specific plan developed to reduce current increase in DTOCs Scheme is regularly monitored to ensure it performing appropriately and action plan reviewed Additional innovations and interventions are developed to reduce DToCs but engagement with providers and reviewing existing systems and processes.
The schemes reduce admissions but do not enable the acute hospital to reduce fixed costs	Acute provider	£1.5m	50%	Accelerated Pilot, as part of Scheme 2 is already implemented seeking to reduce admissions. This plan is to make savings to create the pool and resources to develop community services. Phase 2 of developing the Integrated model (integration of rapid Response and Council into a single base and team being developed- timescale Acute provider engagement with development of the schemes to reduce admission. Scheme is regularly monitored to ensure it performing appropriately and schemes maintain reduced admissions. Payment for Performance is set

				aside to offset against admissions not being reduced
That schemes are successful and the contingency Transformation Fund is not required and remains unspent at the year end	CCG	£1m	10%	Rolling programme of scheme development and implementation will provide for any available contingency.
There is slippage in implementation of schemes leading to unspent budget at the year end.	CCG and LA	£1m	10%	Accelerated Pilot, as part of Scheme 2 is already implemented seeking to reduce admissions. This plan is to make savings to create the pool and resources to develop community services. Phase 2 of developing the Integrated model (integration of rapid Response and Council into a single base and team being developed- timescale Scheme is regularly monitored to ensure it performing appropriately. Review of the structure of Implementation Plan with Executive sponsor to ensure plans are maintained on track. Slippage on new schemes likely to be held back only as a contingency against potential cost pressures. Once cost pressures are managed the rolling programme and / or cost benefits clarified of scheme development they will be implemented.
That there are cost pressures or overspends on individual schemes within the pool not accounted for at budget setting	CCG and LA	£0.5m	10%	On-going review of schemes to ensure they are progressing and identify opportunities for efficiencies to offset against cost pressures. Payment for Performance money is set aside to offset against admissions not being reduced

				Financial agreement will include risk share for overspends/ over performances not managed within the fund.

The financial agreement will be developed to include risk share for overspends/ over performances not managed within the fund is based on a number of principles:

- Sharing risk is based on both risk sharing and gain sharing, wherever possible, to support the more effective use of monies to deliver to BCF aims and objectives

- All parties support the best use of resources to deliver the overall aims and objectives of the BCF

- It is important that mitigation and contingency are addressed where the risk was incurred. This enables the risk to be effectively managed, ensures that the most appropriate mitigation is implemented, and embeds accountability at the relevant point within the health and social care system. This supports the shared commitment for the development of the overall programme.

- The statutory responsibilities for each organisation need to be delivered. The CCG has a responsibility for funded NHS treatments; the Council statutory responsibility is the assessment of patients and providing eligible care. Decisions related to use monies within the pool to fund any over-performances will be based on ensuring those statutory responsibilities, level of risk to each organisation and the levels of contributions made to the pool.

- All stakeholders carry a level of financial risk within their respective organisations.

Relevant principles of the risk sharing agreement will also be set out within the Section 75 agreement between T&W CCG and TWC.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Like many Councils, the local Adult Social Services is facing significant financial challenges, with increasing demand and reducing resource. For local health and social care services to be sustainable there is a need for a program of accelerated change. Locally, there is a history of partnership and integration which provides sound foundations for taking forward BCF. All partners, both commissioners and providers are committed to providing care closer home improving both improved clinical outcomes and the patients experience. The Adult Social Services transformation agenda supports and compliments BCF in the following ways:

- By improving and enhancing the Information and Advice Service across both health and social care will enable vulnerable people to access low level preventative services to reduce the demand for more expensive and traditional services. As part of our preparation for the Care Act Adult Social Care will be undertaking a fundamental review the My –Life portal and locally produced fact sheets.

- A multi-disciplinary, centralised Access and Assessment Hub will provide a much more effective management of demand creating savings through self-service, one single entry point to services and speedier and more appropriate referral to other services, in particular Reablement. This will be achieved by a joint review of the current Enablement teams; building upon the Accelerated Pilot and the co-location of the current Enablement, Rapid Response and Rehabilitation into a single point of access for care services. This will be supported by a newly systems to provide robust and accurate management data.

- Managing Safeguarding Alerts and Referrals more effectively, through the Access and Assessment Hub will save a full time post and improve performance across the service by reducing inappropriate and unnecessary referrals into the wider system.

- Assessment and Case Management teams are being transformed and re-focused with an emphasis on the principle of assets based social work; teams been integrated into local communities working alongside and developing community resources and resilience. This will be underpinned by an early intervention and prevention strategy.

- The Resource Allocation System (RAS), personal budgets and personal health budgets were introduced in January 2014. While providing an equitable and transparent process for allocating resources, locally this has not lead to greater choice, control or efficiencies . Working with commissioners there will be a separation of the assessment, case management function from support planning. Support planning will be implemented by a voluntary organisation, maximising the use of community resources reducing the need for more traditional services

- With the more effective targeting of Telecare and Assistive Technology across the economy there is an aspiration for creating a community service which provides a

single point of access for Assistive Technology, Equipment, advocacy, support planning and Brokerage. This will bring together local low level preventative services into a single hub reducing demand on the health and social care economy

- The Council must also work on its Early Help/Preventative offer in a similar way. The Council wants to further develop its early help offer by working with local providers, the voluntary sector and by refocusing some of local services through the BCF with a view to improving how it manages demand for high cost social care and health interventions.

- There is a focus on greater integration or process and structure and by doing this through the BCF there is a consensus of improved outcomes and the patient experience at a lower cost.

- The Council will also separate assessment from support planning. It is currently investigating a different approach to support planning by introducing a support broker model whereby a highly skilled independent broker with knowledge and expertise works with the service user to develop a Care and Support Plans tailored to meet their needs. The broker will be working with the service user to identify creative lower cost solutions to meet needs from within their personal budgets.

- The support broker model will be supported by an evolving strong micro market of voluntary sector providers working alongside existing providers. The Council is also working with the CCG to review existing contracts/grants with the voluntary sector providers to ensure that they deliver outcomes in line with aim and priorities set out in the local BCF submission.

Resilience Plans

This is a whole system plan to ascertain the wider Shropshire community's current position, the continuing risks and how the CCGs will work in partnership with wider system partners to plan for known variations in demand in Q3 and Q4. It also addresses how the economy, as a system respond to changes in capacity through surge planning. A key focus is to ensure the whole system will work collectively to deliver against the constitutional targets of 18 weeks and 95%.

SMART plan

A SMART Plan has been developed to rapidly deliver sustainable system, process and capacity improvements by the end of September. The aim is to deliver 74 less Emergency Department breaches per week which it is calculated will enable achievement of the 95% target through a number of schemes contributing to the overall aim. Each scheme within the plan has an identified lead and defined metrics.

Single Referral and Trusted Assessor initiative

This initiative aims to improve the identification of patients who could be discharges and ensures this is expedited without delay. It includes developing a single referral document, replacing the existing notification system to the Council, in order to improve the quality of referral information, reduce confusion and inappropriate referral and avoid duplication.

This development will support the progress to a 'Trusted Assessor' status for the acute

hospital staff, whose assessments are accepted and responded to in order to facilitate discharge or transfer of care to Enablement beds or community services .

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

The 2 year plan identifies that: The BCF plan was signed off by the Health & Well Being Board on 12/02/2014. There is strong engagement with T&W Local Authority and a number of formal mechanisms, including the H&WBB and BCF governance structures, allows consideration of recommendations to amend objectives and programme management arrangements.

An enhanced Enablement Team will be providing integrated health and social care to provide alternatives to admission and community based rehabilitation, enablement and end of life care (Theme two of our BCF plan).

In five years' time, the BCF is intended to deliver:

- Enhanced community services for Telford and Wrekin as an alternative to hospital provision
- Fewer hospital wards for non-elective care as we transfer capacity and activity into the community service.
- This will strengthen the ability of hospitals to focus on patients that need hyper-acute care, for example strokes and heart attacks, and to focus increasingly on planned operations.
- An Integrated Enablement/Rehabilitation Service that has a full complement of clinicians and skills, including acute Doctors, Nurses and Therapists, in addition to existing Social Care and Community health professionals able to in-reach into existing residential and social care settings.
- Access to care to support people in the community
- This service will operate 7 days a week.
- A 'Single Referral Point' for Integrated 'Step up/Step down' with patients identified by the NHS number to facilitate better information/data sharing.
- Single triage and assessment processes will be well established.
- Initial activity assumptions for the reductions in acute admissions and reductions in length of stay are below. These assumptions are based on an external organisations audit of patients with SaTH (Oak Group utilising MCAP tool) in 2013.

The CCG and Council, working with partners, will expand integrated community services, by diverting capacity from the acute sector and more traditional expensive models of care into local community care services. Recent years have seen a significant growth in reported emergency admissions, largely zero LoS admissions. The current, projections of the level of activity is unsustainable from a financial point of view and in addition the Trust has not been able to achieve Emergency Department performance on a sustained basis. BCF supports the 'integrated care model' and 'Urgent and Emergency Care' plans to avert unnecessary Emergency Department attendances and acute hospital admissions. In doing so, it improves quality of life for people with long term conditions.

An intention to develop the patient engagement strategy further with patients at the helm of this process as the economy move towards transfer of services via the BCF.

The 5 year Strategic Plan is made up of key component parts: Future Fit, Better Care Fund, Mental Health Modernisation and Adult social Care Transformation. These priorities build on the local intelligence contained with the JSNAs. Strategic thinking in relation to health and wellbeing incorporates the Health and Wellbeing priorities, as part of the work on the BCF.

For those improvement interventions that require investment in integrated health and social care services, Health and Wellbeing Boards will take lead responsibility for commissioning service transformation through the BCF.

CCG objectives align with the core service models being developed as part of our Future Fit programme: "Acute and episodic care" aligns with BCF element 3.

BCF is part of whole system synergies in the development of an Integrated Single Point of Access and access to integrated multi-disciplinary teams for community services.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Following consultation with its member practices, Telford and Wrekin CCG has been accepted to co-commission primary care at level B. This gives the CCG the role of working with member practices on their development and performance, but stops short of the contract management of individual practices.

Currently the CCG is awaiting clarification about the process for developing co-commissioning, including transfer of resources from NHS England to undertake this function.

Practices have debated and approved the CCG plan for whole system transformation, including the Team Around the Practice. In evidence of this, practices have supported the Accelerated Pilot for admission avoidance using a community response. To date, we have demonstrated average savings of admissions of about 2.5 admissions a day.

There has been some movement to cluster small practices locally and this is an ongoing discussion between the CCG and practices, which would support the delivery of the better care fund plans locally.

The CCG has consulted on the Council "Shaping Places" development plan, recognising the expansion of health and social care provision that will be necessary to support the development of Telford and Wrekin. Practices have indicated their wish to expand to support the developing town. This, again, is in keeping with the Team Around the Practice model.

It is recognised that Telford and Wrekin is substantially under-resourced in terms of General Practice. The Co-commissioning plans of the CCG set this as the number one priority for the immediate future. This is the most important intervention that would ensure success of the BCF plans locally. It also presents a risk, since recruitment to general practice is challenged nationally. Mitigation of this risk lies in the team and skill-

mix opportunities of the team around the practice.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

The BCF and Integrated Strategy 2015 – 2020 will work towards achieving a reduction in the demand for avoidable unplanned acute services admissions. This will be achieved by the integration of local health and social care providers (Council, community services and acute hospital) working closely with the voluntary and private sectors. Overall, an integrated approach will deliver increased service provision within the community.

It is anticipated that the increase in demand for community services may require additional support from social care or social care services. To offset any cost of increased assessment and early interventions from social care and additional financial costs incurred, there will be an appropriate level of investment from acute to social care to align the increased activity. This will ensure that social care services are not unduly compromised to deliver the agreed assessments and early interventions within the agreed BCF programme.

The Council will also seek to strengthen arrangements for managing its front door to services. This together with our approach to our approach to promoting wellbeing (using a 'Five Ways to Wellbeing' approach through our Living Well Initiative) will offset some of the impact of identified above.

The Council in partnership with commissioners and health providers will reduce the number of single points of access across the economy Telford & Wrekin and divert resources into the access point/s. This will enable us to manage the demand for services by offering enhances information and advice, seamless and rapid assessment for appropriate enablement services,

Social Care have statutory duties including carrying out statutory assessments and meeting eligible needs in a person centred way. These duties are enhanced and increased in the Care Act 2014.

From carrying out the statutory assessment of need, a range of options will be utilised including seeking to maintain care close to home; reduction in unnecessary admissions into residential care; increased use of personal budgets; increased support to carers thereby enabling them to support the cared for to remain living at home longer. The recent decision to fully endorse and progress integration will support the intention to avoid risk to social care overall.

Through the use of personal budgets and the introduction of the support broker model, it is expected that there will be increased involvement of other key partners from the voluntary, private and community resources as well as access to information, advice and support. There is an expectation that individuals will be signposted to partner agencies including Council services, housing and by providing a range of interventions to meet

assessed eligible need.

During 2015/6 – 2018/19 there is expected be an increase the level of self-help and low level prevention to support the whole population, including those under the age of 65. This includes prevention programmes, Re-ablement and assistive technologies, practical support in the home, equipment and adaptations, carer services and support where necessary to access residential and nursing home provision.

Without this approach the need for primary and secondary care need will increase. Therefore, front-line support must be adequately resourced within a climate of reduced resources. There is a shared risk agreement in place which reflects the overall financial constraints applying to the Council and other partners including the CCG, acute and community services. There is an understanding that the risk strategy must provide a safety net for social care as well as mitigating risk for all providers as a collective whole. In other words, integration is dependent on partnership working and trust. All partners require the same level of 'protection' to support progress.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

The BCF will be used to support adult social care services locally by helping the Council to protect adult social services and make a "positive difference to social care services and outcomes for service users" linked to a "health benefit" including the avoidance of admissions to NHS services, which otherwise would not be possible "in the absence of the funding transfer" and reduced admission to residential care.

The BCF is to redistribute resources to reduce the over reliance on acute services and place more emphasis on earlier help and prevention services. This will maximise the use and impact of resources to reduce costly services.

The BCF plan builds on the existing integrated working of the Enablement team who will find care solutions that meet identified needs in the cost effective way, where resources are directed to maximum benefit and impact at lowest cost.

The Council will also be able to utilise innovations from their Transformation agenda including increased use of Personal Budgets, Personal Assistants, tele-health and tele-care and Brokerage.

Social care services will be protected by understanding their statutory duties; the development of integrated models of care which will reduce duplication, streamline assessment and maximise independence and more joint commissioning focusing on outcomes; pooled resources and a reduction in the duplication of effort. Individuals will be healthier for longer before they need more extensive care packages.

It is already a requirement that the current Enablement provision maximises interventions to reduce likelihood of on-going care. Current expenditure on re-enablement and prevention through the s256 agreement provides resources for

- Community Equipment and adaptations
- Telecare
- Integrated Crisis and rapid response services

- Maintaining eligibility criteria
- Enablement services
- Bed-based Intermediate Care services
- Early Supported Discharge schemes
- Other preventative services

The wider integrated team will be more robust in maximising the use of resources. In addition, developing community capacity as set out above will delay the demand for and reduce the level of extensive care packages – being person-focused with care delivered in the right place at the right time by the right people.

Further protection of social care services will be dependent revising the agreed pooled budget and target population.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The amount within the BCF pooled fund allocated to protect adult social care services in 2014/15 is £6.925m and in 2015/16 £7.334m. This commitment is made in addition to other BCF schemes that will also be providing additional support to social care, both directly and indirectly.

The figure in 2015/16 recognises the need to identify funding to support implementation of the new duties that will come into effect from April 2015 as a result of the Care Act in line with requirements in the BCF guidance. The published national allocations indicate an amount of £409,000 is required.

Work is underway to identify the precise methodology for ensuring this funding can be made available from within the agreed pooled budget. Savings from reduced admissions would initially support the CCG contribution into the pooled budget in order to mitigate the additional cost of funding the Care Act amount of £409,000

There will also be a need to identify £150k from Social Care Capital for the IT requirements associated with the Care Act implementation.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Information on Telford and Wrekin's preparations for the implementation of the Care Act regulations:

The Council has established a Programme Implementation Board set up with representation from both Council and CCG to oversee the changes in relation to the Care Act. Work-stream leads are currently developing detailed plans identifying key actions. There is considerable synergy between BCF and the Care Act and a number of people will be members of both groups:

- Work streams (with links and alignment to BCF project workstreams):
    - Assessment and Safeguarding

- Commissioning
- Information and Advice
- Finance
- Workforce
- Infrastructure
- Communications
- Governance

The emphasis moving forward is on person centred, asset based care. In future people's care and support needs will be met by:

- harnessing existing capacity within neighbourhoods and families to provide support;
- addressing people's needs at an earlier stage and before the need for formal services;
- the provision of high quality state support based on clear national entitlements
- It also envisages that care and support will be more effectively joined up across all local services (particularly health and housing) and will work more collaboratively across local authorities, providers and other statutory organisations.

Changes to adult social care law:

- Focus on prevention and wellbeing rather than crisis intervention
- Clarify entitlement to care and support – consistency from one local authority to another
- Develop a national eligibility criteria
- Treat carers as equal to the person they care for
- Reform how care and support is funded by creating a cap on care costs payable by every individual – all 'self-funders' will need to be assessed at an early point by the LA
- Guarantees regarding service provision between LA and should a service provider fail
- Simplify the system and provide flexibilities for greater integration to achieve better results for people

v) Please specify the level of resource that will be dedicated to carer-specific support

There is a Section 75 Partnership Agreement in place that is set out below:

Services	Council £	Health £
Respite for Carers	254,000	125,000
Emergency Response Services	£54,000	57,000
Joint Post	£12,500	£12,500
Total	£320,500	£195,000

Activity Descriptor	Initiatives	Target Outcomes for 2014-15 linked to Carers Strategy Health and Well Being Priority
Planned personalised support: enabling carers feel supported in their caring role. Reduce crisis admissions to hospital/residential care/nursing care	Time limited, practical and emotional support for carers looking after someone with Dementia and/or a long term condition. Carers will be allocated a personal budget following a carers assessment. Service provision currently being tendered	Time for Me Promotion of Well Being Planning for the Future
Carer Workshops which will provide: • Time away from their caring role • build on knowledge and skills • provide practical advice, knowledge and support • promotes peer support and emotional support	Creative: Arts/Crafts/Painting/Drawing/ Singing Groups Well-being: Peer Support/Looking after yourself/Cookery Education: Dementia/First Aid/Safe Moving/Employment sessions Workshops shop providers will be allocated from Preferred Providers Framework	Time for Me Feeling Safe and Secure Promotion of Well Being Information, advice and Support

The Carers Service Delivery will be linked to four key areas set out below:

Emergency Response Carers Service: Provision of replacement support when the care is in crisis.
Replacement support can be provided up to 48 hours (Monday-Thursday) or 72 hours (Friday to Sunday/Bank Holidays) commissioning from two providers.

Moving and Handling Advice and Support
Moving and Handling Team will provide one to one consultations with family carers with regard to safe moving and handling techniques to carers, as required.

Evaluation material will be used to evidence that service remain person centred and the impact of the service, including 'Comforts scores' of the carer and the person they care for; mobility classification through an Arjo Gallery assessment and collection of carer intelligence pre- and post- service delivery.

Commissioning post for carers
The appointment of a Carers Commissioning Officer (21 hours per week) to working collaboratively across the Council and CCG.

Personalised Respite including the development of recreational opportunities for carers
As part of the NHS Operating Framework specific funding allows additional respite to be

provided to carers to enhance their physical, emotionally and psychological well-being. This will be addressed in line with the Care Act, and information above.

In addition to the above, Carers can access services which provide the following:

Admiral Nursing Service: Funded by CCG. This service provide specialist emotional, psychological support to the carer to ensure they become expert by experience in supporting the person they care for. |

Friends and Family Service: Provided by IMPACT where by those who are affected by someone's drinking and drug intake can receive information, advice and support. Funded by Public Health

Relationship Support for Carers provided by RELATE: Assists carers to adjust to changes in roles and relationships.

Pampering Sessions: Which support the enhancement of carers well-being and quality of life.

The Section 75 agreement will move into the overall Pooled Budget from 2015/16.

The Carers Commissioner will also take a lead role in the delivery of outcomes in line with the Care Act.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

There has been no change in risk from the original submission.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

The strategic commitment for 7 day working has been demonstrated through the following papers:

- Health & Wellbeing Strategy
- Urgent Care High Level project Optimising Capacity proposal supported by Chief Officers Group, approved by CCG Board.
- Joint Rehabilitation and Reablement Strategy 2010- 2013
- Older Adults strategy 2006-2016
- Multi-Agency Living Well with Dementia Strategy
- Multi-agency strategy for Carers 2013- 2016
- NHS Standard contracts

Existing 7 day services
The integrated Enablement team is already a 7 day service – nurses, occupational therapists, physiotherapists and social workers working in an integrated way. Rapid

Response is also an extended hours (8am- 10pm) provision over 7 days providing post hospital nursing care and interventions including IVs – instrumental in early discharge as identified within MCAP data.

Shropdoc provides medical assessment out of hours to ensure a 24 hour medical response is available in the community.

These are set out within existing contracts with providers.

Virtual integration

Virtual integration of other services including Rapid Response and community Nursing will ensure a single location for ease of referral, communication and co-ordination of care. Inclusion of voluntary sector services that provide low level interventions is also possible. One voluntary sector provider is co-located within the Enablement team. Vertical integration through the phased implementation of the Integrated model is identified as being in place within 2014/15.

Wider implications of 7 day working include:

- Ensuring domiciliary care provision at short notice is in place
- Care homes responsiveness to assessments within the acute setting or for step-up care is available
- Access to equipment and adaptations
- Community and voluntary provision to meet basic needs (shopping, household chores)

Domiciliary and care home representation is included within the Programme Management Board through their umbrella organisations. In addition, specific engagement with voluntary organisations through umbrella organisations to develop the sector is taking place and a specific Theme of the BCF programme.

Increased 7 day provision

The establishment of 7 day care will widen during 2014/15 and 2015/16 as part of the phased development of the integrate model, to include support services within the acute sector such as Occupational Therapists and Physiotherapists, medical specialists through Shropdoc and Community services. This will ensure that the next steps in the patients care pathway is clear.

Work will also take place to establish an integrated care record which assists in mitigating the risk of emergency admissions. This is addressed in the section below.

Other services which will support 7 day care include access to support and advice from Pharmacy services (who are included within the service re-design work-stream and Transport services (ambulances – non emergency.)

The local acute provider is committed to developing 7 day services, including medical cover. This is being included within the Integrated model development, while recognising the pressures of recruitment that have. This is part of the Service Delivery Improvement Plan of the NHS contract for 2014/15.

In addition, further development as part of the Integrated model is being formulated. It is

recognised that therapy services are needed 7 days and active planning is taking place to develop integrated approaches within the acute hospital and community services to develop this.

In addition to the existing 7 day working of Rapid Response Shropshire Community Health NHS Trust is committed to rolling out access to services over the 7 day week. During 2014/15 they are planning to scope all service areas and pathways that currently do not provide this to ensure that where the evidence is available to support improved access, outcomes and patient, carer and family experience over the week they will develop the model to support its implementation. This includes the Community Equipment Service. They have, however, been able to provide this extended service during times of surge. Therefore, there is an approach that could be developed.

A number of mental health services are in place over 7 days. These include CR/HT and Dementia Home Treatment. As part of the review of service modernisation consideration about the level of integration into the Integrated Community Enablement service will take place. This could mean a level of virtual integration, co-location or referral through an agreed pathway. Closer alignment will be developed within the phased development of the Integrated team. Mental Health Services are a member of the Programme Management Board and each work-stream.

Active planning is taking place with GPs to ensure that practices will deliver 7 day working as groups of practices within an identified locality area. This will include provision of community based planned care as part of redesigned pathways, clinical and diagnostic facilities type procedures and point of care testing on a cluster basis. The current GP out of hours provision (Shropdoc) is commissioned to deliver this provision. Out of Hours services are provided within the Shropdoc base in Telford and home visits.

Further innovation is being considered to develop effective care management in primary care. National direction to focus on case management of 75 years+ is an integral part of the BCF programme to develop through a separate but linked Primary Care programme.

Ultimately, by 2015/16, within fully implemented model the objectives is that attendance and admission avoidance and early supported discharge from hospital will take over 7 days including nursing, therapies and care and support from statutory and voluntary services. Existing nursing and therapies will be maintained at the same level from the patient experience perspective. This will involve radical resign of working patterns within the acute, community, mental health and voluntary sectors to deliver this.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

The Council, CCG and NHS providers are committed to the use of the NHS number as the primary identifier. This is evident in the organisational Information Management Policies and Plans across the organisations.

The most significant challenge has been introducing the NHS Number as the primary identifier within social care. However, there are developments in this area. Currently the

NHS number is used inconsistently across social care, although the council database 'Care First' does include a field for it. The council have an active project to load the NHS number into all current CareFirst client records using the Migration Analysis Cleansing Service (MACS). The project is estimated to be completed by 31st October 2014, and will include procedures to continue to match NHS numbers for new clients entering Adult Social Services, thereafter. This will enable real-time utilisation of the NHS number as the identifier.

A robust project plan to include training to facilitate cultural change for the systematic recording of the NHS number by social care professionals has been developed and being taken forward.

The acute trust has the facility to batch-match and update the PAS system with NHS numbers. Currently the NHS Number is in use in all patient data areas considered the 'unique identifier' within the acute hospital and community provider. It is recognised that, to support integration of services, wherever the NHS number is used as the unique identifier this ensures consistency and mitigates the risk of getting the 'wrong patient'

This includes clarification of the implementation timescales for the use of the NHS number as the primary personal identifier. This is a specific requirement of the BCF. It is likely that use of the NHS number will be in place before March 2015.

The plan will develop processes to share activity and performance data on key services and we need to ensure the same data sets are being shared across the partnership. If there is a change to existing sharing of data sets or sharing of new data sets then this will need to be mapped and privacy impact checklists completed alongside completion of individual data sharing agreements for each data set. The Infrastructure task and finish group is already in place and responsible for developing this area as a key produce outcome within the identified timescale.

The CSU is looking to develop Personalised Care Planning and supported self-management through the development of a patient portal that is fully integrated with GP clinical systems, Integrated Care Record and Social Care. The objectives are:

- To develop functionality mirroring that used in the national pilot
- Year of Care, care planning templates for local use in personalised care planning
- To develop an electronic health profile which would be used as a shared decision making aid in structured education and personalised care planning consultations
- To develop secure and confidential access to personalised records and information to support personalised care planning and self-care

It is noted that this information sharing is a key component of effective 7 day working.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

There is commitment within the economy to allow information to be exchanged between systems through open standard interfaces, supported by Open Application Programming Interfaces where necessary. There a number of information management policies to

support this. The relevant work-stream will focus on this area as part of its key products outcomes

T&W CCG and TWC are taking part in a regional pilot to implement the sharing of pseudonymised health and social care data this will support the economy with integrated monitoring of the national BCF metrics. It will also provide useful data to support commissioning/decommissioning of services for the BCF; with the ability to analyse cohorts and patent to population level, when IG issues are addressed at a national level.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

There is commitment to ensure appropriate IG controls are in place. Both the Council and the CCG have IG teams that provide guidance and awareness on related matters and are also the key people in completing IG Toolkit requirements.

The IG team liaise with both the Caldicott Guardian and SIRO regularly providing assurance that adequate IG controls are in place. The CCG's IG team is purchased through the Commissioning Support Unit.

There is an overarching Information Sharing Protocol (ISP) This ISP is an agreement between: Shropshire Community Health Trust, Shropshire Primary Care Trust, NHS Telford and Wrekin, SaTH, Robert Jones and Agnes Hunt FT, SSSFT, Shropshire Council and Telford and Wrekin Council. This ISP is in-line with the recommendations from the ICO. For the sharing of information between any of the above mentioned organisations an individual Information Sharing Agreement (ISA) is completed. The ISA will include the data items being shared and all the relevant information required to proceed with any information being disclosed.

Telford and Wrekin CCG submitted version 11 of the IG toolkit with a "Satisfactory" score of 84%. This submission was based on the recommendations of the CCGs internal auditors. An improvement plan is in place, approved by the CCGs Information Governance Group, for the maintenance and development of this score for the version 12 2014/15 submission of the toolkit. The CCG is supported in their compliance with the IG Toolkit and all other aspects of IG by a team based within Midlands and Lancashire Commissioning Support Unit, with a dedicated support officer based on site with the CCG on a pro-rata basis.

Telford and Wrekin Council submitted version 11 of the IG toolkit with a 'Satisfactory' score of 78%. The toolkit was completed by key stakeholders in the Council including ICT, Childrens and Adults social services and public health. The overall co-ordination and quality assuring of responses and requirements was undertaken by the Information Governance Team Leader. Work has been or is being undertaken to further improve the satisfactory score on the toolkit, ready for the next submission.

The Council has a number of policies in place in respect to IG that assist in providing a fit for purpose framework. All officers work within these policies.

The Councils IG team has a close relationship with our commissioners and have worked

together to ensure adequate terms and conditions are included in contractual documents.

All Council officers are required to complete mandatory IG training via our Learning Pool module and they have to read and agree to comply with the Corporate Information Security Policy every 90 days.

Shrewsbury and Telford Hospital NHS Trust (acute hospital) have a statement of assurance for the Information Governance Toolkit Assessment (Satisfactory).

The problem of IG controls has been identified nationally. The outcome of the recent consultations by DoH on the proposed Protecting Health and Care Information Regulations and HSCIC on the Code of Practice on Confidential Information will be monitored and factored into existing IG measures where required

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

High complexity patients with LTCs account for about 3-5% of the population (c5000 patients). Complex -Disease Specific patients with LTCs account for 15-20% (c8,500 patients). Primary care completed 4000 LTC care plans in 2013/14. This was only for respiratory and diabetic LTCs. Plans to extend this are being developed.

The care plans LES evaluation attached for 13/14 practices completed a total of 9,156 care plans. There is further clarification on the number so patients of high risk patients who need a care plan to be developed.

A local risk profiling tool was developed to identify high risk patients within primary care and ensure those patients had advanced care plans. This was included within the Direct Enhanced Service and Care Home Advanced Scheme during winter 2014/15. The criteria asked GPs to profile patients against the list below – differentiating between those most to least at risk:

- Number of admissions. Emergency admissions would be higher risk than planned
- Number of A&E attendances
- Number of GP call outs
- Number of GP phone calls
- Number of LTCs being managed
- Those Nearing end of Life

Work is ongoing with the CSU to develop a risk stratification tool.

The target population has been identified. This is to ensure the BCF is inclusive of all who are at risk or may need enhanced health and social care needs. This approach maximises the potential and impact of self-help; support to primary care for LTCs, reducing admissions and supports early discharge. This approach also provides further opportunities for joint planning and integrated working. The local metric has been devised to monitor the effectiveness in reducing admissions specifically to this target group.

The Accelerated Pilot targets population conditions and diagnoses whose admissions could be avoided if community services were available and responsive. This target population was derived from the MCAP study and has a high correlation when cross-referenced with GP, community services clinicians and acute hospital staff:

- Urinary Tract Infections
- Respiratory conditions
- Chest Pain
- Falls
- End of Life
- Generalised inability to cope at home

During July and August 2014 the Pilot has generated 70% increased referrals against last year. In addition, early evidence indicated they have reduced admissions by an average of 2-2 ½ a day. While the target is an average 4.5-5 a day, this gives an indication that the target population is being targeted and admissions can be avoided. The Accelerated Pilot is providing important intelligence to help modify the original hypotheses.

A significant target group is the 5383 admissions for 65years+ (in 2012/13). This will be reduced through self- help from building community capacity and enhanced Community services (building on the 1400 Enablement episodes in 2012/13).

Further, more detailed, population and risk profiling will be completed as part of the Implementation Plan. This is to enable widening of the target population to reduce admissions where possible. This will include analysing data from MOSAIC, acute hospital data and intelligence and community services data and intelligence.

In addition the CCG and Council are part of a Health and Social Care Population Profiling programme (supported by Midlands and Lancashire CSU and, PI, a private external company). This will provide detailed profiling of high users of services to identify high risk populations; enable stratification of risk; target interventions and future commissioning.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

The current integrated Enablement team have a lead professional to case manage individual service users based on identified need from hospital or need an Enablement provision as an alternative to admission. The Rapid Response and Community Nursing teams case manage patients at risk of admission from escalating conditions that require specific nursing interventions which can be delivered in the community.

There is close working between the Enablement Team and Rapid Response. However the development of phase 2 of Theme 2 (the Integrated Community Enablement team) is intended to ensure joint assessment and planning.

Primary care case manage patients at risk of admission through:

- a LTC Direct Enhance Service - care planning and monitoring
- Risk profiling tools to identify patients who at high risk of admission

- Monthly reports from the CCG about admissions to review those who have been admitted and complete care plans

There is close working between the primary care, community nursing teams and Rapid Response. The local economy has been targeting support for residents of care and nursing homes including a Care Home Advanced Scheme completing care plans for patients at high risk of hospital admission. GPs therefore support the identification of those high risk patients who need a joint care plan and will be the lead professional.

Within the Enhanced Community Enablement Service the lead professional will be determined by a Single Assessment Process – joint assessment using a multi-factorial assessment that can be utilised by NHS, Council and / voluntary sector service. This will identify the most appropriate individual to take that role. This assessment will also determine levels of risk and inform the support plan. Consultant medical capacity and additional OTs, physiotherapy, social work and nursing will be within the Integrated Community Enablement team.

Information Sharing Protocols and development of agreed joint assessments and risk assessments will ensure that that patient information is shared appropriately and securely between teams and services. Within integrated teams delays in sharing information will be minimised.

In line with Optimising Capacity on Discharge the Home from Hospital team, previously based within the acute hospital, has aligned within the Enablement team, in order to streamline discharge. The new model, implemented from the first week of September, is that the widened Enablement team receives referrals from the acute hospital 48 hours prior to discharge. In a further initiative, Trusted Assessors (acute hospital therapists and nurses who have been trained to carry out assessments on behalf of the Enablement team) will provide clinical information to support Discharge to Assess.

A single point of referral is planned as part of the development of an integrated service. The service re-design work-stream will develop this after full consideration of the current 'single points….' within the social care, Shropshire Community Trust, Mental Health Trust and Out of Hours Services. The Programme Management Board agreement is that these areas will have a lead officer to develop this area and an Executive / Council senior officer sponsor to ensure it is delivered within the agreed timescales.

Through BCF the local economy will also focus resources on people living in the community to provide 'step up and step down' support.

The focus for the Better Care Fund is to transform services for adults needing high levels of health or social care support, particularly frail older people at risk of and/or suffering as a result of:

- Falls
- Dementia
- Long term conditions /End of Life
- High risk of admission
- Discharged with a need for rehabilitation and/or enablement

All people who are identified as high risk of admission will have an agreed accountable

lead professional.

Mental health services are a key part of the integrated provision within the acute setting. Mental health clinicians complete the Integrated Health Assessment within the acute setting to support discharge; mental health staff will support acute staff to reduce admissions and length of stay.

Mental health services are within the integrated pathway within the community. Agreed pathways between mental health teams including CR/HT and Dementia Home Treatment ensure effective joint assessment; care management where appropriate and sharing of information. Phased development of the Integrated model will facilitate ever closer alignment.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

GPs have been identifying their most vulnerable patients. The care plans LES evaluation attached for 13/14 practices completed a total of 9,156 care plans

Diabetes: 3,357
COPD: 1,695
Asthma: 4,104

This is a high risk population in relation to admission.

Approximately 200 care plans were also developed from the Care Home Advanced Scheme. This work is being developed further through the care planning of the most high risk 2% of the population.

A risk stratification template has also been recently developed for care homes to identify high risk patients. This is intended to support care homes to identify those most likely to be admitted and seek support, training or advice to improve their care.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Healthwatch is a member of the BCF Project Management Board and work-streams and acts as a valued 'critical friend' in discussions. They have attended and supported various local engagement events during the last year and will attend the next scheduled event on 26 September 2014.

There has been consultation with the Health Round Table. From that engagement a user and carer has been identified as members of the Programme Management Board.

Presentations on the BCF have been made to the Carers Partnership Board, Health Scrutiny Committee and Local Strategic Partnership

Over recent years a number of strategic exercises have engaged the public, service users, carers, clinicians and providers to steer the planning of future services.
These include:

- A range of joint strategies have been in place for several years, driven by a joint commissioning approach
- Development of the Urgent Care Strategy where key patient messages and expectations of local services included:
    - Be joined up and responsible for my care
    - Help me understand my (urgent care) needs
    - Assess and treat me promptly and in the right place
    - Admit me to hospital only when necessary
    - Try to care for me at home, even when I am ill
- A council led 'Thinking Ahead' project working group established to steer and coordinate the health and social care review of the Rehabilitation and Re-ablement Strategy.
- 'Optimising capacity' - a work stream led by a management consultancy agency ATOS which designed a model to support early discharge/better rehabilitation. Stakeholders highlighted the need for any model to support alternatives to admission and admission avoidance.
- A review of the Multi-Agency Carer's Strategy led by the Carer's Partnership Board, chaired by a local carer and attended by various organisations including the voluntary sector, senior officers from the Council and CCG, and cabinet lead for adult social care.
- A major conference as part of 'The Call for Action' on local healthcare provision. This served as the culmination of several months of consultation informed by over 3,000 of the Shropshire/Telford & Wrekin population, and over 200 clinicians reflecting the views of primary, secondary, specialist and therapeutic services.
- Our Local Health Economy has just launched the next stage to respond to 'A Call for Action' - a 'Strategic Clinical Review' which will specifically focus on the configuration of hospital based care, but which will be informed by progress of the BCF plan to provide out of hospital care, wherever possible and appropriate.

- This may lead to recommendations for further reconfiguration of hospital services. There will be ongoing and extensive engagement in accordance with the statutory engagement requirements of the 2006 NHS Act, and the so called 'Lansley' tests.

Common messages have emerged from consultative exercises to date:

- People want care close to home.
- They want it personalised to meet their specific needs.
- There is currently insufficient 'joining up' between NHS (including acute) and social care services. The impact of this is confusion and dis-satisfaction for individuals and potential duplication and/or fragmentation by NHS/social care, which is not cost effective.
- There is too much variation across parts of Telford and Wrekin particularly for access to services and/or patchy co-ordination.
- Discharges are far too slow - from user experience

The Health and Wellbeing Board have undertaken regular consultation sessions with a wide range of stakeholders over the last two years via 'Working Together' events. The next major event is planned for 26 September 2014 and will focus specifically based on a performance-based interactive session bringing the Care Act and BCF to life. The performance will cover six 'real life scenarios' and people attending the session will be asked to comment, discuss and determine the 'next steps'. The performance, called 'the Royale Family' will deal with some tricky emotional issues that occur in families linked to hospitals, health and social care. The intention is to make the session interactive, so that people can respond directly to the scenarios and have a real opportunity to reflect on 'what the changes mean'.

The whole production will be recorded, available on a DVD and used for future training. The evaluation will provide feedback on this approach and whether similar events should be planned in the future.

As a product of working together with users and carers, who are members of the planning group, to prepare this session there is a strong sense of co-production. Future, quarterly meetings will continue post the September event. The next meeting is planned for early December.

The Communication and Engagement work stream developed a BCF Launch event to engage all sectors, which took place at Enginuity on 9th July. 69 stakeholders participated including from Healthwatch, primary care, voluntary organisations, users and carer representatives, SaTH, SCT and the Council.

The event summarised the BCF, its context – Care Bill and Future Fit - expected benefits of the programme; how partner organisations can support and contribute to Better Care. In addition to a range of presentations setting out Future Fit, the Care Bill and BCF and workshop discussions, two patient stories helped to illustrate the BCF as seen through the eyes of individuals in receipt of services.

Feedback forms from 39 participants described the event as 'Interesting', 'Important' and 'Relevant'. In response to questions raised in the Evaluation participants reported that they had gained a better understanding of BCF; the videos helped highlight the benefits of the planned model of care and helped them understand how they fitted into the BCF

plan. There was a keen interest to meet again to ensure that patient and carer views continue to be taken into account.

Key feedback included:

- 'Prevention is key'
- 'Stop being so risk averse'
- 'Solution must be seven day working across the economy; nit just part of it'
- 'Stop shouting at each other, lets work together, more sharing'
- 'We all know each others problems, lets pool resources to get best value'
- 'Care follows the patients, acute phase stops, physio, OT follow the patient'
- 'To support carers both identified and not identified to prevent carer breakdown…'
- 'Respect and acknowledgement for the voluntary sector that their skills fill the gaps'
- 'Being able to trust other professionals information'
- 'Shared integrated record…. Not requiring individuals to repeat their story'

The feedback related to participant views of the event were:

Interesting 18	Important 17	Relevant 25	Complicated 5	Enjoyable 4	Clear 6
Comfortable 2	Rushed 5	Thorough 2	Confusing 5	Boring 0	Irrelevant 0

There is a plan to respond to the suggestions made on the 9 July at the launch of the BCF including by establishing a webpage linked to all stakeholder organisations. In addition feedback to stakeholders on 26th September to feedback on progress in a 'you said; we did' session.

Meetings have taken place with the voluntary sector Chief Officer Group (COG) in May and July 2014. The voluntary sector is keen to be involved in co-production of future plans. The COG is in the process of completing a matrix to map activity through levels of provision from prevention to acute and recovery. The feedback received highlighted that they wanted their contribution to be valued; were concerned about the impact of efficiencies while expecting them to develop services and support users within increasingly complex needs. While strongly committed to supporting the 'preventative' agenda they thought that more resources were required to enable this to take place. The plan is to work with the sector to achieve efficiencies which will, in part, further reinvest to support planned growth.

As an example of partnership working, the CVS has proposed that a Voluntary Sector Network is established to interface with other organisations and feedback to the Programme Management Board. The proposal is to include six organisations: British Red Cross, Age UK, Citizens Advice Bureau, Listen Not Label (ULO), Royal Voluntary Services (RVS) and Council for Voluntary Services (CVS). Monthly meetings are now planned until the end of the calendar year. In recent correspondence the head of Projects for CVS said:

'*Hopefully we can then collectively get some actions to feed into the whole BCF agenda. We'll provide feedback from those meetings to the larger COG membership. One of the tasks for the group may be to fine tune the VCS accelerated pilot model which originated from discussions with Lyn and Tina. This mimics the crisis network*

model, which is proving a great way of organisations coming together to provide collective service delivery.'

This level of engagement is to ensure a co-production approach within BCF. It has engaged people in an iterative process as this plan will inform the Strategic Clinical Review of hospital care and vice versa locally branded 'Future Fit'. It is recognised that it is essential to clarify 'what' can be provided out of hospital, and 'how much of it', at the same time as determining how to reconfigure acute services.

As part of wider engagement , BCF was presented at the Shropshire Partners in Care (SPIC) AGM on 18 September 2014. This umbrella organisation covers care homes and domiciliary care providers and gave an opportunity to highlight the BCF approach and seek views and potential roles for the sector.

As part of the BCF, a Communication and Engagement working group has met on a two-weekly regular basis. However, steps are now taking place to introduce changes which will improve effectiveness in widening the level of engagement and communication with a wider number of stakeholders. Discussions within this group have highlighted the significant cultural changes that are required amongst the population as a whole to deliver an integrated BCF care system. This is both understood and used by professionals and accepted as reasonable and appropriate to meeting individual needs as well as avoiding unnecessary admissions.

As the Council progresses work to support the introduction of the Care Act 2014, areas of overlap with the BCF are being aligned to improve overall engagement and communication on key issues.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

There has been a close partnership between all health and social care providers in the Local Health and Social Care Economy, who have worked together to improve integrated care for several years. This includes:

Various formal partnerships including all local organisations that have been involved in steering the development of the closer integration of services to date. These same groups will continue to be closely involved:

- Health and Wellbeing Board (HWBB)
- Urgent Care Working Group
- Winter Planning Group and Senior Managers Group (including representation from each commissioner and provider organisation)
- Optimising Capacity on Discharge Project Group (including representation from each commissioner and provider organisation to develop and agree the future model)

- Stakeholder partnership groups led by the Telford and Wrekin Council (Council)/ Telford and Wrekin Clinical Commissioning Group (CCG) involving users, carers, independent and voluntary sector providers
- Local Strategic Partnership

Consultation with key stakeholders took place prior to completion of the draft submission. Since then, key stakeholders, as members of the Programme Management Board provided comments and feedback in the following:

- revising the submission and re-submission
- developing the Integrated model
- shaping and agreeing the work-stream key product outcomes, and
- development of the detailed Implementation plan.

Regular stakeholder engagement events (locally branded 'Working Together') are already in place – meeting on a six monthly cycle. A further session will take place (summarised below in section 8biii) to highlight the BCF further.

As part of the development of the BCF a Launch event took place on 9th June. Managers and staff from all local NHS Trusts and Councils participated in the event.

Specific engagement with the community provider has also taken place. Their feedback to the TDA is included below as evidence of their view about engagement:

- Meetings with Executives to set out BCF principles and need for increased community activity
- Member of Programme Management Board work-streams
- Separate meetings held to consider activity assumptions methodology
- Admission avoidance workshop developing Accelerated Pilot
- Additional meetings to develop the Accelerated Pilot and monitor the performance

There has been active engagement and participation from the community provider throughout the development of the BCF programme.

Specific engagement with the acute hospital has also taken place:

- BCF presentation in February 2014 including activity assumptions
- Member of Programme Management Board work-streams
- Separate meeting held to consider activity assumptions methodology
- Admission avoidance workshop developing Accelerated Pilot
- Additional meetings to consider admission avoidance –Ambulatory care

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ii) primary care providers

GPs have been aware of the BCF programme development though a number of processes:

A CCG GP Board member is a member of the Programme Management Board and work-streams.

GP Forums
Lead GP and practice managers received updated within the formal monthly meeting. As well as regular updates on the programme, an extended presentation about the BCF took place on 16th September. GPs are aware of the key aims of the BCF programme- reduced avoidable admissions. This has been simplified to 1 ½ patients a week per practice over and above what was achieved last year.

GP newsletter
BCF has been highlighted within the newsletter that is sent to all GPs and practice managers. in addition, progress on the Accelerated Pilot, phase 1 towards an integrated model, has been shared for each of the first two months of the Pilot

Admission avoidance workshop
A workshop to focus on admission avoidance was held in June. Development of attendance avoidance (developing The Accelerated pilot) and admission avoidance eg the use of GPs in ED or AMU to stop avoidable admissions, took place. GPs and other clinical and management staff supported the target population for the Pilot and the pathways developed.

A GP has been identified to provide some clinical engagement within the Accelerated pilot. This is likely to be in place from November to support fellow GPs to avoid admissions.

Shropdoc/ CCC is the out of hours primary care provision. Shropdoc have participated in developing the Accelerated Pilot, aligned to the single point of referral to avoid admissions by working more closely with Shropshire Community Trust. There is evidence that referrals are shared between provider organisation across the agreed pathways to enable the right level of support to maintain service users at home.

West Midlands Ambulance engagement has been taking place. They attended the Admission Avoidance workshop and BCF Launch event and engaged about the development of the Accelerated Pilot. A part of hosting NHS111 there has been engagement about the pathways associated with the Pilot. The pathways have been developed and are not within the pathways of care alternating from hospital.

West Midlands Ambulance have been invited to attend future Programme Management Board meetings and expected to attend the next meeting on 19th September 2014.

iii) social care and providers from the voluntary and community sector

Social care operational staff are part of the Programme Management Board and work-streams as well as commissioners. Finance colleagues from the Council also attend and have played a critical role in the financial modelling to support BCF.

Key operational staff from social services have engaged effectively while developing the Trusted Assessor model and pathway development for the Accelerated Pilot and developing the Integrated model. They have also developed templates to support

gathering information to evidence change in patterns an outcomes.

Social care operational staff also participated in the launch event.

The Community Voluntary Service (CVS) is a member of the Programme Management Board. The CVS Chief Officers Group Chief Officers Group (COG) (the over-arching body for voluntary organisations in the Borough) has identified representatives for each work-stream within the BCF programme.

To support the development of both schemes, several meetings have taken place with the COG during the last few months and the Chief Officer of the CVS provides regular reports to the COG on the work of the BCF Programme Management Board.

In response to a range of questions put to the COG by the CCG and Council in relation to BCF, detailed discussions have taken place and the COG have provided written answers. The questions asked were:

- Do we know everything or how well the voluntary sector currently delivers services that would support BCF?
- How can the voluntary sector demonstrate/provide evidence of value for money to maintain or increase resources within the sector?
- What are the areas that could be developed further to avoid or delay use of health and/or social care services?
- Where are the key challenges for the voluntary sector that would promote or hinder engagement and development?
- How can organisations become more sustainable with less public sector funding in the future?
- How do we develop more effective partnership working.

In addition to responding to these questions, 14 of the COG member organisations have submitted a completed template outlining how they engage with:

- Preventative activity
- Team about the GP
- Rapid response
- Acute hospital
- Recovery
- Quality Marks

As an example of partnership working, the CVS has proposed that a Voluntary Sector Network is established to interface with other organisations and feedback to the Programme Management Board. The proposal is to include six organisations: British Red Cross, Age UK, Citizens Advice Bureau, Listen Not Label (ULO), Royal Voluntary Services (RVS) and Council for Voluntary Services (CVS). Monthly meetings are now planned until the end of the calendar year.

Overall, the COG is supportive of the current Accelerated Pilot. They are seeking to produce an overarching template to match the Accelerated Pilot template, showing where the voluntary sector actually interfaces with the different parts of the model. In recent correspondence the head of Projects for CVS said:

'*Hopefully we can then collectively get some actions to feed into the whole BCF agenda. We'll provide feedback from those meetings to the larger COG membership. One of the tasks for the group may be to fine tune the VCS accelerated pilot model which originated from discussions with Lyn and Tina. This mimics the crisis network model, which is proving a great way of organisations coming together to provide collective service delivery.'*

The next major event is planned for 26 September 2014 and will focus specifically based on a performance-based interactive session bringing the Care Act and BCF to life. The performance will cover six 'real life scenarios' and people attending the session will be asked to comment, discuss and determine the 'next steps'. The performance, called 'the Royale Family' will deal with some tricky emotional issues that occur in families linked to hospitals, health and social care. The intention is to make the session interactive, so that people can respond directly to the scenarios and have a real opportunity to reflect on 'what the changes mean'.

The whole production will be recorded, available on a DVD and used for future training. The evaluation will provide feedback on this approach and whether similar events should be planned in the future.

At the event, 43 organisations from the voluntary and provider sector will have stands to talk to people about their work in Telford and Wrekin.

As BCF moves forward, they wish to proactively continue to support the statutory services in supporting people to remain in the community and to support early discharge. The voluntary sector is seeking to work with us in co-production to reduce duplication and remove efficiencies in support of BCF. There is a commitment to working together to produce a Business Plan which supports some further investment in the voluntary sector to enable them to more actively support BCF as it evolves. This work will begin in Autumn 2014 and progress into 2015.

The Local Strategic Partnership (senior executive leaders across the local economy including Police, Ambulance, Probation, Education, council, CCG) has been consulted in relation to BCF. They support both the proposals and themes.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The BCF plan proposes reduced activity within the acute sector. This includes reduced admissions and length of stay. Modelling indicated c1200 reduced admissions (utilised from MCAP audit data) and 1500- 2000 early discharges. This includes reduced admissions related to respiratory conditions, UTIs, cardiac complaints, falls and increased End of Life care within the community from enhanced services. These conditions/ diagnoses also related to highest number and costs of admissions. (indicated in the chart below for 2012/13 activity). Most NHS rehabilitation will be community based

rather than within the acute setting. The CCG has given formal notice to de-commission hospital based rehabilitation.

	Age Band								
	65-74			75+			Total Activity	Total Sum of Cost	Total Average of LengthOfStay
Spell Duration	Activity	Sum of Cost	Average o	Activity	Sum of Cost	Average of LengthOfStay			
Urinary tract infection, site not specified	83	£ 192,412	6	290	£ 952,616	14	373	£ 1,145,028	12
Chest pain, unspecified	105	£ 78,761	1	128	£ 97,737	2	233	£ 176,498	2
Lobar pneumonia, unspecified	54	£ 159,318	10	139	£ 426,042	11	193	£ 585,360	11
Pneumonia, unspecified	45	£ 138,245	9	126	£ 368,433	9	171	£ 506,678	9
Unspecified acute lower respiratory infection	52	£ 106,909	6	118	£ 267,972	8	170	£ 374,881	7
Chronic obstructive pulmonary disease with acute lower resp	79	£ 182,636	5	91	£ 209,593	7	170	£ 392,229	6
Chronic obstructive pulmonary disease with acute exacerbati	60	£ 144,388	6	67	£ 153,558	7	127	£ 297,946	6
Atrial fibrillation and flutter	51	£ 70,561	3	71	£ 133,778	7	122	£ 204,339	5
Congestive heart failure	24	£ 71,390	11	94	£ 294,375	10	118	£ 365,765	11
Fracture of neck of femur	16	£ 73,661	21	99	£ 523,089	25	115	£ 596,750	25
Acute myocardial infarction, unspecified	20	£ 63,564	10	66	£ 207,306	7	86	£ 270,870	8
Cellulitis of other parts of limb	26	£ 49,116	4	56	£ 138,347	7	82	£ 187,463	6
Gastroenteritis and colitis of unspecified origin	26	£ 63,652	4	50	£ 154,234	7	76	£ 217,886	6
Acute renal failure, unspecified	20	£ 69,564	11	39	£ 132,942	11	59	£ 202,506	11
Cerebral infarction, unspecified	20	£ 64,230	10	38	£ 146,001	18	58	£ 210,231	15
Pulmonary embolism without mention of acute cor pulmonal	22	£ 57,823	8	31	£ 80,715	11	53	£ 138,538	10
Cerebral infarction due to thrombosis of cerebral arteries	14	£ 55,220	19	36	£ 127,355	19	50	£ 182,575	19
Tendency to fall, not elsewhere classified	9	£ 30,372	7	41	£ 123,850	10	50	£ 154,222	10
Disorientation, unspecified	10	£ 25,804	3	35	£ 100,781	15	45	£ 126,585	12
Pertrochanteric fracture	4	£ 26,367	28	23	£ 113,316	26	27	£ 139,683	27
Grand Total	**740**	**£1,723,993**	**7**	**1,638**	**£4,752,040**	**11**	**2,378**	**£ 6,476,033**	**10**

This level of admission reduction is indicated to the level of activity reduction required to enable to removal of fixed costs within the acute hospital It has been recognised that reductions in activity the CCG may need to continue to fund the transitional costs of reduced activity subject to the development of a Business case.

On-going discussions are taking place with the acute provider in relation to the impact of various numbers of admissions avoided and how they would manage that situation.

Indicative savings are £2.1m – £4.5m full year effect on activity reductions (dependent on Threshold costs). Commissioning intentions for 2014/15 included a £3m reduction to the acute hospital to be included within the BCF pooled budget. In practical terms, the sum was aligned to the pooled budget and would fund activity or be able to develop community services as admissions reduced.

The model within Theme Two includes acute clinical capacity working within the integrated model. This will be as part of in-reach and out-reach functions to ensure sufficient specialists skills and interventions are available, thereby avoiding emergency admissions. This will also develop further community capacity to support planned care reductions within the acute sector where possible.

In addition, the acute sector developments to support the principle aims of the BCF 2014/15 include:

- Creating an Emergency Care Centre that will include:
    - Urgent Care Centre where those who do not need emergency care can have interventions. This would be through an integrated approach including Shropdoc, primary care, community services, social services and acute hospital specialists. A 'Perfect Fortnight' planning exercise is taking place currently to ascertain awareness of the most effective approaches to urgent care for the future.
    - Ambulatory care process to ensure early diagnostics and investigations

- Creating a Care of the Elderly Centre comprising:
    - Medical Day Unit for ambulatory care where community service providers work alongside acute hospital specialists to reduce admissions through improved assessments, investigations and diagnostics
    - Elderly Care assessment and short stay unit where community service providers including social care staff work alongside acute hospital specialists to reduce length of stay

There is evidence that that these innovations can transform the functioning at the 'front door' – reducing admissions and length of stay.

Community contacts to reduce admissions and health and care needs to respond to early discharge is modelled as 300-400 contacts across health and social care (based on MCAP data) full year effect. This is and will continue to be evaluated based on evidence from the Accelerated Pilot, which is providing data of additional community based activity to avoid admissions.

Risks associated with savings not being realised are highlighted within the risk register and risk sharing agreement.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

Theme 1
ANNEX 1 – Detailed Scheme Description

Through discussion we have become aware of ‘good practice’ in other locations including Cheshire West, and will be seeking to gain more information on the approach used there, so as to assist us in making speedy, sustainable change.

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
1
Scheme name
Building Community Capacity
What is the strategic objective of this scheme?
Theme/ Scheme 1 Building Capacity will develop community capacity where individuals abilities to self-manage long term conditions, and the enormous potential of communities to provide voluntary care and support are seen as valuable assets. We will strengthen the role of the voluntary sector, community networks, self help groups, and individuals in both 'patient' and 'caring' roles. • A strong voluntary sector infrastructure, with strong links with our 'Teams around GP Practices' and integrated with the Integrated Community Enablement Service. • A significant increase, based on modelling data in local people volunteering. • Community networks in every locality in the Borough offering support as part of the wider Telford and Wrekin 'Extended Family'. • More Self Help groups for people with Long Term Conditions to help them manage their own health. • Access to information through a wide range of traditional and modern social media mechanisms. • Access to Advice and Guidance from health and care professionals when required. This approach is with a view to reducing the number of people who need to access ongoing care support and/or treatment from NHS and / or Council services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The model for care and support is being incrementally developed through a number of inter-connected processes. Work has taken place over the last six months to support progress in developing community capacity as part of the BCF Implementation plan. Voluntary sector provision that provides support across all four safety nets is essential to reduce the demand for NHS and Council services. Detailed analysis of how voluntary organisations work within those safety nets has been carried out (attached below within the matrix / framework document).

The six areas are being progressed to design and enhance the models of support while focussing on the key objectives set out above:

- To review current spend by both organisations on the voluntary sector services to help improve understanding of how to improve the effectiveness of the sector
- To support improvements in the infrastructure of the voluntary sector
- To jointly design and procure a range of support services that can be delivered by voluntary and community organisations
- To work through a robust engagement process with self-help organisations to clarify how best to strengthen them, and how to improve signposting for people to the help and support on offer
- To expand engagement with communities to understand how best to extend volunteering, neighbour support schemes and generate community capital.
- Achieving efficiency and reducing duplication

Progress and further developments are set out below for each area.

<u>To review current spend by both organisations on the voluntary sector services to help improve understanding of how to improve the effectiveness of the sector</u>
Several internal meetings have taken place between the LA and the CCG to consider the level of spend on the voluntary sector. As an outcome of this work, duplication and levels of inefficiency have become evident. Equally, there is evidence that some organisation are seeking to make changes to enable them to contribute to the wider BCF agenda.

During 2014 commissioners have been trying to better understand what outcomes are currently delivered and whether the arrangements with the third sector provide value for money. The CCG inherited a variety of historical arrangements - Grants, SLA's and contracts with the voluntary sector. After reviewing the agreements and carrying out a value for money evaluation of all expenditure within the sector, the CCG have developed Grant Making process so that we can continue to fund voluntary sector organisations that are making a valuable contribution to the health within the economy.

The 'Grant Making Framework' which has been developed by the Central Midlands CSU, is being consulted on, with the sector with implementation from April 2015. This is an important focus on self-care, community engagement an strengthening the contribution of community and voluntary groups - a key theme in the BCF

The CCG and LA are proposing to take similar courses of action, but taking account of internal factors, the timescale is slightly different. In addition, under the Care Act the council has particular responsibilities in relation to Advocacy.

Overall, the Council is still reviewing their processes in relation to the sector. The underlying principle is to secure interventions which support community involvement and engagement, thereby helping to maintain individuals health and well-being, delaying the need for access to public sector services. Also, to provide support to individuals to reduce the need for higher cost funded interventions.

The longer term plan is to develop a pooled budget for voluntary services, when the processes can align.

To support improvements in the infrastructure of the voluntary sector

Detailed discussions have taken place on the importance of developing a co-production approach to future partnership working with the voluntary sector. They recognise that due to the need for efficiencies, as the public sector reduces engagement with some client groups, they are 'stepping in'. They have expressed the view that they no longer wish to simply 'be told what to do' linked to contracts, but to work with us to develop innovative solutions.

To support this, they are undertaking work themselves to better understand the nature and level of current contribution and how to record evidence which demonstrates the same. Specific tasks that will be progressed during the next 6 months includes development of a more robust voluntary sector business plan to support growth and development. They are also recognise that:

- Bidding for money takes time, effort and energy which detracts from 'what they are meant to be doing'
- Everyone is bidding for the same money
- Due to the efficiencies, less money is available.

Therefore, more collaborative and aligned work will help to reduce and remove some of these types of barriers and instead provide a more stimulating and rewarding environment for all partners to work together. The Grants and Bidding process for CCG funding, highlighted above, will focus the need for actions in this area.

To jointly design and procure a range of support services that can be delivered by voluntary and community organisations.

Meetings have taken place with the voluntary sector Chief Officer Group (COG) in May and July 2014, they agreed to undertake and have completed a matrix to map activity through levels of provision from prevention to acute and recovery. (attached below)

The voluntary sector is keen to be involved in co-production of future plans. They have been keen to see greater attention given to how they can support initiatives linked to the BCF. As an example, they have been involved in the development of the Accelerated Pilot identified how an additional template can be produced which accurately represents their current involvement and capacity to provide further support. This Pathway will be produced during the next month and shared with other stakeholder organisations.

Meetings with the voluntary sector have taken place over the last two years with various 'Working Together' engagement events. One product that will be launched in the 26 September is the Information and Guidance Charter. The Charter reflects considerable work and dialogue amongst the sector to agree on the content.

The event planned for the 26 September (described in other sections) was developed directly from voluntary sector. On the 26 September the combined programme of launching the IG Charter and delivering the interactive performance will help to ensure people are properly signposted and the sector achieve a shared understanding of the future needs from the sector.

Through on-going engagement with self- help organisations there will be further clarification on how best to strengthen them, and how to improve signposting for people to the help and support on offer. This is intended to:

- more self-help groups for people with Long Term Conditions to help them manage their own health.
- access to information through a wide range of traditional and modern social media mechanisms.
- access to Advice and Guidance from health and care professionals when required.

<u>To expand engagement with communities to understand how best to extend volunteering, neighbourhood support schemes and generate community capital.</u>
Currently, work is taking place within the Council to explore how to greater engagement in working in the voluntary sector from members of our local communities, partially to support securing efficiencies.

There is local representation at a Regional group seeking to increase community capital and recognise many people within our communities have much to contribute and are often keen to 'give something back'. Equally, the voluntary sector itself is seeking to grow through recruitment of more members. However, there is local recognition of real barriers that need to be discussed so that steps can be taken to mitigate them. For example, many unemployed people view volunteering as a means to an end in terms of gaining longer term employment. While beneficial, it also means that time, effort and resources go into supporting individuals to be skilled and trained to work within voluntary organisations only for them to 'move on'. The pool is also diminished further by older people working longer, who would have previously retired and volunteered.

This will develop community capacity where individuals abilities to self-manage long term conditions, and the enormous potential of communities to provide voluntary care and support are seen as valuable assets. We will strengthen the role of the voluntary sector, community networks, self-help groups, and individuals in both 'patient' and 'caring' roles. Successful growth of the voluntary sector and the number of volunteers will also support overall health and well-being and maintaining social interaction of individuals who may be feeling isolated and yet have much to offer.

The patient population is broadly adults under and 65 years at high risk of enhanced NHS and/ or social care are the target population. This includes the frail elderly at risk of and/or suffering as a result of:

- Complex needs
- Falls
- Dementia
- Multiple long term conditions
- End of Life
- High risk of admission
- Discharged with a need for health or support care interventions

Local voluntary sector organisations will work more flexibly to identity patient populations will a level of need that, without support, would led to higher level needs from health and / or social care services.


Better Care Fund framework for July 20


05 CCG Board Aug 14 Voluntary Sector F

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:
Telford and Wrekin CCG
Telford and Wrekin Council

Provider and partner organisations:
Shropshire Community Health NHS Trust – Rapid Response, community nursing teams, specialist nurses, Single Pint of Access
Telford and Wrekin Council Cohesion Services
GP practices
Shrewsbury and Telford Hospitals NHS Trust
South Staffordshire and Shropshire NHS Foundation Trust
Council for Voluntary Services
Royal Voluntary Services
Shropshire Partners in Care
West Midlands Ambulance Service
Shropdoc
NHS 111

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There is an evidence base for the approach being taken in relation Theme 1. This is set out below.

Public Health guidance on community engagement highlights that involving communities in health-related activities improves health outcomes - getting communities involved in decisions that affect them, includes the planning, development and management of services. https://www.nice.org.uk/Guidance/PH9

Improving self-care support for long-term conditions has been a drive for some years: supports choice, links to Expert by Experience programme and raises the profile and message of self-management of LTCs.
https://www.nice.org.uk/savingsAndProductivityAndLocalPracticeResource?ci=http%3a%2f%2farms.evidence.nhs.uk%2fresources%2fQIPP%2f29520%3fniceorg%3dtrue

Kings Fund set out in 'Transforming our health care system: Ten priorities for commissioners' (2011) that active support for self -management needed to be a priority for commissioners.

In addition, the Kings Fund identified key success criteria for co-ordinated care for complex chronic conditions (2013):
- A holistic focus that supports patients and carers to become more functional,

independent and resilient (seeing the whole person)

- Building community awareness of and trust in care co-ordination programmes Effective communication based on good working relationships between members of the multidisciplinary team.
- Care co-ordination programmes should be localised so that they address the priorities of specific communities.
- Integrated health and social care commissioning can support longer-term strategies and provide greater stability

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

No money has been formally identified within the pooled budget monies for this programme. However, the CCG forecast spend £552,000 (2014/15) funding voluntary organisations. The Council expenditure forecast c£800,000.

There is a commitment to develop a pooled budget for voluntary organisations when the reviews of spending and commissioning for 2014/15 are completed. Planning is being carried out jointly with this specific plan.

Impact of the scheme is expected to contribute to:

- Reducing non-elective hospital admissions, re-admissions and length of stay.
- Reducing permanent admissions to residential and nursing care.
- Improved patient experience
- Reducing delayed transfers of care.
- Improving the effectiveness of reablement/rehabilitation services.
- Reducing emergency admissions in 65 years + age group.

It is recognised that it will not always be easy to provide direct evidence to support impacting on the BCF targets. Therefore the additional financial and not –financial benefits will also be considered (identified below)

The matrix mapping being completed by the COG for the voluntary sector will provide more clarity on the target population, level of performance, costs and outcomes for each provider. This will also clarify the levels of support provided across the four safety net levels indicated in section 2a is in the process of completing a matrix to map activity through levels of provision from prevention to acute and recovery.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The area was monitored via the BCF Implementation Plan. Following a review of the Implementation Plan monitoring process this areas will have an:

Executive/ Senior Officer lead: Liz Noakes -Director of Public Health
Project Lead: Kit Roberts BCF Lead - Telford Wrekin Council

All progress will be through the Programme Management Board. This will include

- Development and monitoring of metrics
- Feedback from COG
- Feedback from Voluntary Sector Network

What are the key success factors for implementation of this scheme?

The financial benefits of building community capacity are the identified outcomes:

- Improved levels of confidence in self-care
- Carers feeling better supported
- Enhanced Community involvement
- Growth of community engagement
- Increase in uptake of carer assessments and support services

The non-financial benefits of building community capacity are the identified outcomes:

- More people are empowered to manage their own condition
- More people are supported to meet their urgent care needs in the community
- People get the appropriate level of help when they need it
- People only spend the time in hospital that is needed
- More voluntary organisations become engaged
- More local people volunteer
- People become more aware of how they can 'self-care'
- People receiving care and their carers feel supported and confident and know where to go to, to access help and support rather than using ED services

Theme 2
ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
2
Scheme name
Integrated Enhanced Community Services
What is the strategic objective of this scheme?
The objectives of the Integrated Enhanced Community services for Telford and Wrekin as an alternative to hospital provision are: • Fewer hospital wards for non-elective care as we transfer capacity and activity into the community service. • This will strengthen the ability of hospitals to focus on patients that need hyper-acute care, for example strokes and heart attacks, and to focus increasingly on planned operations. • An Integrated community- based Enablement/Rehabilitation Service that has a full complement of clinicians and skills, including acute doctors, nurses and therapists, mental health specialists in addition to existing social care and Community health professionals able to in-reach into existing residential and social care settings. • Access to care to support people in the community • This service will operate 7 days a week. • A 'Single Referral Point' for Integrated 'Step up/Step down' with patients identified by the NHS number to facilitate better information/data sharing. • Single triage and assessment processes will be well established. This Scheme/ Theme will deliver a viable alternative to in-patient hospital care for people who can be cared for closer to home. This will build on the existing integrated community health and social care Enablement/Rehabilitation model and Accelerated Pilot by transferring capacity from the acute sector, so that we offer a viable alternative community service rather than hospital bed based care. The vision is for fully integrated delivery of care from a single point of referral; single assessment and integrated care delivery. The case for change is consistent and articulates the need to provide services which follow the patient/client; maintain people living in the community; avoid unnecessary admissions into acute sector and where these do occur, ensuring speedy, planned discharge. The discussions are now actively taking place at a strategic and operational level across all providers (acute and community provider, voluntary sector and the Council).
Overview of the scheme Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The integrated model is included within section 2a (Vision) and attached below

Through virtual integration across existing acute, community and social care an Integrated Community Enablement Team would ultimately deliver and Inreach and Outreach approach to care devliver:

- Integrated health and social care community-led team for attendance avoidance, admission avoidance and early discharge
- Home from Hospital approach to support care at home whenever aptients conditions escalte to the point of potnetial admission or enhanced care
- Case management for complex patients eg 3+ LTCs
- Virtual ward approach to target identified very high risk patients - those who are at high risk due to the number of LTCs or with a history of frequent admissions
- Enhanced medical support (eg GPwSI, Geriatrician, Specilaity Doctor) deliver community interventions, support the Community Enablement team, Team Around the Practice, provide community-based rapid access clinics and 'Interface' at AMU.
- Interventions at the 'Front Door' of the acute hospital to provide specialist assessment and interventions to avoid admission and/ or reduce length of stay

This will be deliver through phased implementation already determined:

- Phase 2 by December 2014
- Phase 3 by April 2015
- Phase 4 by June 2015

Through the phased implementation of four key priority areas that support the development of the Integrated provision, this will ensure the phases of integrated working are achieved on time and improve patient experience, reduce duplication and achieve:

- A single Single Point of Referral
- Single assessment and care planning
- Development of the Integrated Community Enablement Service (all phases)
- Integrated record

The treatment and care delivered within the integrated Community Enablement Team will in-Reach into the hospital and be one single point of access, seven days a week, for primary, hospital, ambulance, care home, mental health or social care professionals or concerned older people or carers. The team will ultimately incorporate a range of disciplines including specialist medical staff, GPwSI, nurse specialists in case management/disease management and nurse practitioners skilled in Hospital at Home interventions, therapists, rehabilitation assistants, social workers, support staff and access to night sitters. It would also include voluntary sector organisations for signposting and support as part of the integrated team.

The current Enablement Team currently includes Social Workers, Domiciliary Carers, Nurses and Therapists as an integrated service. Additional staff to form the Community

Enablement Team would be drawn from:

- Shropshire Community Trust Community Teams – District Nurses, Rapid Response Nurses, Occupational Therapists, Physiotherapists
- Early Supported Discharge Team for Stroke
- Neuro-Rehabilitation Team
- SaTH Geriatricians/ medical staff as resource is identified
- SaTH Falls Prevention and Rehabilitation
- SaTH therapists
- GPwSI
- Additional nurses and therapists
- Additional social workers and domiciliary carers
- Voluntary sector organisations

The patient population is adults under and 65 years at high risk of enhanced NHS and/ or social care are the target population. This includes the frail elderly at risk of and/or suffering as a result of:

- Complex needs
- Falls
- Dementia
- Multiple long term conditions
- End of Life
- High risk of admission
- Discharged with a need for health or support care interventions

The target population will be expanded in line with JSNA evidence and local analysis over time.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:
Telford and Wrekin CCG
Telford and Wrekin Council

Provider and partner organisations:
Shropshire Community Health NHS Trust – Rapid Response, community nursing teams, specialist nurses, Single Pint of Access
Telford and Wrekin Council
GP practices
Shrewsbury and Telford Hospitals NHS Trust
South Staffordshire and Shropshire NHS Foundation Trust
Council for Voluntary Services
Shropshire Partners in Care
West Midlands Ambulance Service
Shropdoc
NHS 111

There is significant evidence, particularly for older people, that hospital based care can have a negative impact; reducing confidence, exacerbating dementia, confusion, increasing risk of falls, and eroding levels of independence. Mental health services are in place within the acute setting to provide early assessment, advice and support. Integration to the Integrated Community Enablement service will ensure community support is maximised and, where admission to acute hospital is necessary, it is for the shortest possible duration.

Dementia Home Treatment is introducing SHIELD (Support at Home- Interventions to Enhance Life with Dementia) as a pilot. This will provide training in psychological approaches to staff within community and acute settings. Mental health services are an integral part of the BCF development as a provider and stakeholder.

Work will be undertaken in care homes to address and reduce the need for acute interventions resulting from inadequate nutrition or hydration.

With improved use of tele-health, tele- care and information technology, enhanced capacity and greater skill mixing in community services it is possible, and in line with patient feedback to offer more care out of hospital and reduce dependence on on-going care in the community.

BCF integrated model representation

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The evidence for the development of theme 2 includes:

An audit completed in 2013 which was commissioned as part of our Urgent Care Project Group 'Optimising Capacity on Discharge' highlighted that 15% of those admitted could have been treated in the community if the appropriate provision was in place. It also highlighted that 48% of patients in a hospital non-elective bed could have been supported with 'lower levels' of care in a community setting.

The local Reablement/ Rehabilitation service is multi-disciplinary. It previously included Rapid Response and local evidence indicates it was more integrated with less duplication. It delivered a single assessment and care plan process.

The Accelerated Pilot demonstrated admission avoidance interventions are achievable. There were 30 Rapid response referrals in July 2013. The Pilot started on 7th July 2014. There were 68 referrals in July 2014.

Referrals from 7th -30th July	July 2013/14	30
	July 2014/15	61
Source Of Referral	GPs	34

	CCC 7 Council 4 SaTH 6 WMAS 2
Referrals at week-end	12/13th 0 19/20th 1 26/27th 5
Average Age	78yrs
Brokering care	Admitted into nursing beds 4 New care brokered 2 Night sitting 2 Increase in the current care packages 5

Comparison of admissions shows that there was a reduction in admissions on both PRH and RSH sites. RSH was 94% of last year (2491 in July 2013; 2365 last month); PRH 89.6% of last year below.

The evidence for August shows a similar trend. Clinical staff indicate that 2- 2 ½ patients each day were people that would have been admitted prior to the Pilot being implemented.

The target population was determined from the JSNA and MCAP data carried out by the Oak Group This was cross referenced with the acute hospital, GPs, Shropdoc and community services about those who were most likely to be avoidable admissions, Making our health and social care systems fit for the ageing population *Kings Fund* 2014

Research from published studies have helped shape the integrated model including:

Community services involvement in the discharge of older adults from hospital into the community *International Journal of integrated Care* September 2013

Health and Independence- Strategic vision and implementation plan for the Shropshire Frail and Complex Service September 2012

Making integrated out of hospital care a reality *NHS Confederation* 2012

Integrated care for high risk patients using a virtual ward *International Journal of integrated Care* November 2013

Integrated care What is it? Does it work? What does it mean for the NHS? *Kings Fund* 2011

Community Services How can they transform care *Kings Fund* 2014

Integrating services without structural change *BMA* 2012

Safe compassionate care for frail older people using an integrated care pathway *NHS*

2014

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Schemes identified within Tab 3 relate to this Theme. Funding from

- Rehabilitation and Reablement
- Support for carers
- Supporting Transformation
- Integrated Enhanced Community Service

contribute to existing services through 2s56 agreements or NHS contracts with the acute or community service providers. The intention is that services will virtually integrate.

Financial benefits for 2013/14: 430 admissions reduced.
This supports the use of the Transformation monies in reducing avoidable admissions and the creation of funding to develop community services.

Financial benefits for 2014/15 are summarised below:

Level of reduction of admissions	Number of admissions	Rationale for Figure	Impact on Scheme
3.5 %	564	Payment for Performance	If achieved can be utilised for community services; if not will fund acute services
5%	805	3rd Temperature Check projection of reduction in activity	Potential reduced community capacity to develop community services. Insufficient reduction to enable acute to reduce fixe costs. Recognise challenge to reduce admissions against previous trend of increases.
7%	1260	Target based on 15% reduction in avoidable admissions of 65+ within April 2014 submission, previous modelling and within the 2-5 year plan	Total £3m contribution to the pooled budget. Potential for acute service to reduce fixed costs.

The target of 1260 has been the focus throughout the development of the Frailty model development and then BCF Integrated model. While recognising the challenges this remains the ultimate goal for community services: 5 reduced admissions a day; 1 ½ reduced admissions a week from each GP practice over baseline activity. Monitoring against target and ensuring community capacity will be carried out through the Programme Management Board.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

A Programme Management Office will oversee the performance of the Programme as a whole through monthly Programme Management Board weekly work-stream meetings.

Identified work-streams for the four specific areas of development will report monthly. Each area and key outcome has an CCG Executive or Council Assistant Director sponsor and project lead to ensure progress:

- A single Single Point of Referral
- Single assessment and care planning
- Development of the Integrated Community Enablement Service
- Integrated record

Accelerated Pilot data is analysed and shared monthly.

Performance reporting for the BCF targets is already takes place. This will continue on a monthly

Two-monthly reporting to the Strategic Commissioning Group takes place and will continue. Formal reporting processes to the Council and CCG are also in place

Further development of the reporting on financial and non-financial benefits will also take place.

What are the key success factors for implementation of this scheme?

The six performance measures (detailed in Template 2) will be used to monitor progress through the Programme Management Board and work-streams :

- Reducing non-elective hospital admissions, re-admissions and length of stay.
- Reducing permanent admissions to residential and nursing care.
- Patient experience
- Reducing delayed transfers of care.
- Improving the effectiveness of reablement/rehabilitation services.
- Reducing emergency admissions in 65 years + age group.

In addition further financial and non-financial benefits and outcomes have also been identified. Additional financial benefits are:

- Reduced unnecessary emergency admissions *by 15-25%*
- Reductions in hospital admissions

- Reductions in zero length of stay
- Reductions in 1-5 day length of stay
- Reductions in excess bed days in acute hospitals
- Reductions in admissions to care/nursing homes from hospital
- Reductions in admissions due to falls/falls in hospital
- Reduction in need for longer episodes of more intensive care.
- Reduced delayed transfers of care
- Maximising flow through enablement, monitoring periods of intervention, which may be less than 6 weeks, to maximise capacity of the service.
- Reduction in domiciliary care packages or reduce the rate of cumulative costs increase
- Improved, expanded and effective support services facilitating more people in independent living
- Delayed admission to residential care/nursing home care
- Fewer avoidable admissions through better management of long term conditions
- Increased access to community based activities that support overall health and well-being

Non-financial benefits are:

- People are enabled to recover and regain their independence
- Reduced duplication, through single points of access, assessment and potentially, intervention.
- Improved transfers of responsibility of care – 'passing the baton', ensuring a smoother and more coordinated journey.
- In-reach to care settings to reduce admissions to acute setting
- Better end of life care experiences, with more people able to die in a place of their choice
- Improved patient experience of the quality of care received
- Improved end of life care outside hospital
- Reductions in admissions due to falls and long term implications of falls
- Achieving cultural change within our community, encouraging and supporting self-help and self-care
- Increased engagement of volunteers
- Maintaining people in employment longer

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Telford and Wrekin
Name of Provider organisation	
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	17277
	2014/15 Plan	15889
	2015/16 Plan	13661
	14/15 Change compared to 13/14 outturn	-1388 (-8%)
	15/16 Change compared to planned 14/15 outturn	-2228 (-14%)
	How many non-elective admissions is the BCF planned to prevent in 14-15?	430
	How many non-elective admissions is the BCF planned to prevent in 15-16?	1260

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD

24th SEPTEMBER 2014

HEALTHWATCH TELFORD AND WREKIN ANNUAL REPORT

REPORT OF KATE BALLINGER: MANAGER: HEALTHWATCH TELFORD AND WREKIN

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

The report provides an overview of the work undertaken by Healthwatch Telford and Wrekin in its first year.

2. RECOMMENDATIONS

The Board is invited to receive and note this report and the full annual report attached.

2. IMPACT OF ACTION

- To keep the Health and Wellbeing Board informed of the progress of Healthwatch Telford and Wrekin
- Increase public awareness of Healthwatch Telford and Wrekin
- Increase public involvement in decision making in Health and Social Care in the borough.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	*All*
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	Yes	*All*
	Will the proposals impact on specific groups of people?	
	No	*N/A*
TARGET COMPLETION/DELIVERY DATE	*N/A*	
FINANCIAL/VALUE FOR MONEY IMPACT	No	*None*
LEGAL ISSUES	No	*None*
EQUALITY & DIVERSITY	No	*None*
IMPACT ON SPECIFIC WARDS	No	*Borough wide impact*
PATIENTS & PUBLIC ENGAGEMENT	Yes	*Range of events throughout the year*
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	*None*

PART B) – ADDITIONAL INFORMATION

1. INFORMATION

The annual report of Healthwatch Telford and Wrekin shows the development of the organisation from its commencement in April 2013 to March 2014 and details key activities and core support given to the local community within the Borough.

During the year there were several elements which have developed the service provided, these include:

- Recruitment of Healthwatch Board
- Recruitment of volunteers
- Establishment of Enter & View policy and training programme for volunteers
- Increasing awareness of Healthwatch among the public and professionals

The annual report (see attached) was written to guidelines produced by Healthwatch England and has been distributed in accordance with their instructions

Update on Healthwatch Activity April – August 2014

Since production of the annual report, Healthwatch Telford and Wrekin have:

- Completed Enter & View training for 9 Authorised Representatives
- Carried out 6 Enter & View visits to Social, Primary and Secondary Care providers and gathered patient and carer feedback on service provision. The first of these reports will be published with the papers for the October Healthwatch Telford and Wrekin Board meeting.
- Engaged with 1952 members of the public at events across the borough
- Contributed to both Future Fit and Better Care Fund work programmes, and ensured that the public events in the borough have been proportionate to population size
- Escalated 4 public concerns – 2 to Adult Safeguarding, 1 to National Health Service England local area team and 1 to Healthwatch England
- Published a report into Phlebotomy services in the borough which is being integrated into a review by both Clinical Commissioning Groups of phlebotomy services across Shropshire/Telford & Wrekin
- Taken part in the Review of the Modernisation of Mental Health Services

Healthwatch Telford and Wrekin are currently developing projects in CAMHS and Autism, Mental Health Services, Sexual Health Service uptake in young people, and in collaboration with other local Healthwatch, access to GP

appointments. We will report back to the Health and Wellbeing Board upon completion of the projects.

2. BACKGROUND PAPERS

Healthwatch England annual report guidelines

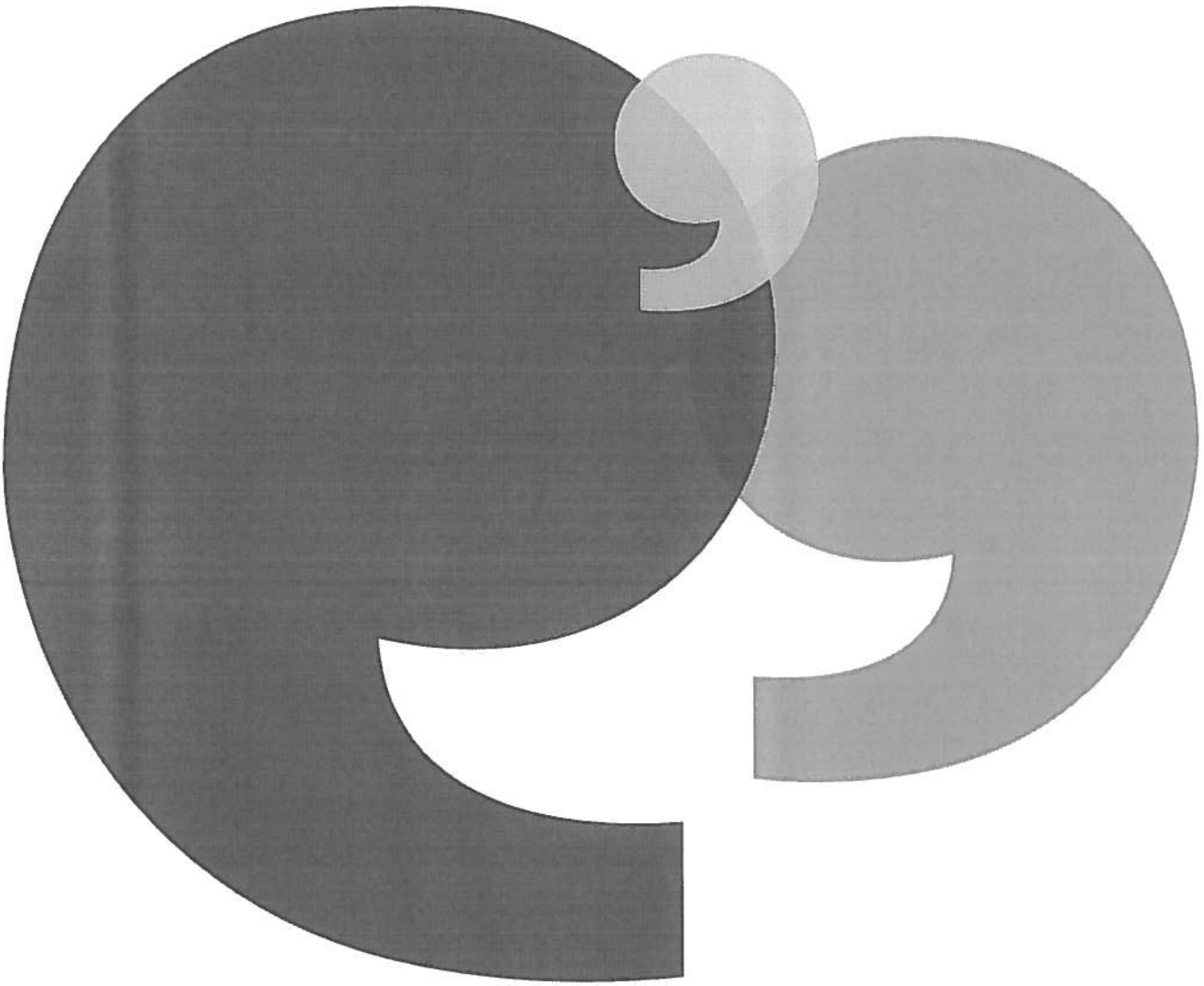
Healthwatch Telford & Wrekin Annual Report 2013 – 14 (see attached)

Report prepared by Kate Ballinger, Manager: Healthwatch Telford and Wrekin, Telephone: 01952 739540

PARKWOOD HEALTHCARE

healthwatch Telford and Wrekin

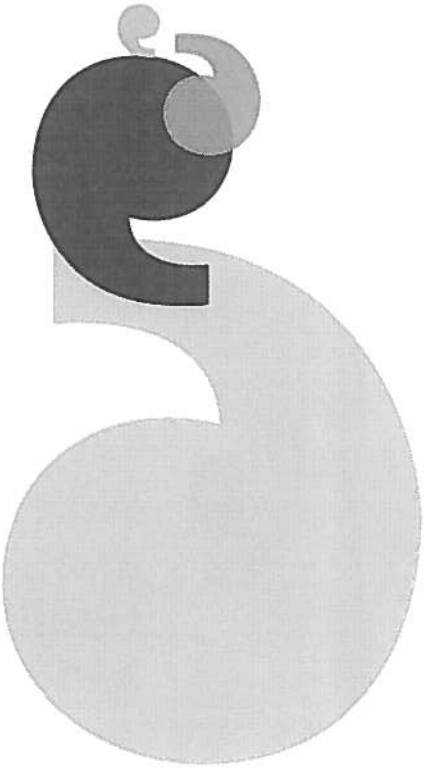
Healthwatch Telford and Wrekin
Annual Report 2013/14



Any enquiries regarding this publication should be sent to us at info@healthwatchtelfordandwrekin.org.uk

You can download this publication from www.healthwatchtelfordandwrekin.org.uk

PARKWOOD HEALTHCARE



Contents

Foreword from our chairs

Welcome to the first annual report of Healthwatch Telford and Wrekin.

This document provides an account of the development in our first year for our statutory partners, for our partners and providers in the National Health Service and local government, and for the local voluntary and community sector and "network of networks".

This report is also for our diverse and growing community in Telford and Wrekin, including all who use the wide variety of local health and social care services.

Healthwatch Telford and Wrekin was established in April 2013 in partnership with Telford & Wrekin Council and Parkwood Healthcare Ltd, and replaces the former Telford and Wrekin LINk service. Healthwatch is part of a series of significant reforms in the way local health services are delivered.

"Under the health and care reforms, local authorities will be given greater responsibility for improving the quality of health and social care outcomes at a local level. One way of achieving this is through the better integration of local health and care services. Health and Wellbeing Boards and local Healthwatch both have a key part to play in delivering this outcome."

The introduction of Healthwatch by the Health and Social Care Bill 2011

Introduction

Healthwatch organisations have been introduced to give local people greater influence over their health and social care services, and to support individuals to access information about the increased choices available to them under the reforms.

Local experience shows that people don't always know who they can tell about their experiences, their concerns, or their compliments, nor do they know what difference it will make if they do speak up. It isn't always clear where people can get help if they can't find information, or if they need to make a complaint. There is a wide variety of voluntary as well as statutory organisations that help people, but finding them, and using their services, can sometimes be difficult and confusing.

Healthwatch Telford and Wrekin provides local people with a single point of contact. We put people in touch with the right advocacy organisations or help them find information about the choices they have. We support people to speak out and can give those who want to be involved the opportunity to do so.

Healthwatch Telford and Wrekin is a developing, learning, and listening organisation - its roles include information and advice, signposting, patient and community engagement, Enter & View, intelligence, trends and evidence, representing and influencing. Healthwatch exercises certain statutory powers such as Enter & View. We are community-based and aim to make a real difference in the quality and local delivery of health and social care services.

Jane Chaplin, David Bell

Joint chairs, Healthwatch Telford and Wrekin

Foreword from Richard Overton

NHS services seem to be constantly under review. Demand for services is increasing due to an ageing population and changing lifestyle trends, and this is putting pressure on services at the same time as local authority budgets are being dramatically reduced.

Most of us experience excellent NHS and social care, but people might be worried about how services are changing and do have concerns about their or their families care.

That's why Healthwatch Telford and Wrekin has such a vital role. It's an independent voice of the community, listening to all your views and experiences, good or bad, and using them to challenge those in charge and helping to shape future services.

"They're an independent voice of the community"

Richard Overton, Health and Wellbeing Board chair

Our mission and values

We strive to be...

inclusive
focussed
challenging
independent
caring
listening
representative

Our mission:

"To make health and social care services in Telford & Wrekin as good as they can be...

...by holding public engagement events."

...by informing people where to go for help."

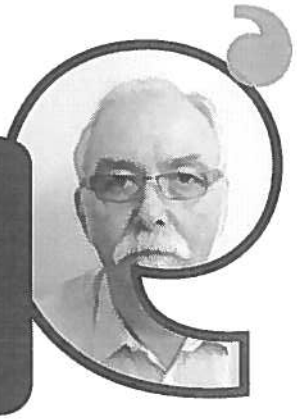
...by sharing the views of the public in Telford and Wrekin with decision makers to drive change."

...by keeping the people of Telford and Wrekin at the heart of decision making."

...by reacting to concerns raised by the public in Telford and Wrekin."

...by making informed and evidence-based judgements about the quality of local services."

Our roles: explained



Given the amount of change that both health and social care services are going through at the moment, our role becomes increasingly important.

Martyn Withnall Director, Healthwatch Telford and Wrekin

Signposting

Signposting is an essential part of the service provided by Healthwatch Telford and Wrekin. Our staff and volunteers are trained to listen carefully to the issues brought to us and use their knowledge and experience to direct people to the most appropriate service.

We work with a range of local voluntary and statutory organisations to ensure that the information we have is up to date and relevant.

Patient & community engagement

We hold regular engagement events throughout the year and are continually looking for ways to engage with hard-to-reach communities across Telford and Wrekin. We use these events to raise the profile of Healthwatch and to gather information about specific issues where appropriate; we share our programme of events widely, and we invite other organisations to accompany us where appropriate.

Influence & making a difference

Healthwatch Telford and Wrekin uses the information gathered from local people to influence decision makers. We are able to give a voice to seldom heard groups and individuals in discussions about services that affect them.

Representation

We are asked to represent the public of Telford and Wrekin in a number of meetings throughout the local area. These include:

- Maternity Service User Group
- Better Care Fund Programme Board
- Future Fit Programme Board
- Carers Partnership Board
- Local Health Economy Steering Group for Dementia
- Dementia Providers Forum
- Future Fit Officer Group
- SaTH Meeting
- Healthwatch Shropshire
- Joint Health Overview Scrutiny Committee
- Scrutiny Committee
- Health Roundtable
- Adult Safeguarding Board Engagement Workgroup
- Pharmaceutical Needs Assessment T&W Working Group
- Health & Wellbeing Board
- CQC LA liaison Meeting
- Quality Surveillance Group
- PALS network Meeting
- Urgent Care Transformation Board
- Local health Economy Engagement Network
- Winterbourne View Review Meeting
- Primary Care Joint Commissioning Board (NHS local area team)

Introduction

Looking forward to Enter & View and putting all my training into practice.

Janet O'Loughlin Healthwatch Champion

Enter & View

Enter & View is a vital part of the work carried out by trained authorised representatives of Healthwatch Telford and Wrekin.

Our authorised representatives go into health and social care services to speak to patients, service users, their families, and their carers about their experiences, and produce reports with recommendations for service providers and commissioners.

We can use our statutory power to 'Enter & View' any publically funded health or social care premises, with the exception of children's social care facilities.

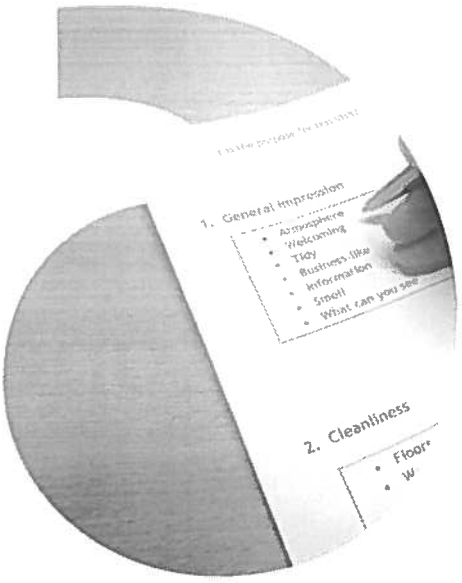
Our work in this area is planned by an Enter & View committee which includes four volunteer authorised representatives. We are currently working on planned Enter & View activity, looking at Dignity and Respect in dementia facilities, alongside more reactive visits which stem from concerns raised by members of the public, commissioners, and service providers.

Gathering intelligence & trends

One of the primary objectives of Healthwatch is to identify areas of public concern before they escalate into serious incidents.

To do this, we have a specialised database where all the information received by Healthwatch Telford and Wrekin is recorded, together with key issues from meetings attended and publically available information relating to the local area.

We are able to interrogate the database to identify the most common areas of concern, and the board uses this to prioritise the work areas of Healthwatch Telford and Wrekin.



First year milestones

Establishing Healthwatch

Since 1st April 2013, Parkwood Healthcare has provided support services to Healthwatch Telford and Wrekin, thereby allowing it to conduct its work as an independent champion of health and social care. Parkwood Healthcare has extensive experience managing Healthwatch organisations and currently provides support services to six Healthwatch contracts across the country.

Mark Lambourne Operations Manager, Parkwood Healthcare

The HWTW staff team consists of:

Kate Ballinger, who was the first patient representative on the Telford & Wrekin Clinical Commissioning Group.

Cat Pert, who has been involved in community engagement within Telford for four years.

Matt Lever, who joined following a career specialising in media and communications.

Chris Hancock, who originally took on administrative duties but is increasingly involved with community engagement.

Like many other Healthwatch organisations, our first year of operation has been challenging, with a significant amount of resources spent on:

- Intensive outreach to get the name of Healthwatch out into the community
- Continual review of the operating methods to ensure that we accurately measure what we achieve
- Establishing the governance structure and policies

One of the best examples of where HWTW has had a positive impact on care provision has been the development of a comprehensive report on the provision of phlebotomy services in Telford, which will assist the CCG in understanding the concerns surrounding the provision of the service, based on patient feedback that has been obtained through the Healthwatch network.

This intricate report has indicated just how powerful Healthwatch can be, and is a clear demonstration of the effectiveness of Healthwatch Telford and Wrekin.

Our relationship with Telford & Wrekin Council

Healthwatch Telford and Wrekin has a formal, legal relationship with Telford & Wrekin Council because the council is responsible for commissioning and managing the Local Healthwatch contract.

Beyond this, we are developing relationships both at governance and operational levels to provide mutual support in relation to carrying out our functions as an authoritative and representative voice of health and social care users and the public.

The council recognises the important role played by Healthwatch Telford and Wrekin in ensuring more local people are involved in giving feedback which supports the planning and running of health care services, in line with its 'Co-operative Council' approach.

Launch event

Healthwatch Telford and Wrekin officially launched at The Place, Oakengates on 24th October 2013.

More than 120 people attended from the public, voluntary sector, statutory bodies and providers, and were invited to browse market stalls from other voluntary sector organisations during "down time" in the programme.

Following addresses from Dag Saunders, former Chair of Healthwatch Telford and Wrekin, and Susan Robinson, Development Manager for Healthwatch England, the audience was shown the launch video; a collection of interviews with Healthwatch volunteers and staff, the Clinical Commissioning Group, Telford and Wrekin Council, and Shropshire Community Health (representing providers in the borough).

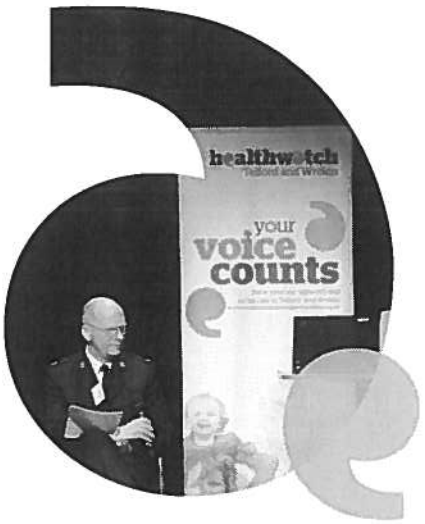
"Service users etc. should be involved in re-inventing services"

"The sense of commitment from Healthwatch to get out and meet people to listen to their point of view"

"Useful comments - good understanding of how Healthwatch is going to work. Enjoyed the open mike session"

Quotes from launch attendees

The audience was treated to a performance of The Stolen Heart by Kaleidoscope. This was the highlight of the morning for many of the audience, who found the performance thought provoking and a fantastic forerunner to the table top discussion about what the most important health and social care issues are for the people of Telford and Wrekin.



The morning concluded with an onstage discussion between Dr Mike Innes, Chair of Telford and Wrekin Clinical Commissioning Group, Councillors Arnold England and Richard Overton, and the KIP project, represented by Major Julian Rowley.

"I get used to waiting... Sometimes it's hours."

One of the comments that inspired the survey

Our first project - phlebotomy services

Following concerns raised by members of the Diabetes UK group at Princess Royal Hospital, Healthwatch Telford and Wrekin carried out a survey to establish patient experience of phlebotomy services both at the hospital and at their GP practice.

We received more than 130 responses from the public and simultaneously completed a survey at each of the GP surgeries in Telford and Wrekin.

The results of this work are currently being discussed with both the hospital and the Clinical Commissioning Group and it is hoped that by putting patient experience at the centre of commissioning decisions, the service in Telford and Wrekin will improve.

Where we have influenced change

Where we have influenced change

I had wonderful care throughout pregnancy, labour and after my baby was born. I was able to spend a few days recuperating at the Wrekin Maternity Unit after leaving Shrewsbury and received great support from all the staff.

Service user quote from the Maternity Services Review

Maternity Services Review

Healthwatch Telford and Wrekin was invited to sit on the programme board for the Maternity Services Review in June 2013. Together with Healthwatch Shropshire, we ensured that patients were at the heart of the review.

HWTW took an active role in the Service User Engagement workstream, offering an independent space for people to voice their experiences. This was particularly useful when speaking to a group of new mums in Woodside, where HWTW was able to gather additional service user comments which may otherwise have been lost.

HWTW continues to monitor the progress of recommendations made in the report which is available at: http://www.telfordccg.nhs.uk/search/Text%20Content/maternity-services-review-1913

New Options

One of the first invitations HWTW received was from a group of parent carers of adults with learning disabilities, who were concerned about the provision of respite care in Telford and Wrekin following the closure of Lee Court.

After raising these concerns with commissioners, HWTW was invited to take part in a broad consultation about in-house services provided by Telford & Wrekin Council. The "New Options" consultation involved service users, family and carers, and shared lives carers in different events across Telford. HWTW was able to listen to a wide variety of concerns, including those originally raised by the parent carers we spoke to in May and increased our awareness of the services available and the needs of this community.

Healthwatch again provided an independent space for individuals to voice their experiences, and established ongoing relationships with some of the most vulnerable members of the local population.

Call to Action

Telford & Wrekin CCG joined forces with Shropshire CCG to hold a Call to Action Conference in November 2013.

Healthwatch Telford and Wrekin were involved in the pre-publicity for the event. We raised awareness of the event through social media, our newsletter, and website. The event was attended by more than 250 people from across Shropshire/Telford & Wrekin.

It was disappointing that the public numbered only 36 on the day, but HWTW, through staff and directors, was able to take part in table top discussions and raise issues communicated to us by the public of Telford and Wrekin.

Where we have influenced change

NHS FutureFit

First the Call to Action, then the Clinical Services Review, then the Excellent and Sustainable Acute and Community Hospital Services Programme Board, and now FutureFit.

HWTW has a seat on the programme board, the engagement and communications work stream, the assurance panel and several of the clinical work streams. This is a major project in the local area and it is essential that the voice of people in Telford and Wrekin is heard. HWTW has been able to increase the opportunity for Telford residents to take part by not only increasing the number of public meetings held in the borough, but also by suggesting the use of teleconferencing to allow meetings to be held in different locations simultaneously.

HWTW continues to champion the use of plain English in communications from FutureFit to the public.

Blue Butterfly Scheme

Following an initial discussion at the Local Health Economy Steering Group for Dementia, HWTW was able to use the Healthwatch network to research the use of symbols to identify patients with dementia across the country. The information we received was presented to the group and was part of the decision to recommend the adoption of the scheme locally.

This has been progressed throughout the health economy and was recently launched in Shrewsbury and Telford Hospital Trust.

Healthwatch Telford and Wrekin would like to congratulate the Trust on their recent third prize for Innovation in Dementia Care by the Royal College of Nursing (RCN).

HWTW has planned a series of Enter & View visits throughout the area to explore Dignity and Respect in Dementia Care, and reports will be available on our website.

Working Together

Healthwatch Telford and Wrekin was involved in the T&W Working Together event at The Place, Oakengates in September 2013. We worked with commissioners and other voluntary sector organisations over the summer and used social media and our website to promote the event.

Winterbourne View

HWTW was invited to join the Winterbourne View Programme Board in summer 2013. We provided an independent, safe space for individuals to raise concerns at the "Getting it Right" event in February 2014, and continue to encourage adults with learning disabilities, their families and carers to raise concerns with Healthwatch.

Gathering the views of local people

Gathering the views of local people

Community Engagement

We aim to include the local community in our work and proactively create opportunities for everyone to engage and participate.

Tanya Love Equality and Diversity Champion

Since Healthwatch Telford and Wrekin was launched, the priority has always been meeting patients, service users and carers face-to-face to find out how services are meeting people's needs across Telford and Wrekin. Over the year we have worked hard to ensure that people from all different backgrounds have the opportunity to have their say and be heard. This vital work is underpinned by a number of core values such as being widely recognised, inclusive, visible, collaborative, and independent.

Since April, HWTW has carried out 356 engagement activities that have been supported by a mix of staff and volunteers.

These activities consisted of:

- 38 events where we have directly engaged with patients through face-to-face contact around the county
- 103 volunteer meetings and training events to build our volunteer workforce and create sustainability
- 66 introductions and presentations to other organisations on Healthwatch and the role it has, enabling greater awareness and giving organisations the opportunity to sign-post patients to us
- 149 instances where we have represented patients, service users and carers at formal meetings and forums

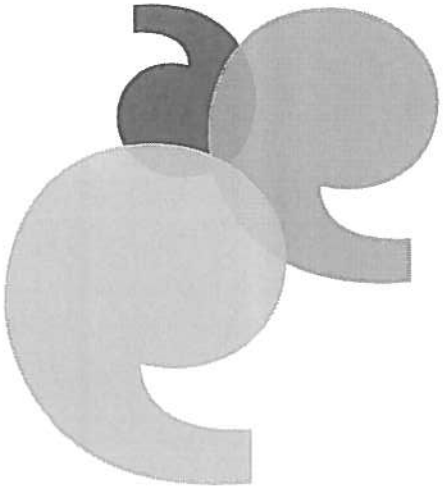
HWTW has used a wide range of engagement methods to demonstrate our understanding and commitment to equality and diversity issues at all times. We have maintained from the outset that we are an independent 'safe space' that is accessible to anyone who wants to come and talk to us, and one of the ways that we have shown this is by having specific easy read versions of our literature. We also have an 'Equality and Diversity Champion' who has spent a lot of time working with us to ensure that our physical and online forms are as accessible as possible for everyone.

Part of our engagement strategy is to become a 'friendly face' within the community and we have done this by developing an ongoing presence at key sites at regular intervals throughout the year, so the Healthwatch brand is instantly recognisable to the public.

These sites are:

- Telford Town Centre (where we have a quarterly stall)
- Princess Royal Hospital Friends cafe (where we have a stall on the first Friday of every month)
- Asda Donnington Wood or Asda Telford town centre (we alternate with monthly stalls)

Gathering the views of local people



Through this work, we are able to talk to a range of people from the 'working well' (people who may not use NHS services currently) to people who have long term conditions, and have ongoing interactions with services.

Our office is centrally located and we encourage people to 'drop in'. We carry out our engagement activities on evenings and weekends - as well as during office hours - to be as accessible as possible.

To build up a full picture of service provision we talk to patients, service users, families, carers and staff to gather intelligence and people's experiences. We also signpost anyone who asks for further information on a service or to help find a service to support them.

Through our work over the last 12 months we have met our main outcome from the community engagement strategy, which was to create:

"Greater patient and public involvement in health, social care and other associated services."

We have done this by:

- Increasing our membership through proactive engagement
- Actively recruiting new volunteers through activities, as well as retaining and re-training some of the Telford and Wrekin LINk volunteers
- Holding specific recruitment events for volunteers
- Delivering training sessions to volunteers in order to support the engagement strategy
- Utilising social media to engage with a wider audience
- Ensuring that we go to patients, rather than expecting them to come to us
- Holding mini publicity campaigns through local newspaper and radio, in particular around issues such as phlebotomy services and the new maternity services coming across to the Princess Royal Hospital
- Investing in promotional materials to build up the HWTW branding portfolio which include leaflets and 'give-away' items specifically to use at engagement events
- Building a strong local network through the HWTW membership to raise awareness and promote continual dialogue through the sending out of e-bulletins, newsletters and relevant news articles
- Giving notice of public meetings through local press

Speak out

"Big thank you to all the team of Ward 16 Acute Stroke PRH for all their care, kindness and support."

"My daughter was fast-tracked through the triage service in the A&E department and it saved her eye. Please pass on the praise to the A&E nursing staff."

Just two of the many comments we've received from service users via our Speak Out forms

Getting people to talk about the quality of care they have received is what we're all about. We need to know what the public think and feel about health and social care services if we are to represent their interests at the various meetings we attend, and it's the evidence we need to decide where our authorised representatives should conduct an Enter & View visit.

While we are constantly listening out for people's thoughts and experiences wherever we go, we have two key methods of gathering them: the Speak Out section on our website, and the similarly-titled forms we designed and produced in September 2013.

The forms are particularly valuable. We take them with us to all of our engagement events, various organisations have kindly offered to hand them out for us, our volunteers distribute them to people they know, and we have made efforts to have them provided for patients at GP surgeries and other health and social care premises.

The net result of these efforts has been 49 completed forms handed back to us, each one telling stories of good and not-so-good experiences. An additional 19 Speak Outs were sent to us through the website.

But we don't stop with just Speak Out forms and website submissions. We proactively trawl the Internet, visiting such websites as Patient Opinions and NHS Choices to see what people are saying about local services there, and we note down your thoughts whenever they are expressed to us in person.

All of these thoughts, opinions, stories, and experiences are entered into our database - in our first year of operation, we recorded 362 individual issues from members of the public.

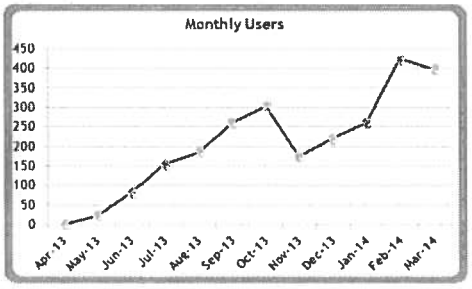
Database

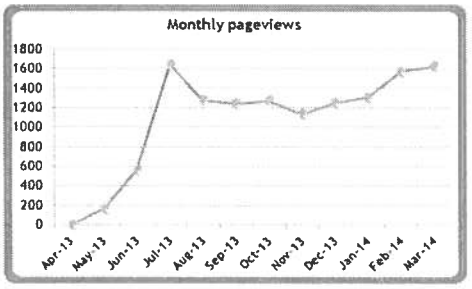
Healthwatch Telford and Wrekin uses the bespoke Healthwatch Database, developed and maintained by Parkwood Healthcare Ltd.

Installed in August 2013, the Healthwatch Database is an essential tool that hosts all of the information we need to do our work. It's tailor-made for Healthwatch use; built around the coding matrix supplied by Healthwatch England, it allows us to effectively classify the issues we receive from members of the public, and then generates reports from those which highlight trends in different services across the region. Secure and robust, it also stores details about our members, as well as keeping track of the content and status of any signposting requests we receive.

Many of the statistics in the annual report were drawn straight from the reporting system of the database, a facility which is also essential for producing the figures for our contract monitoring meetings with Telford & Wrekin Council.

Website and social media





When our website went live on May 22nd 2013, we were visited by just three users, with just 22 page views. Since then, www.healthwatchtelfordandwrekin.org.uk has been visited by over 2,200 people more than 13,000 times. With the successful implementation of the newer, fresher design at the end of December, these figures have continued to grow steadily.

The site offers people a variety of ways to get in touch with us, not limited to just the Contact Us page. Our Speak Out page is a quick and easy way to submit views on health and social care services to us, and it was visited 375 times. Meanwhile our Get Involved page is the simplest way for tech-savvy people to express their interest in volunteering with us, and some of our most valued volunteers were first introduced to us that way.

But it's not just about getting in touch with us. Many people were curious to learn about our staff on the Meet the Team page, viewing it more than 680 times, and a similar number wanted to find out about our board directors. Our About Us page, on the other hand, provides an easy-to-digest overview of what Healthwatch Telford and Wrekin does, and it was viewed 777 times.

In addition, our website is one of the most useful tools at our disposal when it comes to supporting our projects. The phlebotomy survey page, as an example, was viewed 422 times - and generated 40 responses, which is just over 30% of the total responses we had. A good chunk of people who attended our launch event signed up through the website too, and we've used it to help local organisations promote their community events.

We can use the stats from our website to get a feel for what kind of technology is available to the people who are interested in us, too. For example, we now know that roughly 20% of our visitors prefer to view the site on a mobile phone or tablet, instead of on a desktop computer.

Looking ahead, the newly-launched Enter & View hub promises to help expand the value of our web portal even further, and we plan to continue using it to provide interesting content and support our future projects.

I created our Twitter account while at the Healthwatch England conference in 2013. To have gathered more than 500 followers in just 10 months is fantastic and we are keen to expand our use of social media to make sure we are engaging with as many people as possible.

Kate Ballinger Manager, Healthwatch Telford and Wrekin

Social media

Social networking platforms have been a key part of our online presence. In our first year on Twitter, we composed 890 tweets and attracted 554 followers. On top of that, we were mentioned 215 times - which could potentially have been seen by over 326 thousand people.

While these statistics are important, the main reason Healthwatch Telford and Wrekin maintains a social networking presence is to offer yet another way for people to talk to us, and in that regard it has worked very well. We've made connections with local organisations, spoken to members of the public on Twitter about their thoughts and experiences, and we've even recruited a couple of volunteers directly through the platform.

It's also been a key driver of traffic to our website, responsible for some 297 referrals - second only to Google searches and direct visits. We've used it to promote our projects and events, as well as share important news with our followers.

As time goes on, we hope to tailor our feed to better engage with the community and reach even more people.

Who are our members?

Board of directors

Our board members provide Healthwatch Telford and Wrekin with strategic direction, deciding what our priorities will be and what projects we should undertake.

All of the members of the board - also known as directors - are volunteers who bring a wealth of knowledge and experience to the team.

The board was formed with 10 members initially, but as the year progressed we had to say goodbye to a number of them. We now have four directors, with two joint chairs taking over from Dag Saunders, our former chair.

Healthwatch Telford and Wrekin would like to say thank you to Dag Saunders, Christine Choudhary, Paul Wallace, Keith Norton, Muriel Fellows and Jeevan Jones for their contributions to the establishment of Healthwatch Telford and Wrekin.

From left to right...

David Bell
Joint chair

Jane Chaplin
Joint chair

Tina Jones
Director

Martyn Withnall
Director

Volunteers and subscribers

> Healthwatch has given me my confidence back through training and the support from the staff.
>
> Janet O'Loughlin Healthwatch Champion

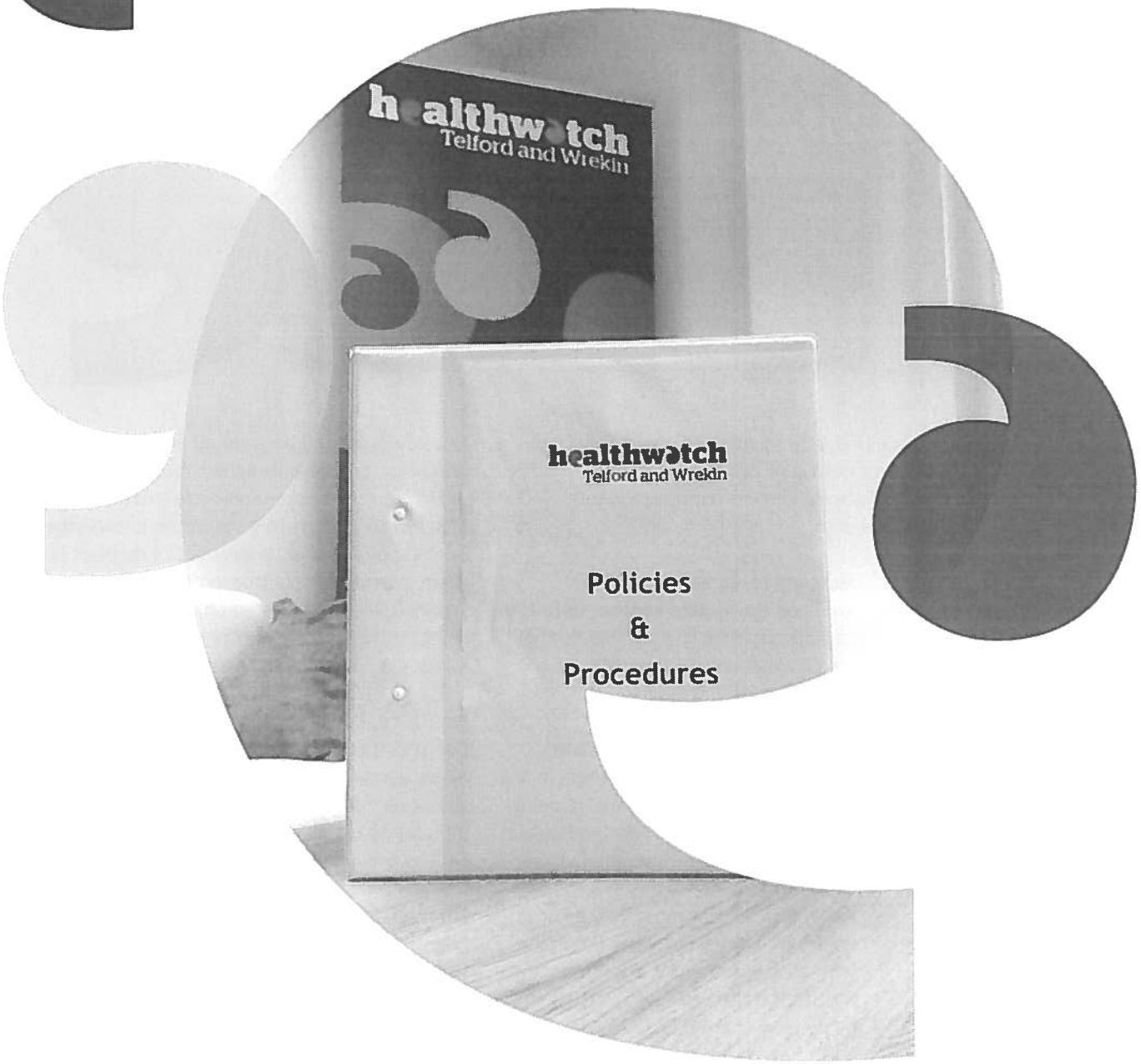
In our first year of operation, we collected the contact details of 292 individuals and organisations who were interested in Healthwatch.

- **Mapping (organisations): 78**
  We keep up-to-date contact details of various organisations on file, so that we can keep in touch with them or signpost people to them.
- **Mapping (individuals): 15**
  People who have been volunteers, may wish to become volunteers in the future, or simply people we've come into contact with and received details for, are filed under 'mapping'.
- **'Activators': 46**
  Activators are our most active volunteers. They regularly help us with all kinds of work, from manning our stalls at engagement events, to being fully-trained Enter & View authorised representatives.
- **'Involvers': 18**
  Involvers are our 'occasional volunteers' - they are keen to be a part of Healthwatch and help us when they can, but can't devote as much time as activators due to other commitments.
- **'Investors': 135**
  These members receive our newsletter, and may possibly be interested in volunteer work on an *ad hoc* basis in the future.

Our volunteers come from all walks of life and, like the board directors, bring a variety of skills to the table - some are experts at office work, others have in-depth knowledge of NHS policies and procedures. A number of them previously volunteered for Telford and Wrekin LINk and transferred over to HWTW, bringing their previous training and experience along with them.

HWTW couldn't function without volunteers. Our staff team is too small to be everywhere at once, and it's imperative that our volunteers are well-trained, kept busy with interesting work, and that they feel valued. As well as providing a comprehensive and free training programme that is available to all of our members, we hosted an informal Christmas party for our volunteers in December 2013 as a small way of saying "thank you".

To those people who have expressed a desire to receive it, we send a bi-monthly newsletter. This bite-sized publication details our most recent activities and successes, as well as any future events or training programmes that might be of interest.
We hope to continue recruiting and training volunteers, and we plan to host another get-together to say "thank you" again at some point in the near future.


healthwatch
Telford and Wrekin
healthwatch
Telford and Wrekin
Policies
&
Procedures

Governance

Governance

Following its establishment in 2013, a chairperson and board members were recruited to become directors of the company.

Directors were selected with relevant skills and to reflect the community of Telford and Wrekin.

The board has held regular, open and public board meetings together with workshops and away days and other meetings to set the strategic direction of Healthwatch Telford and Wrekin.

The board holds regular contract meetings with Telford & Wrekin Council and with Parkwood Healthcare to ensure its required outcomes are met. The board planned the public launch of Healthwatch in October 2013 at The Place in Oakengates, Telford.

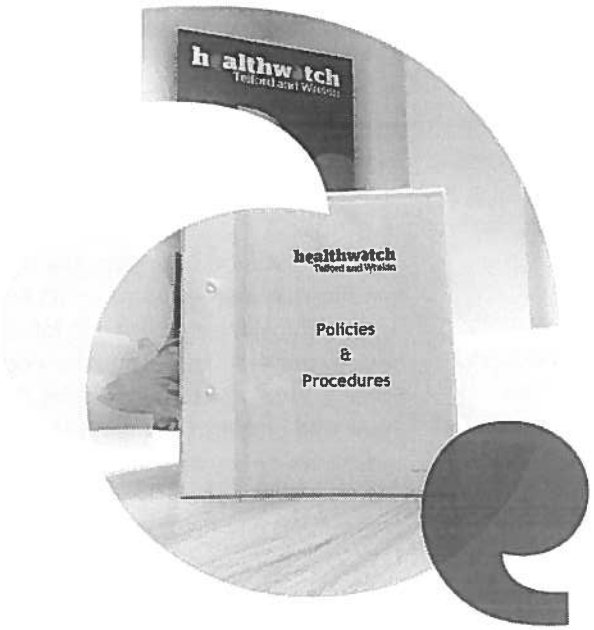
Like all new organisations, the early stages of the development of Healthwatch Telford and Wrekin have been challenging, and the board has recently met with its key stakeholders to review progress and agree its future direction. The board is engaged in a work programme to establish the organisation as a fully independent entity, working co-operatively with the local authority and all parts of the NHS and social care but with a vigorous, independent voice and to be challenging - basing its views on the evidence from consumers and service users.

In 2015 the board will be responsible for the total management of Healthwatch Telford and Wrekin and its staff team, and for delivering on its priorities agreed with its stakeholders and all sections of the community in Telford and Wrekin.

The board will be strengthening its membership and focussing on its key roles to work with partners to provide information and advice, patient and community engagement, Enter & View visits, and to bring community views and concerns to main providers and to those making key decisions on the shape and quality of future health and social care in Telford and Wrekin, Shropshire and beyond.

Policies and procedures

Healthwatch Telford and Wrekin has agreed the following policies, copies of which are available from the office and online:



- Advocacy
- Charging Guidelines
- Code of Conduct
- Complaints
- Conflict of Interest
- Data Protection
- Database
- Decision Making
- Enter and View
- Equality and Diversity
- Escalation
- Freedom of Information
- Information Governance
- Lone Working
- Marketing and Campaigning
- Safeguarding Adults
- Social Media
- Subcontracting
- Supervision
- Training
- Volunteers
- Whistle Blowing

Financial information

	Budget	*Actual*	
Funding	£160,650	£174,879	(*£14,229 additional transition budget)
Staffing	£76,500	£91,766	
Overheads	£84,150	£63,617	
Provision	£0	£19,496	

Circa £48k spent on support servcies eg, rent, IT, telecoms etc.

All other funding was spent on staffing and costs directly associated with community engagement and delivery of the service.

healthwatch
Telford and Wrekin

Healthwatch Telford and Wrekin
Meeting Point House, Southwater Square,
TELFORD, TF3 4HS
Tel 01952 739540
info@healthwatchtelfordandwrekin.org.uk
www.healthwatchtelfordandwrekin.org.uk

PARKWOOD
HEALTHCARE

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD

NHS FUTUREFIT PROGRAMME REPORT

DAVID EVANS, CHIEF OFFICER, TELFORD & WREKIN CLINICAL COMMISSIONING GROUP

LEAD CABINET MEMBER – N/A

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

The attached report seeks to provide an update on the current progress and forward plans of the NHS FutureFit Programme.

2. RECOMMENDATIONS (AND TO WHOM ACTIONS APPLY eg CCG, Council)

The Board is invited to note the update report.

3. IMPACT OF ACTION - (How it is intended that action will make a difference)

The Programme is focused on acute and community hospital services in Shropshire and Telford & Wrekin. It involves all communities who use those services, particularly across Shropshire, Telford & Wrekin and mid Wales. The aim is to develop a clear vision for excellent and sustainable acute and community hospitals - safe, accessible, offering the best clinical outcomes, attracting and developing skilled and experienced staff, providing rapid access to expert clinicians, working closely with community services, focused on those specialist services that can only be provided in hospital.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	No	
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	No	
	Will the proposals impact on specific groups of people?	
	Yes/No	This is unknown at the moment, however the Future Fit Programme has a specific workstream investigating the equality and quality impact of the proposals the programme produces.
TARGET COMPLETION/DELIVERY DATE	Key milestones are outlined in the Future Fit programme project execution plan: http://www.nhsfuturefit.co.uk/key-documents/documents/2-140120-shrop-csr-pep-v1-0-excl-appendix-3-2	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes/No	This is not known at the moment, however the Future Fit Programme has a finance workstream focussing on the financial impact of the final proposals.
LEGAL ISSUES	No	None specifically arising from this report.
EQUALITY & DIVERSITY	Yes/No	This is unknown at the moment, however the Future Fit Programme has a specific workstream investigating the equality and quality impact of the proposals the programme produces.
IMPACT ON SPECIFIC WARDS	No	
PATIENTS & PUBLIC ENGAGEMENT	Yes	The Future Fit Programme has a specific Communications and Engagement Workstream designing and delivering the engagement and communications activity supporting this programme.
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	

PART B) – ADDITIONAL INFORMATION

Please refer to the attached report "Programme Update Report"

futurefit
Shaping healthcare together

Programme Update Report

Report to:	Telford & Wrekin Council Health & Wellbeing Board
Subject:	Programme Update Report
Report by:	Joint Senior Responsible Officer – David Evans
Date:	9th September 2014

1 ACTIVITY AND CAPACITY MODELLING

An activity baseline was established earlier this year (Phase 1) which assumed no radical system change but factored in a range of efficiency strategies and key elements of demographic change.

The second phase of work is nearing completion by the combined Clinical Design and Activity & Capacity Workstreams. This sets out activity projections till 2018/19 based on the implementation of the agreed Clinical Model.

A third phase will be undertaken from October to develop projections specific to each shortlisted option.

2 FINANCIAL MODELLING

The Finance Workstream has built an overarching financial model and this is now being populated with baseline information from both providers and commissioners. This will then be used to model shortlisted options.

The Core Group has also commissioned work to develop a definition of affordability to inform the shortlisting process. This work will be reported through this workstream.

The Core Group has also asked for additional financial and economic analysis to be undertaken on long listed options once these are agreed. This is to respond to enquiries raised by the public in the deliberative events and in a survey about the resourcing of the FutureFit clinical model, and to reduce the risk that unaffordable options are included in the shortlist of options. This means that the time between long listing and short listing will be increased.

It is expected that this additional work will take a few weeks rather than months to complete and a revised programme timetable will be produced once the work has been scoped in more detail.

3 EMERGENCY CENTRE FEASIBILITY STUDY

This high level study is now completed and considers the feasibility of a 5 scenarios for a single Emergency Centre. For each scenario it sets out the assumed building requirements, estimated capital costs (and annual capital charges) and likely timescale for completion.

4 EVALUATION PROCESS & CRITERIA

Following its initial workshops in June, the Evaluation Panel has met again to propose to the Programme Board a long list of options and the evaluation criteria to be used in determining the shortlist. The Panel's proposals have been informed by reports from Public Engagement events and a stratified telephone survey of 1000 people.

5 IMPACT ASSESSMENT

An additional workstream has been created to assess the impact of the Programme's proposals across a range of areas. This will encompass the mandatory Equality Impact Assessment and will also provide significant opportunity for channelling public feedback on the Shortlisted options.

Work is underway to complete a baseline assessment in September (which will both inform the Shortlisting process and add further detail to the Case for Change). This will detail the impact of the current configuration of services.

Following the confirmation of a Shortlist the workstream will commence detailed assessment of the impact of each option. This will be an iterative process, allowing for options to be improved through the mitigation of any adverse impacts that are identified. The areas of impact that will be assessed are being aligned with the Evaluation Criteria that will be used in evaluating options so that the impact assessment (and the public engagement which has fed into in) can directly inform the evaluation of options.

6 ENGAGEMENT & COMMUNICATIONS PLANS

In August, workshops were held to offer an opportunity for people to understand Future Fit and the reasons for change. These sessions focused on explaining the clinical design in more detail as well as exploring where each part of the model could be located. People were also asked to identify how they would judge different ideas based on what matters most to them and why. An independent report on these events has been produced and will be supplied to the Evaluation Panel, as will the results of the stratified telephone survey.

Further events in September will focus on the long list that has been agreed by the Programme Board on 17 September and seek public opinions that will inform the final Short Listing.

From the agreement of the shortlist to March (when the pre-election period begins) we will be touring the Shropshire, Telford & Wrekin and mid-Wales area with details of the short list of options for delivering the clinical model. These events will help us understand how the

different options could impact on communities and will enable public feedback to contribute directly to the evaluation of Shortlisted options next Summer.

7 PROGRAMME BOARD

At its next meeting on 17th September the Board will receive the recommended Long List and Evaluation Criteria, the Emergency Centre Feasibility Study. A fuller Programme Update Report plus key documents will be published on the website shortly afterwards.

The Board will also receive a report on red-rated items on the Programme's Risk Register. The full document is now being published on the website and will be updated monthly following review by the Programme Team (and input from workstreams).

David Evans

Joint Senior Responsible Officer

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD

24th SEPTEMBER 2014

SHROPSHIRE / TELFORD AND WREKIN CLINICAL COMMISSIONING GROUP 5 YEAR STRATEGIC PLAN

REPORT OF FRAN BECK: EXECUTIVE LEAD COMISSIONING, TELFORD & WREKIN CLINICAL COMMISSIONING GROUP

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

There is a requirement for the Clinical Commissioning Group (CCG) to collectively produce a 5 year strategic commissioning plan in conjunction with our key commissioning partners – which for Telford is Shropshire CCG. A copy of the final draft plan is attached together with a set of summary slides which are have been prepared for use across the County. The plan is for 5 years running from 2014/15 through to 2018/19 and describes the system vision for the next 5 years. It has also been developed in consultation with our main provider organisations. For further details please see Part B Section 1 below.

2. RECOMMENDATIONS

- Health and Wellbeing Board are asked to comment on the 5 year plan and make recommendations for improvement.
- There is a requirement for a Council signature to be appended to the Plan as verification of joint working and Health and Wellbeing Board are requested to nominate a signatory.

3. IMPACT OF ACTION

In terms of the objectives of the 5 year strategic plan, it has 6 over-arching system objectives around 4 service patterns that:

- attract the best staff and be sustainable clinically and economically
- delivers the right coordinated care in the right place at the right time

- ensures a positive experience of care
- and which are developed in full dialogue with patients, public and staff

and 2 service needs of:-

- supporting care closer to home
- minimising the need to go to hospital and meeting the distinct needs of our population.

These objectives will be delivered via 5 approaches of clinical models, workforce; change management, shifting finance and focus and working together to manage risks.

4. SUMMARY IMPACT ASSESSMENT

<table>
<tr><td rowspan="7">COMMUNITY IMPACT</td><td colspan="2">Do these proposals contribute to a specific HWB Priority</td></tr>
<tr><td>Yes</td><td>· Improve emotional health and wellbeing
· Improve life expectancy and reduce health inequality
· Support people to live independently
· Support people with dementia</td></tr>
<tr><td colspan="2">Do these proposals contribute to specific Co-Operative Council priority objective(s)?</td></tr>
<tr><td>Yes/No</td><td>N/A</td></tr>
<tr><td colspan="2">Will the proposals impact on specific groups of people?</td></tr>
<tr><td>Yes</td><td>The plan is covering all patients who access NHS services.</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td>TARGET COMPLETION/DELIVERY DATE</td><td colspan="2">This is a plan to deliver over 5 years.</td></tr>
<tr><td>FINANCIAL/VALUE FOR MONEY IMPACT</td><td>No</td><td>Not specifically addressed</td></tr>
<tr><td>LEGAL ISSUES</td><td>No</td><td>Not specifically addressed</td></tr>
<tr><td>EQUALITY & DIVERSITY</td><td>Yes</td><td>This plan will ensure that all aspects of care are accessible to all who need it.</td></tr>
</table>

IMPACT ON SPECIFIC WARDS	Yes	*The geography of Telford and Wrekin CCG*
PATIENTS & PUBLIC ENGAGEMENT	Yes	*This plan will go out for consultation with patients and is on the CCG website*
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	*Opportunities to work collaboratively to agree one 5 year plan across health and social care*

PART B) – ADDITIONAL INFORMATION

1. INFORMATION

The strategic plan has been based on 3 key areas of activity, NHS Future Fit, Better Care Fund and the Mental Health modernisation. The first stages of the plan are included in an Operational Plan which is the more detailed plan which covers the first 2 years 2014/15 – 2015/16. The process is iterative and ongoing and this is the base document on which we hope to build.

The 5 year plan identifies specific healthcare challenges with particular reference to improving quality, sustainability and capacity and in particular in relation to mental Health - Parity of Esteem. One of our other challenges is in relation to workforce with national recruitment challenges and more specialist training in place, it is more difficult to access the people with the correct skills at specialism level. Specifically we have local challenges in medical staff for A&E, Stroke, critical care and anaesthetics.

Moving on to our system vision the plan identifies this as envisaging a system where, through working together, we have created a pattern of services that offer excellence in meeting the distinctive and particular needs of the rural and urban populations of Shropshire and Telford & Wrekin.

The whole 5 year strategic plan as you have seen is based on programmes of work which are already underway, however the aim of the of 5 year strategic plan is to improve quality and outcomes. **T**his will be done by improving the effectiveness of systems already in place to monitor quality; tackling health inequalities, partnership working and continuous engagement with our GP member practices as well as our population.

In terms of Governance arrangements the plan suggests that the following arrangements will oversee and ensure delivery:-

- CCG Boards
- FutureFit
- Health & Wellbeing Boards (Better Care Fund)
- Planned Care Working group
- Urgent Care Working Group
- Possible development of a clinical senate
- System Resilience Group

Finally the overarching system values are that:-

- above all else the extent to which our collective efforts will achieve real improvements in services for the people we serve
- We recognise that everything we do will be achieved through our staff, stakeholder partners, with the help and support of patients, their carers and the general public and volunteers.
- We will demonstrate the high esteem in which we hold people, and the respect we have for them, by leading in accordance with the principles set out in the Concordat we have collectively signed up to. In particular, we will make sure that there is a clear clinical vision for change that inspires those involved in delivering it.

In terms of the principles:

- Home is normal.
- The level of care should match the level of need and unnecessary escalation of care should be avoided.
- A commitment to 7 day working as part of an integrated local health economy approach.
- The Recognition that a commitment to quality and safety is paramount for clinicians.
- And The need to get the system right for the next 10-20 years

The 5 year strategic plan is currently going through consultation and any suggested amendments will be included in a final version.

The Telford and Wrekin CCG Board held on 8th July 2014 received the 5 year plan and the following key points were highlighted:

- The CCG had produced the plan in partnership with Shropshire CCG.
- The plan was available on the CCG's website.
- Shropshire CCG was due to receive the plan and the same presentation at its next Board meeting.
- The plan described the CCG's vision for 2014/15 to 2018/19.
- The Local Authority had been asked to support the plan and it was due to presented to the Joint Strategic Commissioning meeting in August 2014 following which it would be presented to the September meeting of the HWB.
- SaTH, RJAH and the Community Health Trust had signed up to the current version of the plan.
- The plan identified specific local healthcare challenges; improving quality, sustainability and capacity and mental health.
- Other challenges included workforce, national recruitment challenges and shortages of medical staff in A&E, stroke, medicine, critical care and anaesthetics.

- The CCG was acutely aware of the funding gap within the NHS and the key financial challenges in terms of investment within a limited resource.
- Dr Inglis referred to the governance arrangements and commented that the CCG Board should be included as part of the governance arrangements.
- Dr Innes commented that this was a substantial piece of collaborative work and its success was based on a key player - NHS England as they commissioned primary care. He commented that although the plan would be scrutinised by NHS England they would also be contributing to the plan and therefore the plan should be scrutinised by another independent body. Members were informed that NHS England had their own 5 year plan and they needed to share this. Members commented that it would be useful to have NHS England sign up to the plan and work in partnership.
- Miss Smith commented that there was no indication in the plan of when the plan would be reviewed or revised.
- Mr Taylor referred to page 56 of the plan and commented that this section described what was happening in Shropshire but he could not see a similar reference to Telford and Wrekin and this may lead to confusion when the plan was presented to the HWB. Mrs Wilde explained that there was some ambiguity in terms to reference to Shropshire as this included Telford and Wrekin.

2. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

Full impact assessment will be undertaken as part of the process – See Section 4 above

3. PREVIOUS MINUTES

N/A

4. BACKGROUND PAPERS

Report prepared by Nicky Wilde, Interim Deputy Executive Lead for Commissioning and Quality, Telephone: 01952 580418

NHS Shropshire and NHS Telford and Wrekin CCGs

Draft Strategic Plan

2014/15 – 2018/19

Shropshire, Telford & Wrekin

Draft Strategic Plan

2014/15 – 2018/19

Submission details	Which organisation(s) are completing this submission?	Shropshire, Telford and Wrekin CCGs	
	In case of enquiry, please provide a contact name and contact details	Sam Tilley Head of Planning & Partnerships Shropshire Clinical Commissioning Group (CCG) Tel: 01743 277500 E-mail: samantha.tilley@shropshireccg.nhs.uk Website: www.shropshire.nhs.uk Address: William Farr House Site, Mytton Oak Road, Shrewsbury, Shropshire, SY3 8XL Andrew Nash Chief Finance Officer/Deputy Chief Officer Telford and Wrekin CCG Tel: 01952 580359 E-mail: andrew.nash@nhs.net Website: www.telfordccg.nhs.uk Address: Halesfield 6, Telford, TF7 4BF	

Contents

Foreword

This strategic plan has been prepared to meet the requirements of the NHS England planning guidance *Everyone Counts: Planning for Patients 2014/15 to 2018/19.*

It should be read in the context of the Future Fit programme - through which local partners are working to address some of the strategic challenges facing the health and social care system - and in particular the Clinical Model document which has recently been approved by the Programme Board: the opportunities for improvement have been clearly articulated; the case for change is widely accepted within the clinical community, by patient and public representatives, by partner organisations and by the Joint Health Overview Scrutiny Committee; and programme structures have been put in place to develop the clinical vision and new models of care which will form the cornerstone for the transformation of health and care services in Shropshire. Over the coming months these service models will be subject to extensive clinical and public engagement both to test the principles and to develop the more granular detail which will be needed to both inform an option appraisal for the configuration of hospital services and to develop transformation plans for those elements of the models which are not dependent on major changes to hospital configuration. Alongside longer term plans for service transformation, individual organisations need to ensure that health and care services can effectively respond in the short and medium terms to the clinical, operational and financial challenges which they face.

As a plan developed at a point in time, this document does not describe in detail the transformation of service models which we will be implementing as this detailed work has not yet been completed. That does not mean that there are no plans for change, and specific service improvement plans, consistent with the vision described in this strategic plan, are included in the plans of individual partner organisations. The health and care system also recognises the critical role that the Better Care Fund is going to have in shaping the future of health and care services in Shropshire/Telford & Wrekin in particular as a powerful enabler for the development of integrated community services.

The Shropshire/Telford & Wrekin health and care system faces very real challenges. We are committed to meeting those challenges, individually and together, to deliver the vision for excellent and sustainable health and care which the Future Fit Clinical Model describes and which is outlined in this plan.

Caron Morton
Accountable Officer
Shropshire Clinical
Commissioning Group

Dave Evans
Chief Officer
Telford & Wrekin Clinical
Commissioning Group

Peter Herring
Chief Executive
Shrewsbury & Telford
Hospital NHS Trust

Neil Carr
Chief Executive
South Staffordshire& Shropshire

Jan Ditheridge
Chief Executive
Shropshire Community

Wendy Farrington Chadd
Chief Executive
Robert Jones &Agnes Hunt
Orthopaedic Hospital NHS
Foundation Trust

Stephen Chandler
Director of Adult Care
Shropshire Council

Paul Taylor
Director of Adult Care
Telford & Wrekin Council

Current Position	Key Lines of Enquiry addressed
The Strategic Context in Shropshire The Shropshire/Telford & Wrekin (STW) area is served by Shropshire Clinical Commissioning Group (44 GP practices), and by the Telford and Wrekin Clinical Commissioning Group (22 GP practices). Clinical Commissioning Groups are responsible for commissioning the following services: Community health services. GP out of hours services. Ambulance services. Mental health services. Specialist health services for people with learning disabilities. Acute hospital services. Telford and Wrekin Clinical Commissioning Group serves a population of approximately 172,000, which is mainly centred on the new town of Telford but covers the surrounding rural areas and towns including Newport. It has co-terminus boundaries with Telford Borough Council and there are strong partnership links between the two bodies in health and social care. Shropshire Clinical Commissioning Group serves a population of approximately 302,000. Shropshire is a large rural county. The county town of Shrewsbury is central to the county with a number of market towns geographically spread across the area. Shropshire Clinical Commissioning Group has co-terminus boundaries with Shropshire Council and the two agencies work closely together. Specialised services, primary care, services, offender healthcare and services for members of the Armed Forces are commissioned by NHS England.	Has an assessment of the current state been undertaken? Have opportunities and challenges been identified and agreed? Does this correlate to the Commissioning for Value packs and other benchmarking materials?
National Picture The NHS belongs to the People - A call to Action (NHS England 2013) set out a number of future challenges for the NHS: Ageing society, Long Term Conditions and rising expectations. Shropshire is not exceptional in this and JSNAs across both CCGs reflect these trends. *Changing patterns of illness.* Long-term conditions are on the rise as well, due to changing lifestyles. This means the	Are assumptions made by the health economy consistent with the challenges identified in a Call to Action?

emphasis needs to move away from services that support short-term, episodic illness and infections towards services that support earlier interventions to improve health and deliver sustained continuing support, again in the community.

Higher expectations. Quite rightly, the population demands the highest quality of care and also a greater convenience of care, designed around the realities of their daily lives. For both reasons, there is a push towards 7-day provision or extended hours of some services, and both of these require a redesign given the inevitability of resource constraints

However, there are additional challenges that must be also be considered.

Local Picture

Changes in our population profile - The remarkable and welcome improvement in the life expectancy of older people that has been experienced across the UK in recent years is particularly pronounced in Shropshire where the population over 65 has increased by 25% in just 10 years. The general population is anticipated to grow by at least 15,000 over the next 10 years according to ONS data. However, further to this the Shropshire Core Strategy Policy (CS10) suggests that 21,799 new homes will be built by 2016. There will continue to be expansion of Telford, with the addition of an estimated 20,000 new homes over the next 10 years with an estimated population increase as a result in the order of 50,000. The demography of Telford has changed over the past 10 years and now is more reflective in age of the national picture. This growth is forecast to continue over the next decade and more. As a result the pattern of demand for services has shifted with greater need for the type of services that can support frailer people, often with multiple long-term conditions, to continue to live with dignity and independence at home and in the community.

Rurality and Access

Shropshire is one of the largest and most rural inland counties of England and incorporates two unitary councils: Shropshire Council and Telford and Wrekin Council. The county is characterised by a combination of large and small market towns, villages and small isolated hamlets, together with the new town of Telford and its associated housing developments and the county town of Shrewsbury.

The geography of Shropshire County, with its long distances and travel times to acute hospitals, scattered and disproportionately elderly population and limited public transport, makes the provision of a comprehensive range and increased scale of community-based health services especially important. This becomes vital if the local health economy is to respond effectively to the challenge of the increasing elderly population combined with funding pressures. The geography of rural areas means particular challenges around providing services efficiently. Limited public transport increases the need for care close to home for the elderly and those from lower socio-economic groups without easy access to their own transport.

Improved and timely access to services is a very real issue and one which the public sees as a high priority. There is a network of provision across Community Hospitals that is part of the redesign of services to increase local care. Quality The Publication of the Francis Inquiry into failings at Mid Staffordshire Hospital has been one of the most significant events in the recent history of the NHS and has firmly placed quality at the top of the NHS agenda. Further to this the NHS Outcomes Framework sets out the improvements against which the NHS Commissioning Board will be held to account. All service development and improvement initiatives will be assessed against quality and safety standards supported by an agreed Quality Impact Assessment (QIA) Tool with quality assurance and improvement as the key guiding principles Two Site working In Shropshire and Telford and Wrekin the inherited pattern of services, especially hospital services, across multiple sites means that services are struggling to avoid fragmentation and are incurring additional costs of duplication. The clinical and financial sustainability of acute hospital services has been a concern for more than a decade. Shropshire has a large enough population to support a full range of acute general hospital services, but splitting these services over two sites is increasingly difficult to maintain without compromising the quality and safety of the service. Most pressingly, the Acute Trust currently runs two full A&E departments and does not have a consultant delivered service 16 hours/day 7 days a week. Even without achieving Royal College standards the Trust currently has particular medical workforce recruitment issues around A&E services, stroke, critical care and anaesthetic cover. All of these services are currently delivered on two sites, although stroke services have recently been brought together on an interim basis. This latter move has delivered measurable improvements in clinical outcomes. Developing the future clinical services strategy for the acute Trust and any proposed change to the configuration of services across its two main sites, has to address any clinical quality, safety and sustainability issues and therefore ensure the maintenance of safe and appropriate staffing levels; it has to ensure services are designed to respond to future demands and demographic trends; and it has to ensure improvements in efficiency and productivity as well as presenting a financially viable future for the Trust. Workforce *The Human Resource*. Shropshire is not exceptional in relation to the health care related workforce challenges it faces: issues of recruitment and retention in relation to medical posts, an aging workforce and the need to address a shift form an acute centred workforce to a more community centred workforce are evident. Shropshire's rural profile and the issues of access and travel distances this brings are also a consideration. In particular current workforce issues relate to A&E services, stroke, medicine, critical care and anaesthetic cover.	

Clinical standards and developments in medical technology. Specialisation in medical and other clinical training has brought with it significant advances as medical technology and capability have increased over the years. But it also brings challenges. It is no longer acceptable nor possible to staff services with generalists or juniors and the evidence shows, that for particularly serious conditions, to do so risks poorer outcomes. Staff are, of course, aware of this. If they are working in services that, for whatever reason, cannot meet accepted professional standards, morale falls and staff may seek to move somewhere that can offer these standards. It is also far more difficult to attract new staff to work in such a service. Clinicians are a scarce and valuable resource. Future plans must seek to deploy them to greatest effect.

Finance

The NHS budget has grown year on year for the first 60 years of its life .....in one decade across the turn of the 21st century its budget doubled in real terms. But now the world economy and the UK economy within that is in a different place. The NHS will, at best, have a static budget in real terms going forward. Yet the changing patterns of population and resultant need, the increasing costs of ever improving medical technology, the difficulties in simply driving constant productivity improvements in a service that is 75% staff costs and that works to deliver care to people through people, mean that without changing the basic pattern of services then costs will rapidly outstrip available resources and services will face the chaos that always arises from deficit crises.

Further to this, recent spending settlements for local government have also slowed, placing greater demand on social care budgets with the potential consequence of increasing demand on health services and therefore increasing health costs.

The local health economy across Telford & Wrekin and Shropshire has recently refreshed its analysis of the financial challenge which it faces over the next five years and from this work it is evident The health system has a significant financial challenge to meet over the next five years.

Technology

The case that technology is changing the way that we live our lives is irrefutable. The need to promote this technology to support the health and social care sector in the future has been made, but to date there is less impact than would have been expected in the way people are cared for. The need to improve the understanding of what technology can do and its limitations is something that needs collaborative working across commissioners and providers. It may also need significant changes in systems and working patterns for some areas.

Provider Landscape

South Staffordshire and Shropshire Healthcare NHS Foundation Trust provide adult and older people's mental health services in the county. Multidisciplinary and multi-agency teams work in partnership with local councils and closely with the

voluntary sector, and independent and private organisations to promote the independence, rehabilitation, social inclusion and recovery of people with a mental illness. Facilities include the Redwoods Centre in Shrewsbury which opened in 2012 and provides 80 adult mental health beds for Shropshire, Telford and Wrekin and Powys and 23 low secure beds for the West Midlands.

The Shrewsbury and Telford Hospital NHS Trust (SaTH) is the main provider of district general hospital services for half a million people living in Shropshire, Telford and Wrekin and mid Wales, Services are delivered from two main acute sites: Royal Shrewsbury Hospital (RSH) in Shrewsbury and the Princess Royal Hospital (PRH) in Telford. Both hospitals provide a wide range of acute hospital services including accident and emergency, outpatients, diagnostics, inpatient medical care and critical care. Total bed capacity across the two hospitals is 819.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) is a leading orthopaedic centre of excellence. The Trust provides a comprehensive range of musculoskeletal surgical, medical and rehabilitation services; locally, regionally and nationally from a single site hospital based in Oswestry, Shropshire, close to the border with Wales. As such, the Trust serves the people of England and Wales, as well as acting as a national healthcare provider. It also hosts some local services which support the communities in and around Oswestry.

Shropshire Community Health NHS Trust provides community health services to people across Shropshire and Telford and Wrekin in their own homes, local clinics, health centres and GP surgeries. These services include Minor Injury Units, community nursing, health visiting, school nursing, podiatry, physiotherapy, occupational therapy, support to patients with diabetes, respiratory conditions and other long-term health problems. In addition, it provides a range of children's services, including specialist child and adolescent mental health services. Shropshire's four community hospitals have a total of 113 beds.

Of the 66 GP practices across Shropshire and Telford and Wrekin, 44 are in Shropshire and 22 in Telford and Wrekin. Local practices have recently formed a GP Federation. Walk in Centres are located in Shrewsbury, Telford town centre and at the Princess Royal Hospital. Shropshire Doctors Co-operative Ltd (Shropdoc) provides out of hours primary care services to 600,000 patients in Shropshire, Telford and Wrekin and Powys. NHS England holds contracts with 101 dental practices and 127 pharmacies across the STW area.

Wider Social Care Landscape

The STW area is served by the two Unitary Councils of Shropshire and Telford and Wrekin that have responsibility for delivery and oversight of a range of social care and support and for some health related provision for adults and children. There are 74 Councillors in Shropshire Council and 54 in Telford & Wrekin Council.

Health and Wellbeing Boards (HWBB) are in place in both councils. Established under the Health and Social Care Act 2012, they are a key part of broader plans to modernise the way NHS and social care services work together.

Whilst Shropshire and Telford & Wrekin have distinct Health and Wellbeing Strategies there are common themes that run throughout both: reducing health inequalities, supporting people to live independently, lifestyle and health choices and emotional health and wellbeing. The table below sets out the priorities within each Strategy and their correlation around these themes:

	Reducing Health Inequalities	**Supporting People to Live Independently**	**Lifestyle and Health Choices**	**Emotional Health and Wellbeing**
Telford & Wrekin	Improve life expectancy and reduce health inequalities	Support people to live independently	Reduce excess weight in children and adults Reduce teenage pregnancy Reduce the number of people who smoke Reduce the misuse of drugs and alcohol	Support people with Dementia Improve adult and children's carers' health and wellbeing Support people with Autism Improve emotional health and wellbeing
Shropshire	Health inequalities are reduced Health, Social Care and wellbeing	Older people and those with Long Term Conditions will remain independent for longer	People are empowered to make better lifestyle and health choices for their own and their	Better emotional mental health and wellbeing for all

		services are accessible, good quality and 'seamless'		families health and wellbeing	

Both Health and Wellbeing strategies describe how resources will be targeted to areas of greatest need and outline how they will be delivered in partnership by a whole range of organisations across the private, public and voluntary and community sectors.

Summary

There are already some very good health services in Shropshire, Telford and Wrekin. They have developed over many years to try to best meet the needs and expectations of the populations served, including that of Mid-Wales. Nevertheless, when looking at the changing needs of the population now and that forecast for the coming years, the aspiration for quality standards for our population, as medicine becomes ever more sophisticated; and when looking at the economic environment that the NHS must live within; then it becomes obvious that the time has come to look again at how services are designed to meet the needs of the local population and provide excellent healthcare services for the next 20 years.

Local clinicians and respondents to the local Call to Action surveys and events also see this opportunity to systematically improve care as being a necessary response in addressing the many challenges faced by the service as it moves forward into the second and third decades of the 21st century.

System Vision	
We envisage a system where, through working together, we have created a pattern of services that offer excellence in meeting the distinctive and particular needs of the rural and urban populations of Shropshire and Telford & Wrekin.	What is the vision for the system in five years' time?
A Call To Action In November 2013 STW ran a major consultation exercise with public and clinicians under the national Call to Action for the NHS. Information about the Call to Action – who responded and what they said – can be found at http://www.shropshireccg.nhs.uk/call-to-action. The response was very clear in saying that the public wanted full engagement in thinking through options for the future and that nothing should be predetermined. Nevertheless, in the light of the factors described above, there was real consensus between public and clinicians about the following: • An acceptance of there being a case for making significant change. • A belief that this should be clinically-led and with extensive public involvement. • A belief that there were real opportunities to better support people in managing their own health and to provide more excellent care in the community and at home. • An agreement that hospitals are currently misused. This is not deliberate but as a result of poor design of the overall system and the lack of well understood and properly resourced alternatives. • A belief that it is possible to design a new pattern of services that can offer excellence in meeting the distinctive and particular needs of the rural and urban populations of this geography - but if we are to succeed we must avoid being constrained by history, habit and politics. A key message about the design of services was that it needs to be radical and sustainable: a 5-10 year long term plan should be informed by: • Clinicians driving clinically sensible change. • A clear understanding of demand and capacity. • Clinical safety. • "Form follows function" and is not compromised by current building stock.	What key themes arose from the Call to Action engagement programme that have been used to shape the vision?

- The use of technological solutions.
- Simpler assessments to allow easier navigation by clinicians, NHS staff and patients.

The particular challenges identified by this health economy are set out in detail in the Current Position part of this document. These are consistent with the challenges identified in 'A Call To Action' and the local response to these results runs as a theme through this document.

Work underway locally to *reach* the strategic vision is described in more detail later in the document. However, work carried out which has been instrumental in assisting us to develop this vision can be best described under the following headings:

- Future Fit
- Health & Wellbeing
- Mental Health Modernisation

For those areas that are not the commissioning responsibility of the CCG's, such as primary care, there is an acknowledgement of the importance of building this into local planning to compete the picture and more details of this can be found in the sections below.

Future Fit

In order to address the challenges set out above Shropshire CCG, Telford & Wrekin CCG, Shrewsbury and Telford Hospitals trust (SaTH), Shropshire Community Health Trust and Powys LHB have committed to work collaboratively to undertake a Clinical Service review (CSR) engaging fully with their patient populations, to secure long term high quality and sustainable patient care. The review will focus on acute and community hospital services in Shropshire and Telford & Wrekin.

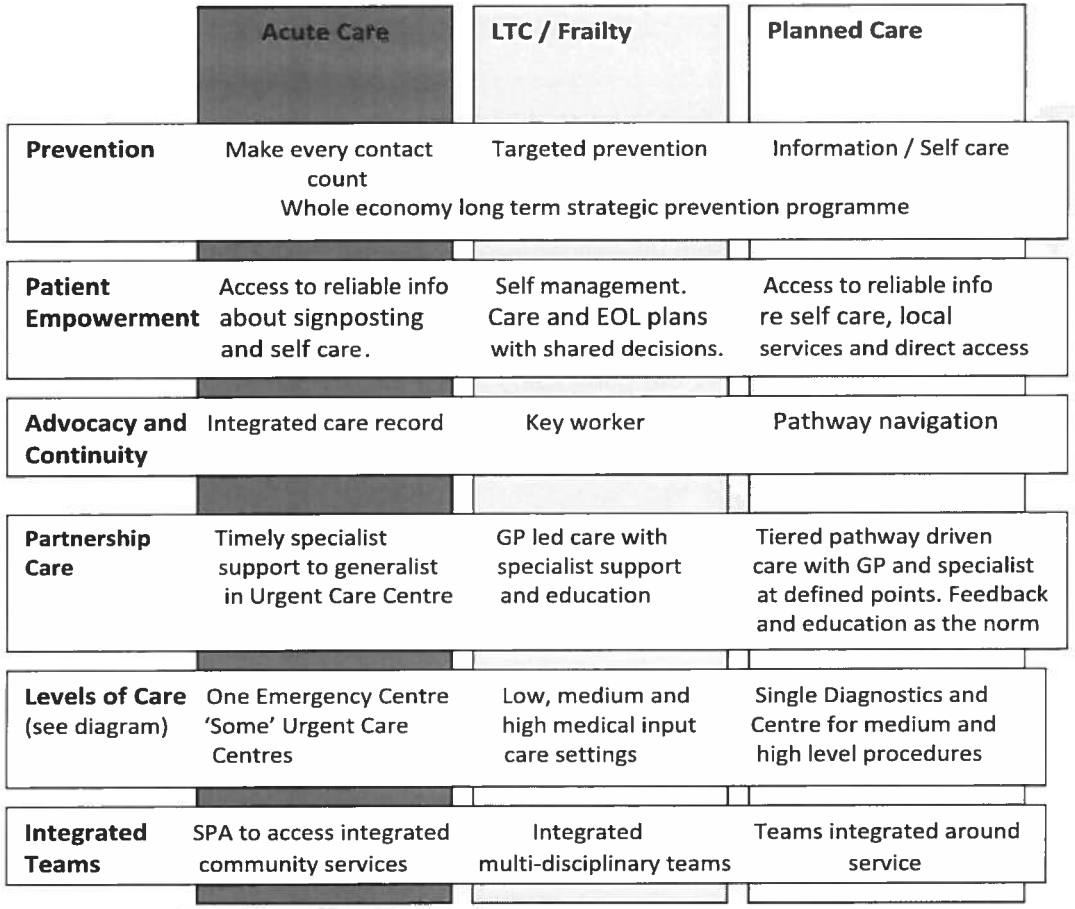
The vision for the transformation of service models set out in this plan draws heavily on the clinical design work stream of the NHS Future Fit programme, through which local partners are working to address some of the strategic challenges facing the health and social care system. This has, in turn, drawn on the strategy, service redesign and pathway development that CCGs have been leading over recent years, working closely with patients, providers and partners, including the two Health and Wellbeing Boards as well as a range of local, national and regional intelligence, detailed later in the document.

Over the coming months these service models will be subject to extensive clinical and public engagement both to test the

principles and to develop the more granular detail which will be needed to both inform an option appraisal for the configuration of hospital services and to develop transformation plans for those elements of the models which are not dependent on major changes to hospital configuration.

This strategy must be read in the context of the Future Fit programme: the opportunities for improvement have been clearly articulated; the case for change is widely accepted within the clinical community, by patient and public representatives, by partner organisations and by the Joint Health Overview Scrutiny Committee; and programme structures have been put in place to develop the clinical vision and new models of care which will form the cornerstone for the transformation of health and care services in Shropshire. A detailed clinical vision document has been written to support the FutureFit programme, a copy of which has been supplied with this document.

The vision for service transformation described below is drawn from the output from the Future Fit clinical design work. The figure below presents a high-level representation of the key elements of models of these models of care.



Whole system synergies

Health and Wellbeing (Better Care Fund)

Strategic thinking in relation to health and wellbeing incorporates the Health and Wellbeing priorities, set out on pg11 of this document, as part of the work on the Better Care Fund. These priorities build on the local intelligence contained with the JSNAs

As a result of dedicated Health & Wellbeing Board sessions, provider discussions and drawing on patient and public engagement programmes across Health and Local Authorities, it is clear that for STW the Better Care Fund represents an opportunity to transform the local health and social care landscape. What has emerged is the commitment to focus on four overarching principles and to use the Fund as an enabler to develop a system which has these principles at its heart:

- Prevention
- Early intervention
- Building community resilience
- Independent living

These align with the core service models being developed as part of our FutureFit programme:-

"Acute and episodic care" aligns with BCF element 3
"LTC/Frailty" aligns with BCF elements 2 and 4

The cross cutting theme of prevention is fully aligned with BCF element 1.

Further detail on the interventions aligned with the Better Care Fund are set out in the Improvement Interventions section. However, it is important to note that the service delivery of these models within the strategic vision will to a degree vary across Shropshire and T&W due to the differences in demography and rurality. For example Telford & Wrekin are planning to deliver an alternative to in-patient hospital care for people who can be cared for closer to home, building on existing integrated community health and social care Enablement/Rehabilitation model. Shropshire will achieve the same aims with a combination of an integrated community service and community hospital facilities. Nevertheless the overarching principles remain as a common thread across the plans

During the transition year of 2014/15 work will continue with providers, local stakeholders, patients and the public to further refine and develop this vision.

How does your plan for the Better Care Fund align/fit with your 5 year strategic vision?

Mental Health Modernisation

In 1956 a promise was made to the people of Shropshire to build a new patient facility to replace the old asylum 'Shelton Hospital'. In September 2012, over 50 years later, the Redwoods Centre opened and Shelton Hospital finally closed. This was done via a partnership between South Staffordshire & Shropshire Healthcare NHS Foundation Trust, Shropshire County and Telford & Wrekin PCTs and both local authorities.

The opening of the Redwoods Centre did not just represent the availability of better in-patient facilities, but a wider strategic approach to modernising mental health services. Partners recognised that without significant change, the way services were delivered would remain the same; and patients would not benefit from innovation. Consequently, in preparation for the closure of Shelton, all stakeholders involved committed to a wider 'modernisation programme', one which would challenge expectations and transform services

Patient groups were engaged throughout the process and supported the concept of investing more in Home Treatment, Crisis Resolution and Assertive Outreach services. The aim was to ensure these could become more responsive and accessible as the first line of support while increasing the numbers of staff in Community Mental Health Teams and in the Memory Service.

Since the local modernisation programme the Government has confirmed its commitment for the NHS to increase its focus on Mental Health services through the publishing of "Closing the Gap: Priorities for essential change in mental health" (Department of Health, 2014). This includes building on the objectives set out in the 2011 strategy "No health without mental health" and sets out the areas where people should see the fastest change e.g. high quality services with a focus on recovery, establishing clear waiting time limits, tackling inequalities in access.

NHS England has also challenged CCG's to focus on *parity of esteem* to ensure that mental health services are given the same focus as physical health services. This is set out in the 2014/15 mandate from the Government to NHS England to "put mental health on a par with physical health, and close the health gap between people with mental health problems and the population as a whole" (Department of Health, November 2013) The government has also published the "Mental Health Crisis Concordat: Improving outcomes for people experiencing mental health crisis" (HM Government, 2014), the aim of which is to ensure that local agencies work together to improve care provision for those experiencing a mental health crisis.

Parity of esteem between physical and mental health needs and services has also emerged as a core component of the FutureFit clinical vision. The models of care described in the three main areas of Acute, Long Term Conditions and Planned Care have been contributed to by mental health professionals and further detailing will demonstrate more clearly the potential for closer integration. Partnership care in particular was felt to be a model which was equally applicable

to mental health services. Psychological management of all long term conditions should be 'part of the day job' and, within the context of partnership care, mental health specialists should have a greater role in the education and upskilling of generalists. Young people have particularly stressed the need for support for problems with stress and self harm.

Along with delivery against the nation targets set out by Government, highlighted above, the CCG's will be revisiting the assumptions of the original mental health modernisation plan to ensure that the original outcomes have been met.

In summary, in five years' time STW anticipate having a system that provides the right care, at the right time, in the right place, delivering better care within our allocated resources. Local citizens will be fully included in all aspects of service design and patients will be fully empowered in their own care. Patients will have a far greater participatory role and will be at the centre of every decision. All decisions will be evidence based with significant clinical input, there will be an open and transparent culture, and a commitment to listen and learn and constantly strive for improvement. 'Compassion in practice', effective reporting and learning from safety incidents will be standard practice across all providers

The impact of the challenges facing the health system have been factored into the CCGs five year finance and activity modelling and, therefore, the scale of the financial challenge has been quantified for the health economy at £80m over the next five years. The challenge is being addressed through the implementation of Urgent Care, Medicines Management, Long Term Conditions and planned care strategies running in parallel to, and supporting, the Futurefit sustainability programme and the implementation of the Better Care Fund. Each of these strategies and programmes are risk assessed on an ongoing basis with overall risk managed at Governing Body level through the Board Assurance Frameworks.

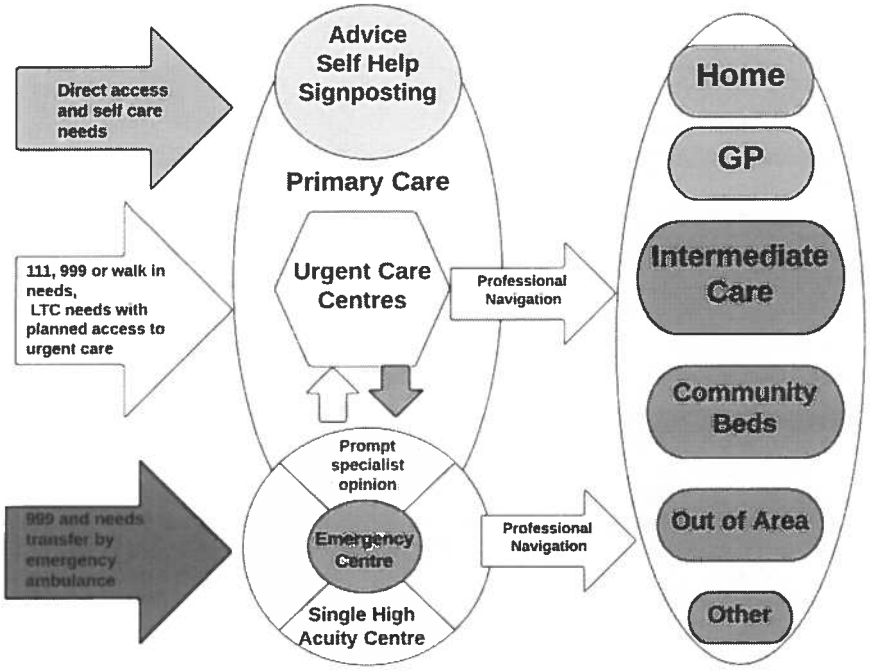
The key benefits to be secured from the FutureFit programme are:

- Highest quality of clinical services with acknowledged excellence in our patch;
- A service pattern that will attract the best staff and be sustainable clinically and economically for the foreseeable future;
- A coherent service pattern that delivers the right care in the right place at the right time, first time, coordinated across all care provision;
- A service which supports care closer to home and minimises the need to go to hospital;
- A service that meets the distinct needs of both our rural and urban populations across Shropshire, Telford & Wrekin and in Wales , and which anticipates changing needs over time;
- A service pattern which ensures a positive experience of care; and
- A service pattern which is developed in full dialogue with patients, public and staff and which

• feels owned locally. The key benefits to be achieved will be set out in a Benefits Realisation Plan which will be developed as part of Phase 1 of the programme. This plan will set out the measurable benefits and key performance indicators to be realised under the following headings: • Improved clinical effectiveness (outcomes); • Improved experience of care, including environment; • Reduced harm; • Better support for people with long term conditions, minimising their need to rely on hospital based care; • Better support for people to live independently; • Most effective use of resources across the whole care system; • Equitable access to the full range of services; and • Improved staff recruitment, retention and satisfaction. The details of deliverables in relation to the Better Care Fund are set out later in the document. However, what our service users will experience is more flexibility of provision, increased choice and more appropriate care settings being provided locally in their localities. They will also experience improved outcomes with better provision for long term conditions and an agenda focused on prevention and ensuring higher quality of life years for our younger generations. The following sections further describe key areas of focus within the system vision: <u>*Urgent and Emergency Care*</u> Urgent and emergency care is one of three core elements of the service model for health care delivery which is being developed by the FutureFit clinical design. The principles and model of care which have been presented in the initial output from the FutureFit programme are fully consistent with the vision set out in the Phase One report from the Urgent and Emergency Care Review. An analysis of the urgent and emergency care system was commissioned by partners in the urgent care system in 2013 and formed the basis of the working programme of the Urgent Care Working Group in 2013/14. This has enabled partners on the Urgent Care Working Group to establish a shared understanding of patient flows, services and facilities and population needs which will inform decisions around the establishment of an urgent and emergency care network during 2014/15. Early discussions have been held with partners across the Shropshire and Staffordshire area regarding the footprint of the	How does the vision include the six characteristics of a high quality and sustainable system and transformational service models highlighted in the guidance? Specifically: 1. Ensuring that citizens will be fully included in all aspects of service design

urgent and emergency care network. The development of urgent and emergency care is detailed and complex work and it will take and careful process management for a final position for future configuration to emerge. However, developments will involve elements of the following: o Patient flows – access to information that will provide easy trustworthy and localised information regarding self help, advice and signposting o Use of telephone single point of access o Urgent and emergency care centres o Partnership support – easily and quickly available to support generalists in lower acuity settings o Professional navigation – a single point of access for professionals to arrange further care and support for patients following their urgent/ emergency care contact o Integrated Community Care – Urgent/ emergency care delivered in a context of whole system integration.	and change, and that patients will be fully empowered in their own care 2. Wider primary care, provided at scale 3. A modern model of integrated care 4. Access to the highest quality urgent and emergency care 5. A step-change in the productivity of elective care 6. Specialised services concentrated in centres of excellence (as relevant to the locality)

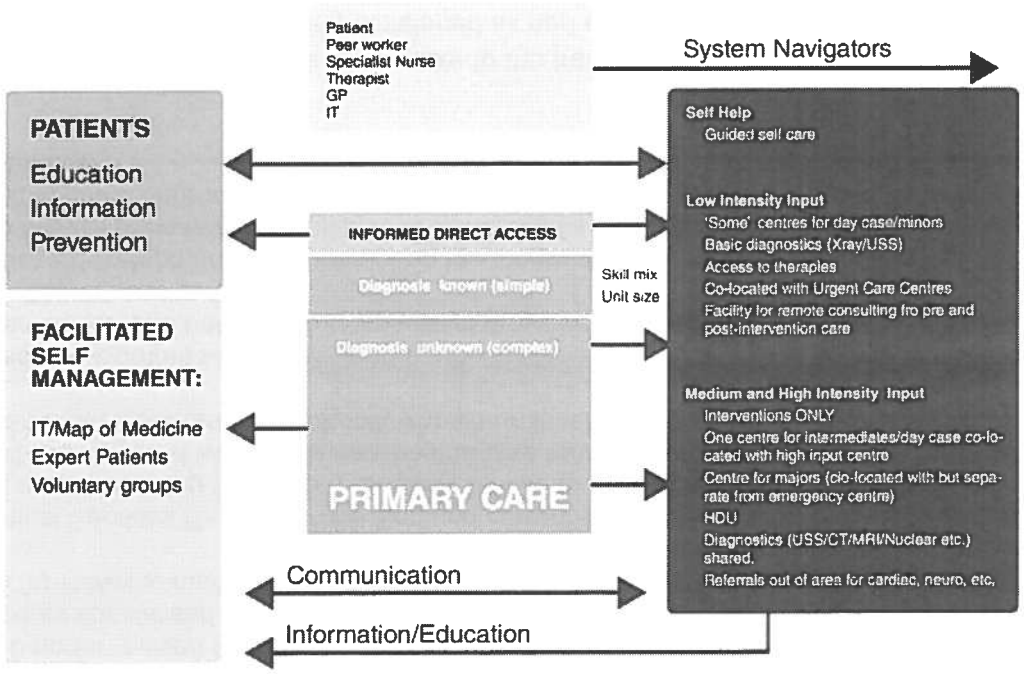
Diagram of the acute and episodic model of care



Both CCGs are part of the collaborative commissioning arrangement led by Sandwell & West Birmingham CCG to commission urgent and emergency ambulance services. The CCGs are working together with WMAS in the review and development of a tariff based system that will deliver the appropriate incentives to support non-conveyance to hospital as appropriate and to maximise the hear & treat and see & treat opportunities. Locally the ambulance service is a member of the Futurefit Programme Board and a key stakeholder in shaping the future of the urgent care landscape in Shropshire. As services are redesigned and develop over the coming months and years it will be essential to maintain co-operation with the provider of the 111 service and to maintain and develop the Directory of Services to reflect local improvements in available service provision to further maximise more suitable care alternatives to admission via the local Urgent Care Working Group

Planned Care Planned care is one of three core elements of the service model for health care delivery which is being developed by the Future Fit clinical design. The model of care which is being developed through this work is aiming to create a less complex and fragmented system that will improve quality (outcomes and patient experience) and achieve improvements in productivity. The ambition is to improve productivity by 20% within 5 years, the specific details of which are contained in individual CCG's operating plans Elements of productivity improvement that have already been implemented for at least some specialties/pathways include greater utilisation of advice and guidance, new pathways for GP access to diagnostics, new community-based services as an alternative to hospital care, promoting day case surgery and the implementation of enhanced recovery utilising local expertise from Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust.	

Diagram of planned care model



New services in the community will continue to be procured to ensure services are appropriately provided as close to the patients' home as possible and the shift towards prevention, intervention and wellbeing progressed.

Specialised Services

The commissioning of Specialised Services has undergone a significant restructure over the last year with the consolidation under NHS England. Much work has been done with the introduction of Clinical Reference Groups to ensure Specialised Services are appropriately defined within prescribed service specifications.

Recently a Staffordshire Shropshire Specialized Commissioning group has been set up with the intention of developing the concept of co-commissioning between CCGS and NHS England. The intention is to :-

- collaborate in developing commissioning strategies for disease pathways where elements of the pathways' are

commissioned by both CCGs and NHS England and

- coordinate the management of providers in their delivery of services for our patients.

Initial priority areas for joint working have been identified as CAMHS Tier 3 / 4, Cancer, Neuro-rehabilitiation and Obesity services.

Whilst for 2014/15, the specialist service contracts have a period of stability, the commissioning intentions beyond this could see some more material changes as outlined in a strategy document issued by NHS England "Prescribed Specialised Services Commissioning Intentions 2014/15 – 2015-16". This is particularly relevant given the recently published financial challenges the specialized commissioners face and we will be kept apprised of developments which may affect the plans of our providers and have a knock-on effect for CCG commissioners.

Locally it is anticipated that the following issues will impact upon our local providers:

- From 2015/16 under revised Identification Rules it is expected that the range of services provided and commissioned as specialised services will grow. This will include areas such as Revision Surgery which may offer opportunities for RJAH to meet demand from surrounding providers who may not meet service specifications.

- Strategic Clinical Services Review – NHS England currently commissions 143 specialised services and will be developing a commissioning framework for each service to ensure consistency of commissioning. As each review is developed NHS England will decide how best to take forward the procurement of services which could result in re testing the market place and may directly impact on local providers and their planned revenue.

- Prime Contractor – Commissioners will lead a process to invite proposals for prime contractor delivery where this enables consolidation and networking of specialist provision which again may directly impact our local providers.

Whilst a number of these developments may impact on the longer term planning of local providers, STW will use the intervening period to ensure providers are well placed in terms of service provision and in developing networks to support a potential future shift in prime contractor role to maximize provider opportunities for growth and minimize any financial risk to the local health economy.

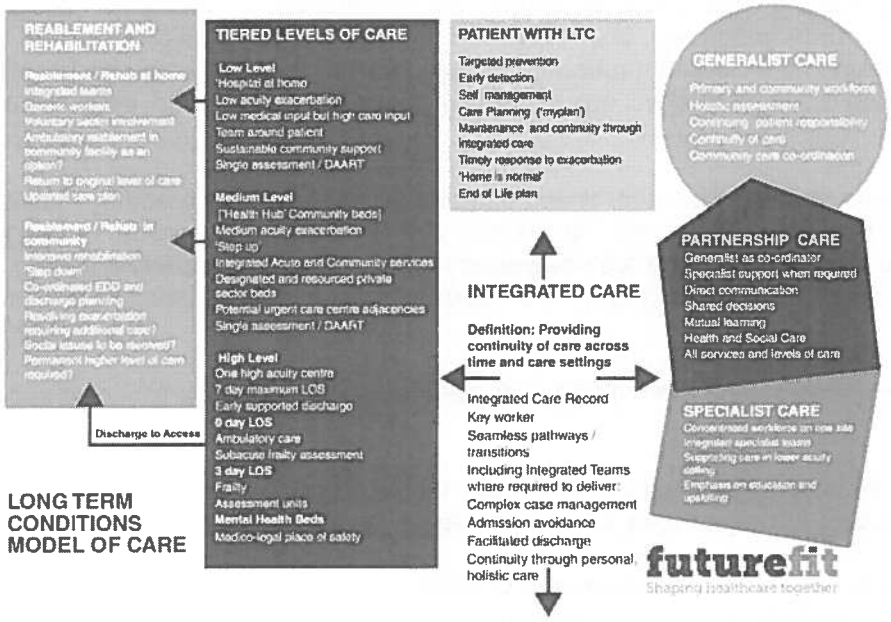
Primary Care

The contribution that primary care will be asked to make to the transformation of health and care services is central to the clinical vision and models of care that are being developed as part of the Future Fit programme.

The Shropshire and Staffordshire Area Team is developing an evolving vision of primary care based active consultation with CCG's, Local Authorities and Healthwatch. The key elements of the desired future state are as follows: - Clear minimum expectations across Shropshire and Staffordshire in terms of access and quality. This is complemented by revalidation requirements and CQC inspection. Therefore understanding what the "core" offer from Primary Care services in the area is will enable individual CCGs alongside NHS England to more effectively support general practice and plan service changes to enhance outcomes. - The guiding principles will be developing sustainable primary care services that enable both clinicians and patients, utilise technology and support the concept that "home is normal". In some areas this will be delivered through a model of Primary Care at scale and in others, due to geography and rurality it will be delivered through an integrated local model. Both models will increase the resilience of the primary care model in that area and improve patient outcomes and experience, to include addressing variation in care and services Whilst primary care delivered at scale may have merit in some of the more urban areas across the geography of Telford & Wrekin and Shropshire, Primary Care through integrated models may also have merit where at scale isn't feasible due to geography or rurality. This model will enable individual GP practices to offer the same services as the "at scale" model within a rural footprint: - Using the local GP practice as the "hub" the core services provided in that area will be integrated, either physically or virtually, into a "team around the practice" - Utilising technology adequately will allow this "team" to link with expert advice from the local acute hospital and other providers in the area and thus ensure that local patients can be treated more effectively within their rural environments without delay, expense and risk of long journeys - A model categorising patient care not into diagnosis categories but "level of care" will be considered to enable adequate development of the team structure thus allowing individual practices the flexibility to use their skills most appropriately whilst being supported by the wider team In taking forward developments in Primary Care the Area Team have established a group to develop a collaborative approach to the commissioning of primary care services and following Simon Steven's recent letter the CCGs have	

submitted a proposal to the Area Team to co-commission elements of Primary Care services along the principles outlined above. *A Modern Model of Integrated Care* Long Term Conditions (LTC) is one of three core elements of the service model for health care delivery which is being developed by the Future Fit clinical design. Collaborative working and service integration are central to the high level model of care.	

Diagram of long term conditions model of care



The key overarching aims in relation to LTC are to shift resources to strengthen self-care and prevention, to ensure that the patient remains at the centre of their care, to work with a multidisciplinary focus with the GP at the centre, ensuring effective case management of patients. In addition work will also be undertaken to reduce time spent in hospital by people with LTC. Further schemes will focus on Pulmonary Rehabilitation, respiratory services, development of diabetes services and the role of telehealth Each of the CCGs has established strategies and plans for long term conditions which support the delivery of the aims set out in the paragraph above. These are consistent with the high level models produced by the Future Fit programme and the development and implementation of existing priorities will continue alongside the Future Fit programme. Both CCG strategies focus on developing care closer to home and the establishment of integrated care teams based on clusters of GP practices. It is anticipated that this approach will result in a reduction of admissions to acute hospital beds. CCG Operating Plans include more detail on the actions which are being taken to improve services for people with long term conditions and ensure that people with multiple long term conditions are offered a fully integrated experience of support and care. CCG BCF submissions also include the detail of the plans to integrate care across health and social care. *Engagement of Citizens* Both CCGs have put the engagement of citizens in their care, in the design of services and in commissioner decision-making at the heart of their everyday business. CCG committees are established which review the work programmes and activities of the CCGs to ensure that patients and the public are being effectively engaged in all aspects of the commissioning process. Support is provided to patient and public representatives to enable them to engage effectively in this work. The CCGs led a major local engagement process as part of the national Call to Action programme. Almost 3,000 responses were received and the Call to Action process was brought together at a conference in November 2013 at which the Chief Executive of NHS England was the keynote speaker. Key messages from the Call to Action – from the public and from local clinicians – are particularly shaping the Future Fit programme but are also being used within other key development strands for the CCGs. There is strong representation from patient groups on the Programme Board and a substantial programme of public and patient engagement will ensure that there is meaningful and authentic citizen participation in the design of the plans and decision-making process. There is a strong network of practice patient participation groups (PPGs) which provide a strong foundation for public engagement. CCGs have also been working closely with Healthwatch organisations and building wide networks of	

engagement to include PPGs, voluntary sector organisations, disease specific groups, groups based in particular localities, disease specific groups and young people.

Engagement with young people includes the development of Youth Champions. The aim is for these young people to become active and valued partners, working with service providers and commissioners, to jointly deliver better health and wellbeing outcomes. In addition to the benefits for local organisations and wider communities, the young people taking part will individually benefit through improved confidence and a sense of pride in their achievements.

Further information on the specific approaches of each CCG are set out in the CCGs' Operational Plan submissions.

Carers
Both Shropshire and Telford & Wrekin CCG's have dedicated work streams focusing on the role of and support for carers. Examples of current schemes are:

- Funding carer breaks – provision of non-residential respite and support services for family carers
- Shared lives for people with dementia - respite provided in people's own homes on a regular basis rather than institutionalised respite care
- Hospital carers link worker - supporting carers of people coming out of hospital in order to ensure they have information about the support and services available to them
- Dementia CQUIN including supporting carers – now included in acute contracts

The Royal College of General Practitioner's recommendations in general practice for improving support to carers will be used the basis to develop the local NHS strategy. The CCG's will also work in partnership with their local councils and voluntary sector organisations to develop a new health economy wide strategy, following the publication of the Care Bill.

Local Councils and CCGs already work together to support carers. This work will form a strand of work under the better Care and will build on existing local arrangements as well as absorbing funding for carer breaks (in line with the NHS Operating Framework 2012-13 stipulations.)

The work within the areas outlined above is linked to the delivery of the system vision via the implementation of the CCG's Operational Plans. A summary of these plans can be found in the Improvement Interventions section of this document.

Alignment with Provider Vision

Provider organisations have been involved in the development of the 5 year strategic plan and the triangulation between system vision and individual provider plans. The following gives a summary of the strategic position of each of the key local

providers:

Shropshire Community Trust is currently reviewing and refreshing its strategy, supported by a new executive team formed in early 2014 and has already adopted a new structured approach to transformation and efficiency. That new approach includes strong leadership for transformation; purposeful engagement with staff, clinical leaders and partners over change; revised governance arrangements and systems, and development of improvement methodologies.

The Trust's core purpose is: " to support adults and children often with complex and long term health needs to cope with those needs at home where they want to be, living their normal lives. We do this by helping people to manage their own health and providing services to them, at or near home'.

Trust strategy is based on the huge potential for community health services to deliver a substantial change to the overall pattern of care in the local health economy in line with local health economy plans to ensure the right care is delivered at the right level in the system. The strategy strives to improve patients' experience and independence through services close to home, and help to manage increasing demand at the most appropriate level within tight financial constraints.

Refreshed strategic objectives are in the process of being refined and developed. In working draft they are:

(a) To deliver locality-based teams and services that are grouped around GP practices and natural localities
(b) To improve the availability of services with flexible hours as standard, including 7 day working and extended hours
(c) To work with partners to deliver more integrated care
(d) To grow and develop community services ,including care and prevention, in the local health economy

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) sets out its strategic intention to become the leading national NHS specialist orthopaedic provider as:
'To be the leading centre for high quality sustainable orthopaedic and related care achieving excellence in both experience and outcomes for patients'

This is supported by three principle strategic objectives:
'To be the provider of choice for patients through the provision of safe, effective and high quality orthopaedic and related care'

'To improve outcomes for patients through partnership working with patients, staff and commissioners of services at a local and national level, and through clinical networks with other providers'

'To develop a vibrant and viable organisation where people achieve their full potential and success leads to investment in services for patients.'

As a specialist hospital working on a national footprint their strategic position reflects this. However, the pressures of managing increasing demand in a financially constrained landscape are still relevant and are cited within their planning assumptions

As well as continuing to achieve internal improvements in productivity the Trust's strategy also seeks to increase its income by attracting referrals from outside the Shropshire and mid Wales area.

The South Staffordshire & Shropshire Healthcare NHS Foundation Trust's strategic ambition recognises the need to improve service delivery and the experience of service users, carers, staff and stakeholders, within the challenges of a reducing financial envelope and that to do so requires major service redesign and development of innovative, efficient ways of working including developing partnerships outside the NHS.

The Trust has set out the following key areas for development over the next two years:

- To ensure all services and service developments support the individual's personal journey of recovery
- To reduce reliance on bed based provision for dementia and acute acre
- To define and agree outcome measures that demonstrate the quality treatments provided
- To remodel the community mental health pathway, which will be primary care led with specialist expertise and interventions easily accessible
- To remodel the acute/ crisis pathway to ensure admission is purposeful with emphasis on home based community support and treatment as soon as safely practical

Shrewsbury and Telford Hospital NHS Trust highlights within its Two Year Operating Plan a number of long standing problems which now place critical pressure on the clinical and financial viability of future services as well as the future challenges of an ageing population and achieving safe staffing levels.

The Trust sets out its main challenges as follows:

- The impact of split–site and significant duplication of services spreading expertise too thinly.
- Recruitment difficulties in key staffing groups.
- Inadequate capacity to consistently deliver healthcare targets.

- Shortcomings in performance management and systems.
- Historic cultural issues.
- Maturity of relationships across the health economy.
- The underlying financial deficit and the cost-inefficiency of the current service model.
- The chronically inadequate liquidity position and a failure to invest in capital equipment, IT and the estate.
- Gaps in junior doctor rotas pose serious risk to medical staffing shortfalls which will create the need for rationalising services onto one site in emergency medicine, critical care and general medicine.
- Inability to fully implement 7 day working on the current model.
- Inability to attract and recruit additional consultants in key specialties and particularly emergency medicine and elderly care does not allow us to achieve minimum Royal College expectations.
- Inability to achieve the highest standards of care that we aspire to as a Trust as we rely on locum for cover and shoring up duplicated services across our two sites.
- Restricted ability to maximise operational efficiency and deliver the 4% productivity improvement that is required of us in the current clinical model leaves us vulnerable in our ability to demonstrate the financial viability of the Trust.

The Trust goes on to outline the following challenges that will have a key focus going forward:

- Quality and Safety: Providing the best clinical outcomes, patient safety and patient experience
- Healthcare Standards: Delivering consistently high performance in healthcare standards
- People and Innovation: Striving for excellence through people and innovation
- Community and Partnership: Improving the health and wellbeing of our community through partnership
- Financial Strength: Building a sustainable future

The Trust also states a number of mitigating actions to address these challenges which include working closely on both the Future Fit and Better Care Fund programme. More details of this can be found in the Improvement Interventions section

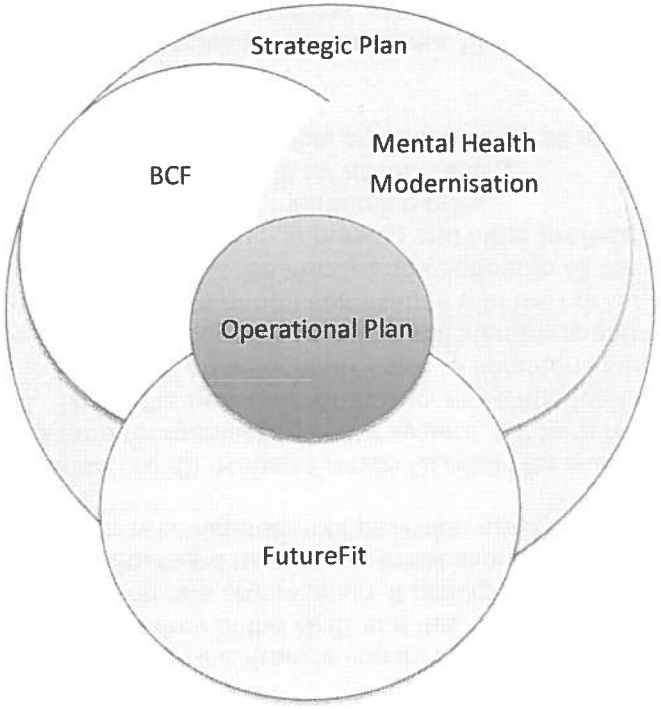
In particular the Trust highlights that having evaluated all possible options it believes that, in the longer term, there is no other feasible clinical solution than to centralise all acute, emergency and critical care facilities on a single site creating a new Specialist Emergency Care hospital for Shropshire.

Provider plans demonstrate a common understanding of the local and national pressures facing the health and care system locally and the willingness to work together to tackle these issues. Plans are cited on Future Fit and Better Care

Fund developments and in particular there is a shared drive towards transforming services and addressing issues of access, quality and demand that show alignment with the CCG's key principles of:

- **Home is normal** – being able to receive care as close to home as possible
- **Sustainability** of services, including developing a local workforce and financial viability
- **Empowering** patients through self-care and maintenance
- **Looking to the future** in everything we do, through new ways of working and integration, use of technology and planning for future generations

Summary



In summary the Strategic Plan is made up of three key component parts: Future Fit, Better Care Fund and Mental Health Modernisation. Contained within them are several strands of work which contribute to achieving this strategic vision. The operational plan acts as the key delivery document for the first two years of the overall five year strategy.

All these interlinking component parts work together to perform overlapping, but also distinct, roles in the achievement of the vision set out to the beginning of this section. As work develops over the coming months to further develop what are significant programmes of work, the way in which the strands of work will contribute to the delivery of the strategic vision will be refined and defined more explicitly.

Improving quality and outcomes	
Quality The Publication of the Francis Inquiry into failings at Mid Staffordshire Hospital has been one of the most significant events in the recent history of the NHS and has firmly placed quality at the top of the NHS agenda. Although the public inquiry was focused on one organisation, it highlights a whole system failure. The 1,782 page report has 290 recommendations which cut across and have major implications for all levels of the health service across England. There is no doubt that any plans for reconfiguration of provision must have quality as its central focus. In his report (2010), Robert Francis QC calls for a whole service, patient centred focus. His detailed recommendations do not call for a reorganisation of the system, but for a re-emphasis on what is important, to ensure that this does not happen again. These themes, outlined below, are embedded within transformation plans: - Emphasis on and commitment to common values throughout the system by all within it; - Readily accessible fundamental standards and means of compliance; - No tolerance of non compliance and the rigorous policing of fundamental standards; - Openness, transparency and candour in all the system's business; - Strong leadership in nursing and other professional values; - Strong support for leadership roles; - A level playing field for accountability; - Information accessible and useable by all allowing effective comparison of performance by individuals, services and organisation. In addition this document demonstrates how the transformation plans over the coming years will contribute to the NHS Outcomes Framework domains, set out below and have these principles at their core: - Preventing people from dying prematurely; - Enhancing quality of life for people with long term conditions; - Helping people to recover from episodes of ill health or following injury; - Ensuring that people have a positive experience of care; and - Treating and caring for people in a safe environment and protecting them from avoidable harm. As well as embedding these principles in the development of future healthcare, they will be reinforced by the implementation of local QIPP programmes, In addition all reconfiguration initiatives will be assessed against quality and safety standards at both a macro and micro level supported by an agreed Quality Impact Assessment (QIA) Tool with quality assurance and improvement as the key guiding principles.	How does the five year vision address the following aims: a) Delivering a sustainable NHS for future generations? b) Improving health outcomes in alignment with the seven ambitions c) Reducing health inequalities?

Significant progress has already been made by the CCG's to ensure systems are in place to monitor quality of health services commissioned across providers. However there is still much to do and there is a recognition of the need to work in partnership to provide assurance of quality, safety and positive patient experiences across the local health and social care economy.

Health Inequalities

As the programme of transformational work develops, clear links will be made between the implementation of key changes and the planned improvement and health outcomes and reducing health inequalities. Both CCGs are working working with Health and Wellbeing Board partners to strengthen commissioning for prevention. The wider strategic commitment for each of the Health & Wellbeing Boards is set out on page 10. Prevention is identified as a priority in both Better Care Fund submissions and work is being carried out using the tools provided in the "Commissioning for Prevention" guidance to target that work even further over the coming months.

Tackling health inequalities is a priority for both CCGs. The JSNAs have been a significant source of information in building up a local profile to support the best use of resources. This intelligence tells us that people living in the most deprived fifth of the population, particularly men are significantly more likely to have lower life expectancy and higher premature mortality than the average. However, different population groups have different experiences of health inequalities: young women from the most deprived areas are more likely to smoke in pregnancy and not breastfeed their babies, mental illness is more likely to be experienced by vulnerable groups (e.g. looked after children) and physical inactivity and prevalence of disease is more likely to be experienced by older age groups. Men with severe mental illness die 20 years younger than average and for women with severe mental illness it is 15 years. 42% of all tobacco is smoked by those with mental health problems and this group also have higher levels of obesity.

Telford and Wrekin as a whole is relatively deprived with certain areas (such as Malinslee and Woodside) ranked within the top 10% most deprived nationally (Index of Multiple Deprivation, 2010). Almost a third of Telford & Wrekin's young people live in areas ranked in the most deprived nationally.

Whilst Shropshire, overall, is less relatively deprived compared to national comparators, the same health inequalities gradient applies to the population within the county, with those who are more deprived consistently having more ill-health and lower life expectancy than those who are less deprived. Shropshire also has a relatively older population and will have an increasingly ageing population over the next five years; therefore it is likely that the prevalence of disease will increase.

Shropshire is also a large, sparsely populated rural county which creates particular challenges in relation to health

inequalities. Smaller pockets of deprivation may not be apparent at the aggregate population levels at which comparative information is compiled so that rural deprivation is less visible within this data. A rural health survey undertaken recently for the Shropshire Health and Wellbeing Board identified access to services and fuel poverty as issues of particular priority for people living in rural areas.

Tackling health inequalities and delivering a sustainable NHS for future generations go hand in hand and to this end the use of local intelligence is key in targeting resources to areas of most need. A summary of the population profile for STW is outlined in the Current Position section of this document. However, the more detailed information set out below outlines why health inequalities is high on the agenda locally and why tackling it is so fundamental to delivering the system vision set out in this Strategic Plan.

Working in Partnership

Shropshire has a long history of working in partnership with the voluntary sector and in 2013 the CCG and Council signed a Compact outlining the principles on which business with the voluntary sector would be carried out. The Voluntary and Community Sector Assembly (VCSA) operates as the co-ordinating body for voluntary sector agencies in the area and is supported by a co-ordinator post funded by Shropshire Council. The VCSA elected chair has a seat on the Health and Wellbeing Board

Telford and Wrekin have an equally robust approach to working with the Voluntary sector which includes co-production via the Programme Management Board and engagement with the Chief Officers Group

STW has comprehensive engagement programmes with stakeholders, patients and carers as part of the fabric of both FutureFit and the Better Care Fund developments over and above core organisational engagement programmes

Locally both CCGs hold patients and the quality of care that they experience at the centre of local work. STW believe that measuring outcomes rather than units of activity will create ambitions that are meaningful across health, social care and most importantly for local patients. Both CCG's will continue work locally with patient participation groups and Healthwatch to develop the use of health outcomes as measures of success for the delivery of good quality health and special care services that meet the needs of patients and their carers. These local measures will vary across Shropshire and Telford & Wrekin CCGs based on the specific needs of their local populations and reflecting the differing degrees of rurality as set out later in this section.

The basis for setting outcome ambitions for STW CCG's is the NHS Outcomes Framework, in particular the seven outcome measures highlighted by NHS England and the local measures selected by the CCGs to reflect individual health priorities. Through the implementation of this plan, the CCG's will deliver improvements in those patient outcomes as set

out in the table below during the next five years.

National Outcome Ambition	Outcome Indicator	Aggregated current performance
Securing additional years of life for the people of England with treatable mental and physical conditions	*Potential years of life lost from conditions considered amenable to healthcare: adults, children and young people*	2182.13
Improving the health related quality of life of the 15+ people with one or more long-term condition, including mental health conditions	*Health related quality of life for people with long-term conditions*	71.1
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	*Unplanned hospitalisation for chronic ambulatory care sensitive conditions*	681.21
	Unplanned hospitalisation for asthma, diabetes end epilepsy in under 19s.	342.66
	Emergency admissions for acute conditions that should not usually require hospital admission	1151.58
	Emergency admissions for children with lower respiratory tract infections	382.46
	Composite measure -	1817.26
Increasing the proportion of older people living independently at home following discharge from hospital	*No indicator available – please see section below.*	
Increasing the number of people with mental and physical health conditions having a positive	*Patient experience of hospital care*	158.6

At the Unit of Planning level, what are the five year local outcome ambitions i.e. the aggregation of individual organisations contribution to the outcome ambitions?

experience of hospital care		
Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community	*Awaiting feedback from area team as CCGs can only see performance on OOH experience*	5.9
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	*Indicator in development – please see section below.*	

Local Outcome Ambition	Outcome Indicator	SHROPSHIRE CCG		TELFORD CCG	
		Baseline	Outcome	Baseline	Outcome
Enhancing quality of life for people with dementia	*Estimated Diagnosis Rate for People with Dementia*	42%	TBA		
Improving functional ability in people with long-term conditions	*People with COPD & MRC Dyspnoea scale >=3 referred to pulmonary rehab programme*	Baseline being determined for Q4 2013/14	20% improvement by March 2015 TBA improvement by March 2018	Baseline being determined for Q4 2013/14	20% improvement by March 2015 TBA improvement by March 2018
Reducing premature deaths in people with learning disabilities	*The % uptake of health checks for adults with learning disabilities*	53.9%	60% by March 2014 TBA by March 2018		
Smoking at time of delivery				23%	18% by March 2018
Experience of integrated care	*To be determined nationally*			TBA	TBA

The following national ambitions have been set but have yet to have indicators agreed: Increasing the proportion of older people living independently at home following discharge from hospital In Shropshire the ambition has been set within the Better Care Fund that the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services will increase by 15% between March 2013 and June 2015. This will be a direct measure of the effectiveness of our new Integrated Community Service piloted during the recent winter period and planned for further roll out and development over the next 6-9 months. In Telford the ambition has been set to increase the proportion of people (65 and over) still at home after 91 day by 10% (N.B. variation between CCGs reflects different populations and current clinical pathways – T&W already has an established Enablement Service). BCF will expand the existing service by integrating acute and more community/social care staff into the community based enablement team. A "team around the practice" concept will also be developed to support integrated working to reduce avoidable admissions; and will integrate commissioning of voluntary sector provision to ensure best value. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care Locally assessment have been made of the contributory factors such as rates of C-Diff and MRSA; harm resulting from falls and avoidable pressure ulcers. Although improvement plans are in place and are supporting significant progress in reducing these causes of harm, our strategic commissioning focus will continue to be on eliminating risk for our patients. The CCGs also plan to work closely with organisations on their mortality review programmes which will include continual surveillance of their mortality statistics and actively participate as a CCG alongside strategic clinical networks and neighbouring CCGs to ensure unwarranted variation is addressed and delivery on the ambition of eliminating avoidable deaths in our hospitals caused by problems in care is achieved. Through this approach The CCG's will also seek assurances around the dissemination of learning and implementation of quality improvement plans across all our providers. Engagement to shape improvement Both CCGs have mechanisms for engaging with their member practices and ensuring clinical expertise is at the heart of decision making. In Shropshire GP Locality Committees meet regularly with the chair of each committee holding a place on the Governing Board. In Telford there is a monthly GP Forum where GP representatives from each of the member Practice attend to discuss and consider decisions which need to be made by them. This Forum is also attended by the CCG Chair, Chief Operating Officer, Executive Leads and Lead Commissioners. Both CCGs also have core organisational engagement programmes with the public and patients that ensure views of local communities play a fundamental role in service planning. The CCGs also link with engagement programmes run via their local councils Stakeholder engagement is also a key part of service management and redesign and is managed on a programme basis. Engagement is also a key	

element of work undertaken via the Health and Wellbeing Boards In relation to the current key areas of work there are specific programmes of activities related to FutureFit, the Better Care Fund and Mental Health modernisation. In relation to Future Fit there is a specific workstream associated with Engagement and Communications. The overall goal of the workstream is to empower patient and community leadership at the heart of the programme, ensuring the creation and delivery of a compelling vision for Excellent and Sustainable Acute and Community Hospital Services. A significant piece of work on engagement was undertaken via the Call to Action campaign. In all 3156 responses were received and this feedback has been utilised in the development of the FutureFit Programme and generally in the development of services across the LHE. There is a commitment to work collectively with stakeholders, including politicians to invite agreement from them to the case for change, the clinically led model and the principles of decision making. Better Care Fund consultation and engagement builds on the platform already in place via organisational core engagement programmes and the Future Fit engagement programme. Across both CCG's Better care Fund plans and implementation structures place patient and clinician representation at each level. In relation to the mental health modernisation work, the current review of progress includes engagement with patients, carers and other stakeholders to determine their experiences as a result of the changes made to date. The questions asked through the period of engagement will be based on the assumptions set out in the initial business case. The CCG Patient & Public Involvement leads and representatives from the Councils will be involved in the process. The intention to engage has been presented at both CCG patient engagement groups. Local Authorities, Healthwatch, Carers groups, Voluntary sector forums and other appropriate groups will be involved. As well as engagement events, information will also be collated from complaints departments, the Friends & Family initiative and the real time patient experience surveys that are on-going. The setting of local ambitions was informed by intelligence and local analysis looking both at historical performance trends and benchmarking of performance against other CCG areas. Health and Wellbeing Boards were involved in setting the outcome ambitions and in determining local outcome priorities. Specifically data, intelligence and local analysis was triangulated from the following resources - JSNA - CSU benchmarking report	How have the community and clinician views been considered when developing plans for improving outcomes and quantifiable ambitions? What data, intelligence and local analysis were explored to support the development of plans for improving outcomes and quantifiable ambitions?

- Anytown planning resources - Commissioning for Prevention toolkit - Patient and Public engagement/ consultation The JSNA's have been a significant resource in developing local plans and have informed the 'Local Picture' section within the Current Position part of the document above. The information contained in the JSNA's has been the key source of intelligence in developing local plans. The outcome ambitions, Health and Wellbeing Board priorities and Better Care Fund Plans are well aligned to the local JSNA's.	How are the plans for improving outcomes and quantifiable ambitions aligned to local JSNAs?
Outcome ambitions were developed with Health and Wellbeing Boards both in informal workshops and formal public meetings.	How have the Health and well-being boards been involved in setting the plans for improving outcomes?

Sustainability

In order to ensure achievement of the outcome ambitions as set out above it is essential that the health and social care economy is financially sustainable.

Are the outcome ambitions included within the sustainability calculations? I.e. the cost of implementation has been evaluated and included in the resource plans moving forwards?

Current Financial Context

Within the Unit of Planning footprint are the following main health organisations:

Shropshire CCG (SCCG)
Telford and Wrekin CCG (T&W CCG)
Shrewsbury and Telford Hospital NHS Trust (SaTH)
Shropshire Community Health Services NHS Trust (SCHT)
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH)
Shropshire and South Staffordshire Mental Health NHS Foundation Trust (SSSFT)

The economy is also supported by the following Local Authorities:

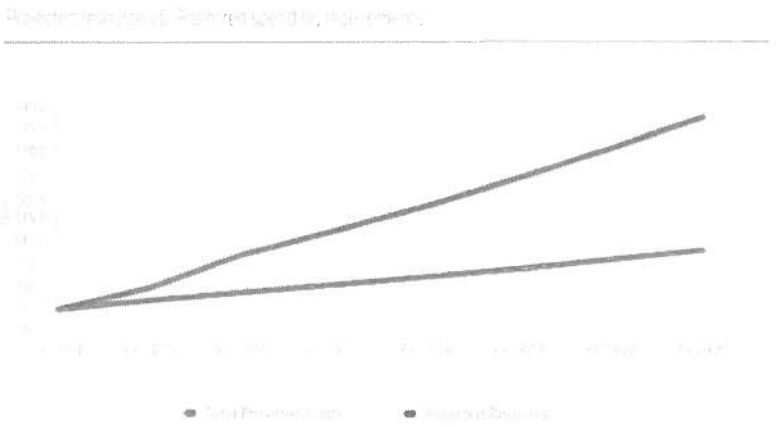
Telford and Wrekin Council
Shropshire County Council

The financial outturns of the health organisations at the end of 2013-14 were as follows:

Organisation	Surplus/ (deficit) £'000
Shropshire CCG	2,166
Telford CCG	73
SaTH	65
SCHT	45
RJAH	1,000
SSSFT	4,000

Financial Planning 2014-15 to 2018-19 - assumptions

NHS England's "A call to Action" document acknowledged that the NHS had succeeded in achieving £20bn in efficiency savings by 2015 but set out a further challenge for £30bn savings by 2021 as a result of an ageing society, changing burden of disease, lifestyle risk factors in the young, rising expectations and increased costs.



The burden of the financial gap will affect both commissioning and Provider organisations through:

- Tariff deflator/in built price efficiency resulting in Cost Improvement Programmes (Providers)
- Zero allocation growth resulting in the requirement for Quality, Innovation, Productivity and Prevention programmes (Commissioners)

Shrewsbury and Telford Hospital's strategic plan includes an assumption that the Future Fit programme will deliver a new single-site emergency care centre, with a capital cost of c£200,000,000, which will be completed within the next 5 years (the plan assumes October 2018). This would provide a sustainable solution to the principal service and workforce sustainability challenges which the Trust currently faces. The cost of capital is assumed to be funded from savings

realised through single site working. However, the Trust has assumed that, having improved its productivity through the move to a new facility, it would not be able to make the full level of efficiency savings built into the national tariff and that the shortfall would be funded by commissioners. This assumption will need to be worked through in detail with the trust once more detailed financial modelling and feasibility study reports are available from the FutureFit work later this year. Currently this assumption has not been formally agreed with the commissioners and therefore is not reflected in CCG financial plans. It is recognised by the Trust that securing approval and delivering the implementation of such a substantial capital development within this timescale will be extremely challenging.

The Trust plan does not assume any change to activity plans and tariff price assumptions arising from the new development and is, in this regard, cost-neutral to commissioners. However, the Trust has assumed that, having made improved its productivity through the move to a new facility, it would not be able to make the full level of efficiency savings built into the national tariff and that the shortfall would be funded by commissioners. This assumption has not been agreed with commissioners and is not reflected in CCG financial plans.

In order to evaluate the level of savings plans required across the health economy the organisations across Shropshire have agreed to use the Future Fit activity modelling base case assumptions as the basis for medium term financial planning. The results from the modelling became available after organisations had submitted plans for 14-15 and 15-16, however, they will be used for financial planning for 16-17 through to 18-19. A summary of the trajectories that will be used are shown below.

Future Fit Base Case Modelling Assumptions

Moderated Improvement in Age Specific Health Status 5 year trajectory		
Commissioned activity - All Admissions	%	0.80
Commissioned activity - Electives (incl Mat and Other)	%	3.10
Commissioned activity - Emergency	%	-2.80
Commissioned activity - First outpatients	%	-3.70
Commissioned activity - Follow up outpatients	%	-0.20
Commissioned activity - Out patient Procedures	%	12.60

No change in Age Specific Health Status		
Commissioned activity - All Admissions	%	2.80
Commissioned activity - Electives (incl Mat and Other)	%	4.70
Commissioned activity - Emergency	%	0.00
Commissioned activity - First outpatients	%	-4.60
Commissioned activity - Follow up outpatients	%	-1.80
Commissioned activity - Out patient Procedures	%	10.90

The modelling includes assumptions around:

Demographic Change - population size, age profile and health status
Commissioner Activity avoidance strategies - Ambulatory care sensitive conditions, Medicines related, Self Harm related, Falls related, Alcohol related, smoking related, Obesity related, End of Life Care, Cancelled Operations, Procedures of Limited Clinical Value, Frail Elderly, readmissions, GP Referral management, New to follow up ratios, Consultant to consultant referrals, frequent A&E attenders
Provider Efficiency Strategies – Increased use of day surgery, Enhanced recovery, excess bed days, Ambulatory emergency care, Stroke early supported discharge, Psychiatric Liaison, Pre-op length of stay, Frail Elderly step down, A&E investigations and attendance duration.

2014-15 Financial Plans for each organisation include the following CIP/QIPP assumptions

	SaTH £'000	SCHT £'000	RJAH £'000	SSSFT/MH £'000	Other £'000	Total £'000
SCCG	2,960	357	1,150	1,100	3,044	8,611
T&WCCG	2,632			500	2,936	6,068
CIP targets	4.6%	4.8%	4.0%	6.4%		

Schemes/workstreams have been identified for the full value of the 14-15 QIPP targets and work is ongoing on a collaborative basis between the CCGs and Providers to refine the detail, implementation and monitoring of the Programmes for 14-15 and to flesh out the detail of the savings requirements for 15-16 which are at a similar financial level. All organisations recognise the key to getting the best out of QIPP/CIP opportunities is to work collaboratively both across organisations and, within organisations, across organisational structures. As such involvement has been and continues to be at the following levels:

a) Provider Clinicians and operational managers working alongside commissioners to develop new pathways/services in line with the CCGs service development plans and the Future Fit Clinical redesign workstream.

b) Divisional heads (both clinical and managerial) invited to engagement workshops to get an overview of the Better Care Fund, QIPP plans and how they impact on the providers and also actively contributing to the Future Fit agenda

c) Directors being involved in high level QIPP discussions through contract related meetings, Health Economy Financial sustainability working groups, through the development of the Better Care Fund and through contributing to the Future Fit agenda.

d) Chief Officers meeting regularly to have oversight of health economy issues, including financial sustainability.

The level of Involvement/engagement with Providers has differed depending on the individual impacts of the QIPP programme

In achieving the above QIPP/CIP savings the planned financial positions of the organisations are:

I&E forecast	14/15 £m	15/16 £m	16/17 £m	17/18 £m	18/19 £m
SATH	- 8.20	- 6.00	- 3.20	- 2.30	0.80
SCHT	0	0	0	0	0
RJAH	1.00	1.00	1.00	1.00	1.00
SSSFT	3.60	2.60	2.90	3.20	3.20
Shropshire	3.60	3.60	3.90	3.90	4.00
Telford & Wrekin	-	2.00	2.00	2.10	2.10

As can be seen from the above table there are a number of organisations not meeting national requirements to maintain at least a 1% surplus each year with SaTH forecasting deficits for 4 of the next 5 years.

The health economy is looking to both the Future Fit programme and the Better Care Fund implementation to design clinically appropriate and financially sustainable services for Shropshire for the future. Successful achievement of these programmes will bring organisations back into financial balance and address the next 5 years QIPP/CIP savings requirements. It is estimated that the total commissioning savings required to meet QIPP targets, achieve the investment required in the better care fund and bring CCGs up to a minimum 1% surplus over the 5 years is £53m with providers also needing to achieve a further £125m in CIPs.

As mentioned above it is anticipated that, in addition to the overall financial gap there will be a movement between points of delivery as a result of the implementation of the Better Care Fund which will have the impact of reducing the financial envelope for acute services at SATH from a combined value of £205.2m in 13-14 to a combined value of £188.9m in 2018/19. This will be achieved through the implementation of the improvement interventions described in the next section. The funding required to invest in the BCF interventions has been accounted for in the QIPP targets of the CCGs for 14-15 and 15-16.

Commissioning and provider organisations are also collaborating to address the gap through congruence of benchmarking

information (e.g. Right Care Right Value, Anytown)

Finance and Activity Triangulation

The 2 year plans submitted by the CCGs and the 2 Acute Providers (The community and mental health provider contracts are mostly block) are triangulated below:

Finance and associated Activity	CCG View 2014/15 Plan Activity	CCG View 2014/15 Plan TOTAL £000s	Trust View 2014/15 Plan Activity	Trust View 2014/15 Plan TOTAL £000s	CCG View 2015/16 Plan Activity	CCG View 2015/16 Plan TOTAL £000s	Trust View 2015/16 Plan Activity	Trust View 2015/16 Plan TOTAL £000s
Shropshire CCG								
2. ACTIVITY WITH MAIN PROVIDERS								
Shrewsbury and Telford Hosptials								
1st O/p attendances	50	7,561	48	7,265	50	7,561	49	7,257
F/u o/p attendances	83	7,012	80	6,848	83	7,012	81	6,840
Elective (IP and DC)	23	21,072	23	21,064	23	21,072	23	21,040

spells								
Outpatient procedures	58	8,528	57	8,326	58	8,528	58	8,316
Non-elective spells	24	44,016	26	45,935	24	44,016	26	45,882
A&E attendances	57	5,922	56	5,897	57	5,922	57	5,890
Other	0	26,491		25,579	0	25,503		25,309
Shrewsbury and Telford Hosptials		119,602		120,914		119,614		120,535
Robert Jones and Agnes Tunt								
First Outpatients attendances	18	3,144	18	3,144	14	3,117	18	3,141
Follow up Outpatients attendances	49	3,541	49	3,541	29	3,510	49	3,537
Elective (inpatient and Daycase spells	6	15,721	6	15,721	6	15,584	6	15,705
Outpatient procedures	3	350	3	350	0	347	3	350
Non-elective spells	0	1,049	0	1,049	0	1,040	0	1,048
A&E	0	0	0	0	0	0	0	0

attendances								
Other	0	4,173	0	4,173	0	4,137	0	4,169
Robert Jones and Agnes Tunt		27,978		27,978		27,735		27,950

Finance and associated Activity	CCG View 2014/15 Plan		Trust View 2014/15 Plan		CCG View 2015/16 Plan		Trust View 2015/16 Plan	
	Activity	TOTAL £000s	Activity	TOTAL £000s	Activity	TOTAL £000s	Activity	TOTAL £000s
	000		000		000		000	

Telford and Wrekin CCG

2. ACTIVITY WITH MAIN PROVIDERS

Shrewsbury and Telford Hosptials								
First Outpatients attendances	38	5,496	61	6,557	38	5,440	61	6,549
Follow up Outpatients attendances	57	4,828	77	4,925	57	4,778	78	4,919
Elective (inpatient and Daycase spells	16	16,809	16	17,173	16	16,636	16	17,153
Outpatient procedures	31	4,516	40	4,811	31	4,470	41	4,805
Non-elective spells	19	31,920	20	32,752	19	31,593	20	32,715
A&E attendances	44	4,376	44	4,439	44	4,332	45	4,434
Other	0	15,571	0	16,819	0	15,411	0	16,640
Total Shrewsbury and Telford Hosptials		83,516		87,476		82,659		87,215

Robert Jones and Agnes Tunt								
First Outpatients attendances	6	432	3	443	6	425	3	443
Follow up Outpatients attendances	7	630	5	646	7	620	5	645
Elective (inpatient and Daycase spells	1	1,966	1	2,025	1	1,935	1	2,023
Outpatient procedures	0	66	0	68	0	65	0	68
Non-elective spells	0	113	0	106	0	111	0	106
A&E attendances	0	0	0	0	0	0	0	0
Other	0	1,655	0	1,574	0	1,629	0	1,572
Total Robert Jones and Agnes Tunt		4,862		4,862		4,787		4,857

The difference between the SCCG and SATH figures for non-elective activity is known about and accounted for by £1.3m of SCCG QIPP schemes which have not been included in the contract value because they will be implemented later in the current year. Once implemented contract variations will be raised to adjust the contract values accordingly. The SATH and T&W CCG contract for 14-15 is currently being finalised and once signed the figures will be triangulated and included in the plan.

From a Telford and Wrekin CCG perspective, the following observation should be noted in respect of the contract with SaTH;

The CCG's plan incorporates adjustments for QIPP and BCF, however the Trust have not aligned their plans with these assumptions at this time.

All parties to the plan will work toward full alignment of the five year plan during July 2014.

Providers are currently updating years 3-5 of their plans and further triangulation will be provided once this work is complete. For SaTH this work includes externally commissioned support to verify that their plans to get back into financial balance are realistic.

Finance and activity triangulation headlines can be found in the Plan on a Page at Appendix A

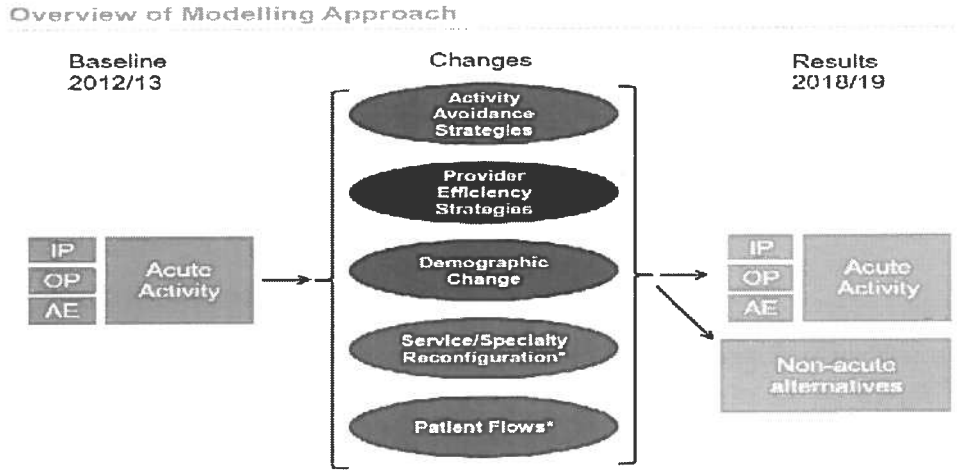
Can the plan on a page elements be identified through examining the activity and financial projections covered in operational and financial templates?

Improvement interventions	
When considering the pattern of services currently provided, local clinicians and indeed many of those members of the public who have responded to the recent Call to Action consultation, accept that there is a case for making significant change provided there is no predetermination and that there is full engagement in thinking through the options. They see the opportunity for: • Better clinical outcomes through bringing specialists together, treating a higher volume of cases routinely so as to maintain and grow skills. • Reduced morbidity and mortality through ensuring a greater degree of consultant-delivered clinical decision-making more hours of the day and more days of the week through bringing teams together to spread the load. • A pattern of services that by better meeting population needs, by delivering quality comparable with the best anywhere, by working through resilient clinical teams, can become highly attractive to the best workforce and can allow the rebuilding of staff morale. • Better adjacencies between services through redesign and bringing them together. • Improved environments for care. • A better match between need and levels of care through a systematic shift towards greater care in the community and in the home. • A reduced dependence on hospitals as a fall-back for inadequate provision elsewhere and instead hospitals doing to the highest standards what they are really there to do (higher dependency care and technological care). • A far more coordinated and integrated pattern of care, across the NHS and across other sectors such as social care and the voluntary sector, with reduced duplication and better placing of the patient at the centre of care. They see the need and the potential to do this in ways which recognise absolutely the differing needs and issues facing the most dispersed local rural populations as well as those urban populations too. This then is the positive case for change - the opportunity to improve the quality of care provided to the local, changing population. **Key Improvement Interventions** There are a number of key schemes which will be implemented over the next 5 years which will deliver real change in Shropshire: Future Fit Better Care Fund Mental Health Modernisation	Please list the material transformational interventions required to move from the current state and deliver the five year vision. For each transformational intervention, please describe the : • Overall aims of the intervention and who is likely to be impacted by the intervention • Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have • Investment costs (time, money, workforce) • Implementation timeline Enablers

FutureFit

FutureFit is a major programme of work through which the significant challenges in acute and community hospitals set out earlier in this document will be addressed. This is supported by the creation of a clinical vision to take forward the development and implementation of the preferred option for the configuration of acute and community hospital provision locally.

Through the Futurefit Programme, bespoke analytical work has been used to identify expected changes in demand and opportunities for improvement. The methodology used is summarised in Figure 1 below.



This work applies best practice to current models of care. Further work will be undertaken to assess the impact of the new models of care being developed through the clinical design workstream.

Similar work has also been undertaken to establish a baseline position on the utilisation of Shropshire's community hospitals.

One of the key tasks for the local health system in the coming year will be to identify which elements of the new models of care are dependent on major changes to hospital configuration (which will be managed through the subsequent phases of

required for example

the programme) and which can be implemented – whether fully or in part – within the current hospital configuration. From this, a comprehensive programme of improvement interventions will be developed aligned with Future Fit clinical models and activity and financial plans.

Better Care Fund

For those improvement interventions that require investment in integrated health and social care services, Health and Wellbeing Boards will take lead responsibility for commissioning service transformation through the Better Care Fund. It is also anticipated that the Urgent and Planned Care Working Groups and the Long Term Conditions Steering Groups will also have a key role to play.

The Better Care Fund, when overlaid with the remit of FutureFit sets out a comprehensive system wide transformation programme on an unprecedented scale which it is anticipated will result in significant improvements in health and social care support available in the county.

The Strategic Vision section of this document sets out the overarching principles adopted in relation to the Better Care Fund. Taking into account the application of these principles to the population needs across the area, Shropshire and Telford and Wrekin will be focusing on the following *key* pieces of work:

Shropshire:

- *Prevention* – To create a multi agency Prevention focus group to identify and deliver key prevention activity. In particular focusing on Falls as the major work stream
- *Early Intervention* – To continue to support the roll out of the Care Home Advanced Scheme (CHAS) across the county
- *Managing and Supporting People in Crisis* – To continue to support the development of the Integrated Community Service (ICS) In particular to support the roll out of the scheme county wide following the successful pilot scheme in Shrewsbury & Atcham
- *Living Independently for Longer* – To support the existing Community & Care Co-ordinators scheme and to facilitate its roll out to all GP practices across the County, to build on the current work developing Compassionate Communities across Shropshire and to work closely with Shropshire Council and the Voluntary sector to build community resilience, in particular building on Shropshire Council's 'Locality Commissioning' schemes.

Building Community Capacity

- To support improvements in the infrastructure of the voluntary and self help sector including reviewing current spend, improving effectiveness, jointly designing services and expanding engagement.

Enhanced community services as an alternative to hospital provision

- To review how existing services funded by the resources being pooled in the BCF can be maximised to improve and enhance quality, value for money, and outcomes.
- To establish an enhanced and expanded integrated and multi-disciplinary 'Out of Hospital Service' and model provision of Out of Hospital care including sourcing funding to assist the transfer of staff from acute to community services.
- To establish processes for referrals/access/assessment and support by the enhanced integrated service including the establishment of a Single Referral Point.

Develop a Team Around the GP Practice.

- To enhance access and collaboration on developing 7 day services.
- To redesign pathways and develop effective case management and risk stratification
- To continue prevention, early intervention and wellbeing within increasing financial pressures

Mental Health Modernisation

It is now 18 months since the new inpatient mental health provision, the Redwoods Centre was opened. Progress delivering the Modernisation Plan has been closely monitored by commissioners. It is important that the assumptions in the original modernisation plan are revicited to establish whether they have been met and the model of care envisaged is still the most appropriate to meet the needs of our future populations. A review of the modernisation of mental health is currently being undertaken.

The scope of the review covers:

- Inpatient bed facilities provided by SSSFT for Shropshire and Telford & Wrekin patients
- Out of Area patient placements where the bed has been purchased due to a gap in local capacity rather than the need for specialist placement
- Community Services provided by SSSFT for Shropshire and Telford & Wrekin patients

<u>Reducing premature death in people with severe mental illness</u>

A number of key work streams have been committed to in order to reduce premature death in people with severe mental illness:

- An external evaluation of the Rapid Assessment Interface and Discharge service
- All service users in receipt of care coordination to receive an annual health check in liaison with primary care to ensure health needs are addressed. This is included in the CQINs agreed as part of the contract with SSSFT.

- Further develop joint working arrangements between the smoking cessation service and mental health service users to ensure access to support both in an impatient and community setting.
- Improve working arrangements with out of hours GP services in order to create a simpler single point of access so that mental health and primary care health services can work together more effectively.
- Development of a single point of access for young people with mental health problems

Parity of Esteem

As well as those work programmes outlines above, the following work will be carried out to ensure the delivery of Parity of Esteem

- *Delivering improvement in access to psychological therapies.* Both CCG's have specific action plans with the SSSFT to ensure achievement of the given targets for 14/15.
- *Improving diagnosis and support for people with dementia.* This is a key priority for both CCG's and targeted work in in train to improve diagnosis rates in line with national expectations.
- *Crisis service provision.* Both CCG's are currently working with providers and other stakeholders to undertake a review of mental health services against the "Closing the Gap" requirements. This includes the need to ensure that people with mental health issues who require urgent care have the same access to care as those with physical health issues.
-

Further to this the CCG's will be working Closely with the Police and other professional colleagues in respect of section 136 patients so that their experience is less often one of a police station as their place of safety. This is in line with the mandate set out in the Crisis Care Concordat (HMG, 2014)

Workforce

STW work in partnership to annually review provider workforce plans in light of future commissioning intentions to ensure workforce issues are appropriately managed and are mitigated against, as far as possible, in a timely manner. In particular as part of this year's review of workforce plans providers were asked to demonstrate how they were working collaboratively with other local providers to address workforce issues on a County wide footprint, sharing resources and expertise to support the development and effectiveness of the workforce as a whole. This sentiment will continue to be reinforced and supported over the coming years

Operational Plans

The Operational Plans of both CCGs set out the improvement interventions which will take place over the first 2 years of this 5 year strategy and will set in motion the beginnings of reaching the strategic vision outlined in the System Vision section of this document. However, whilst the areas of commonality have been clearly highlighted, it is clearly necessary for each CCG to tailor its interventions to its particular populations, which are distinct. The two operational plans therefore reflect the different operational approaches required to address the particular needs of each community.

Summary of Telford & Wrekin Operational Plan

Telford and Wrekin CCGs approach to whole system transformation revolves around the 6 characteristics. Because of areas of commonality with Shropshire the plan reflects this whole economy approach. Telford & Wrekin's 2 year plan approach is to communications and engagement with staff, the public, patients, carers and partners. This is part of the overall review of the approach to equality and inclusion which not only addresses management of staff but work with local patients and other stakeholders.

The 2 year operational plan illustrates how whole system thinking deals with all stages of the interface with member practices, patients and partners e.g. the plan show how the approach to winter planning has been reviewed and improved, the management of projects through the economy-wide project management office and Telford &Wrekin's response to the Call to Action which has resulted in the inclusive Future Fit Programme and a Clinical Strategy review that has given focus to the emerging interventions such as management of patients with long term conditions through expansion of services, redesign of clinical pathways for disease areas and strengthening self-care.

Telford & Wrekin's overall approach to quality has been refreshed and the plan shows how the 6Cs have been embraced as core components of the quality strategy. This will be deployed through staff and provider populations, enhancing patient experience and choice. The TRAQS team will help to track patient feedback and promote choice through their interaction with patients.

The CCG is driving improvements in the care of patients with mental health conditions and is deploying effective mechanisms to ensure and promote a parity of esteem. Work with paediatric patients and their families will be a focus of service redesign and there is a focus on improving compliance with SEND requirements and CAMHS e.g. through the Family Connects process.

Feedback from A Call to Action and engagement with GPs has led to consideration of clustering of practices with tailored teams of integrate care professionals wrapped around the practices based on local need. This will further enable the embedding of 7 day working. Work with CCG members through a series of groups has also underpinned the new models of care emerging from the Future Fit Programme e.g. re-examination of the emergency and urgent care provision to ensure

Do the objectives and interventions identified below take into consideration the current state?

Does the two year detailed operational plan submitted provide the necessary foundations to deliver the strategic vision described?

that it represents the best value for money and care solutions. Work on 18 weeks RTT has now an embedded and robust approach to managing performance which has auditable Remedial Action Plans to improve performance and increase elective care productivity. There is a clear route for sourcing and procuring alternative provision for patients. The plan recognises the importance of working with the Area Team to enable collaborative working for primary care and specialised commissioning. All of Telford & Wrekin CCG's future intentions are evidence based and confirm that key areas of focus such as respiratory, cardiology, and frail and complex are robust. This was further confirmed through the "deep dive" undertaken by the CSU based on the Commissioning for Value packs. This evidence based approach has been used to review and refine the approach to winter planning and to ensure that the 2 year operating plan provides a platform for the 5 year strategy and gives confidence that the 7 interventions will deliver the system vision. The 2 year plan particularly focuses on 7 key interventions based on Telford & Wrekin's commissioning intentions, and the NHS England aspirations for the 6 characteristics of the modern NHS: 1. In collaboration with the Council, support the development of 'self-care' and the voluntary sector. 2. Expand integrated community services, by diverting capacity from the acute sector into community care. 3. Work with the Local Area Team to strengthen primary care, and continue to implement the programme of planned care pathway and service redesign 4. Implement a new whole system approach to Urgent and Emergency Care. 5. In collaboration with Shropshire CCG and Staffordshire and Shropshire Healthcare Foundation Trust, review the Mental Health Modernisation programme to establish: a) whether the original benefits have been achieved; b) to identify next steps towards provision of an 'Excellent Mental Health model' 6. Complete formal Procurement for a number of services to either improve quality/performance; ensure the RTT target is met; and/or to deliver QIPP savings. 7. Continue to improve the quality of medicines management in both primary and secondary care; and to focus on cross-cutting initiatives where the JSNA and other intelligence have highlighted specific problems in our population, e.g. Respiratory conditions, cancer and CVD.	

The CCG is working in partnership with Telford and Wrekin Council in recognition that, as of April 2014, individuals eligible for NHS Continuing Healthcare will have the right to request a personal health budget (PHB). This will lay the foundations and develop an effective infrastructure to respond to the policy direction that the '*right to request*' becomes a *right to have* a personal health budget from October 2014. In addition, from April 2015, the CCG anticipates being in a position to offer a personal health budget to anyone with a long-term condition who could benefit from a PHB. It is anticipated that this will make a significant contribution to strategic aim of the CCG to strengthen capacity for self-care.

Of particular note, as a result of constrained financial resources Telford & Wrekin CCG and SaTH were unable to agree to contract for 2014/15 and as result the two organisations sought support through a process of arbitration. The outcome of the arbitration has had the following implications for the CCG's strategic plan. With the following specific implications for Telford & Wrekin CCG:

- The CCG plans to achieve its statutory financial duty in 2014/15, with a planned breakeven position.
- The CCG faces a 3% QIPP challenge in 2014/15
- In 2015/16 the CCG plans to return to a "business rules" 1% surplus and this will entail a more challenging QIPP target than previously planned

The CCG and the Trust are undertaking a joint review of rehabilitation services and this may lead to service redesign

Summary of Shropshire's Operational Plan

Shropshire 2 year Operational Plan is structured around the 5 Domains and the 21 planning fundamentals, focusing in detail on what will be delivered over the next two year period

Domain 1 – Preventing people from dying prematurely

Shropshire CCG will be working closely with Public Health colleagues to develop a local response to the Commissioning for Prevention guidance in order to identify the local high impact prevention measures and to develop implementation plans to support this. In particular to understand how best to improve life expectancy for men in our most deprived areas and to enhance work on reducing smoking in pregnancy. A full review of cancer services will also be undertaken. The CCG will be developing its response to the 'Closing the Gap: Priorities for essential change in Mental Health' including implementing the recommendations from the RAID review, developing health checks for mental health service users and improved out of hours mental health provision. There will also be continued work on implementing health checks for adults with learning disabilities.

Domain 2 – Enhancing the quality of life for people with Long Term Conditions

There will be a focus on enhancing the diabetes and Pulmonary Rehabilitation services along with admission avoidance and reducing time spent in hospital for people with LTC. There will be an expansion of the Integrated Community Service

(ICS) and the Care Home Advanced Scheme (CHAS) along with the introduction of competency based education and training for care home staff linked to admission avoidance. Further to this three new paediatric pathways will be introduced along with carers champions in GP practices. Domain 3 – Helping people recover from episodes of ill health or following injury As highlighted above the ICS and CHAS schemes will be further developed with the focus on reducing re-admissions and maintaining independence. A new wheezing pathway will also be introduced. There will be clinical reviews of follow up ratios of those specialities above the WM average. In addition there are plans to appoint a joint Rehabilitation and Reablement post with Shropshire Council which will focus on commissioning more integrated rehabilitation to improve recovery. Work will also continue to consolidate stroke services on one hospital site. There will be a review of current Enable services supporting people with mental health issues into employment Domain 4 – Ensuring that people have a positive experience of care The CCG will continue to develop and embed robust systems and processes to engage, empower and support patients in matters relating to their own experiences. This will be achieved by building on current CCG strategic developments including the implementation and evaluation of the Local Health Economy End of Life strategy, engaging with forums such as our Young Health Champions and improving provision and access for people with mental illness. Following a review of local maternity services jointly commissioned by SCCG and TWCCG a programme of improving women and their families experience of maternity settings will continue. In addition the local health economy is part of a national pilot for improving patient feedback and experience across a Long Term Condition (LTC)pathway for Diabetes using the Friends and Family Test (FTT). The evaluation from the pilot will be used to inform further innovative approaches to improving positive engagement with challenging to reach minority groups. A variety of systems and processes ensure that we capture, question and act on relevant contemporaneous feedback and data to improve patient safety, experience and outcomes across all services and the improvements and learning are implemented. Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm Robust systems and processes will be implemented to ensure that relevant contemporaneous feedback is captured, questioned and acted upon and data is used to improve patient safety, experience and outcomes. A programme of the skills and expertise across key roles within CCG to interrogate and act on data to improve transparency will be developed and implemented during 2014/15. The CCG remains committed to reducing the incidence of avoidable harms via the National and Local Health Economy strategy and working groups. Measurable improvements in the prevention and control of Health Care Associated Infections are supporting significant progress towards eliminating avoidable deaths in hospital caused by problems in care and this work will continue. The CCG will continue to Deliver safe care to children in acute settings by ensuring effective implementation of the acute paediatric reconfiguration, with services moving from RSH site to PRH site which will see a reduction in bed provision and ensuring successful implementation of 3 revised pathways for wheeze/diarrhoea and vomiting/constipation Through the structure of the 21 fundamentals the plan also highlights further areas of focus, in particular 7 day services,	

financial resilience, safeguarding and parity of esteem.

Summary of provider planned initiatives contributing to transformational change

As part of their planning activities, local providers have outlined key deliverables for the next 2-5 years. These are summarised below:

Shropshire Community Trust

Development of Community Hubs - (aligned to the Futurefit clinical model)
Development of community bases or 'hubs' based on community hospitals/larger community premises offering proactive sub-acute care and both step up and step down reablement, alongside assessment, a wider range of ambulatory care, and voluntary sector support especially for self care and social needs. There is potential to develop the model using opportunities from optimising current bed use and resulting efficiencies.

Urgent care, including urgent care centres (aligned to the Futurefit clinical model)
Development of MIUs and DAART as part of new urgent care centre provision, with links to ambulatory care and diagnostics at local level.

Teams around the practice and Integrated Community Services (Integrated Community Service)
Development of more productive teams around the practice, and also the roll out and development of Integrated Community Teams. For Shropshire this will build on the new Integrated Community Services (ICS) approach in Shrewsbury implemented in 2013/14, based on discharge to assess, admission avoidance, rapid response and broader multi-agency integration than previously. For Telford it will strengthen wrap around practices, and broaden integration building on the existing reablement team approach.

Childrens' Services – CAMHs and services for children with disabilities and special educational needs (aligned to Mental Health Modernisation)
Development of the CAMHS service including addressing waiting times. Developing services including CAPA, SPA and for autistic spectrum disorder. For children with disabilities and special educational needs, working closely with local Councils to enable jointly planned services including options for personalised budgets and direct payments for support. Maximising the benefit from the new health visitor model, and fully exploring the potential of the community children's nursing service and hospital at home concept in the light of other local strategic work including 'Future Fit'.

Linked working with communities (aligned with Better Care Fund)

Development of stronger links with communities and existing Compassionate Communities and Community and Care Co-ordination initiatives to harness community capacity and contribute to patient empowerment and self management and maximise benefits to patients through seamless working. Cross cutting themes include increased partnerships and integration, including with the third sector and mental health, 7 day working, workforce development and technology support including for integrated care records, mobile working and assistive technology. **Robert Jones and Agnes Hunt** Notwithstanding the Trust's national provision, they are fully committed to working collaboratively with the local CCGs to manage increasing demand on orthopaedic services driven by an ageing population to ensure its services remain both affordable and accessible to the local populations of Shropshire and Telford & Wrekin. The Trust has outlined its alignment with Commissioner plans as: - Supporting commissioners in reducing growth in demand by actively working with them on identifying further QIPP schemes - Agreement of a long term strategic relationship with BCU to support their capacity issues - Reducing reliance on local commissioners by increasing market share across a wider commissioner base - Supporting providers who are struggling to meet RTT for orthopaedic services - Continuing to meet demand and exceed specialised services definition requirements, play an active role in the formation of the future strategy of specialised services and where there is potential consolidation of provision ensure we are well placed to benefit. There will also be specific work focussing on: - Waiting time requirements - Theatre capacity - Clinical capacity - Demand for surgical services - Bed capacity - Service improvement - Enhanced Recovery development - Outpatient pathway development - Seven day service provision - Investments in technology	

The South Staffordshire & Shropshire Healthcare NHS Foundation Trust

The Trust' Clinical Strategy's key priorities include:

1. Providing care based on the holistic principles of Recovery - this is illustrated by the increased emphasis on employment in mental health services
2. Providing care closer to home - leading to increases in community services and reduced reliance on inpatient care through integrated pathways and closer alignment to primary care
3. Providing care based on evidence based best practice - ensuring clinical services are aligned with National Guidance and informed by other data, for example patient feedback, complaints and incidents
4. Providing effective integrated patient centred care working in partnership with other health and social care providers across complex pathways
5. Providing care that recognises the physical care needs of those with mental health problems or learning disabilities
6. Enhancing quality by ensuring that all of the lessons learned from key reviews such as Francis are embedded and delivery of CQUINs and other quality indicators become business as usual
7. Continue to use feedback from partners, staff and service users/ carers to be a lever for improvements, and service change
8. Ensure individual clinicians have their own information about the quality of their care, and take action to make improvements in a way that adds value to both the service delivered to the patient and the support needed by the clinical teams
9. Continue to review and strengthen our systems to ensure good governance, and continue to maintain a culture of openness and learning

The Trust have outlined a number of areas within their business plan which contributes to the overall Future Fit Programme of transformational change. The mental health and dementia services review of models of care focuses on recovery based models which aim to deliver care in partnership with primary care and partners from other sectors, in order to offer earlier assessment and interventions reducing the need for specialist care including admissions into hospital. The details of planned improvement interventions for specific service areas are outlined below.

Mental Health and Dementia Services

- Recovery model
- Reduce need for admission and reduce average length of stay

- Evaluate the quality of services through agreed outcome measures
- Remodelling of community work to be primary care led with clear pathways and ease of access to specialist expertise and interventions as required
- Acute/Crisis Pathways remodelling to ensure that admission where required is purposeful and that there is an emphasis on care at home with support and treatment
- Explore assistive and digital technological enhancements to care
- To work with partners to develop integrated pathways of care so that there is a continuity of provision across the pathway
- Personality Disorder Strategy
- Work with partners and commissioners to develop a response to the Adult ASD Strategy
- Promotion of the service user employment strategy in order to support recovery
- Extended availability of services 8-8 7 days
- Assessment and treatment close to home and increasing access to locally available psychological services
- Work with Facilities and Estates to enhance local provision and support mobile working
- Effective transitions for young people moving from CAMHS to AMH

Learning Disabilities

- Development of intensive support services: enhancing community based care, reducing placement breakdown, avoid hospital admissions and reduce length of stay. Support out of county placements back into local provision.
- Modernisation of provision at Oak House

Specialist Services

- Enhance service models to improve clinical outcomes
- Co production of pathways with partners to enhance localised assessment and intervention
- Development of use of assistive and digital technology

Shrewsbury & Telford Hospital NHS Trust
The future development of Shrewsbury & Telford Hospital NHS Trust is synonymous with the Futurefit programme which has been covered in detail throughout this document. A detailed schedule of work associated with reaching agreement on the future vision for hospital based services in Shropshire and its implementation is underway, the end result of which

cannot be pre-empted in this document. In addition the Trust has established a number of initiatives to address immediate issues including plans to mitigate the risks of two site working outlines earlier in this document. Further details of interventions are listed below: - Progress plans to extend 7 day working - Embed a sustainable 7 day model of care for Stroke services - Scope the development of emergency ambulatory care and Urgent Care Centres - Complete workforce reviews and develop plans in challenges specialties - Complete a service review of challenged specialties, commencing with cardiology and ophthalmology and consider proposals to redesign these services - Scope options for resolving bed capacity shortfalls e.g. Hospital at Home services, working with alternative providers, implementing different models of care both internally and across the LHE - Participate in planning new models of care as part of the Better Care Fund - Complete a root and branch review of Cancer services - Participate in a strategic review of access to Orthopaedic services - Develop community service models and increase direct access for GP's - Transfer Women's and Children's services to Princess Royal Hospital, embed revised pathways and agree implementation model for Women's and Children's services remaining at Royal Shrewsbury Hospital	

Governance Overview

Future Fit is a collaborative programme through which health and care partners across Shropshire, Telford & Wrekin and the area of Powys which looks to Shrewsbury and Telford Hospital as its main provider of acute hospital services, are working together to address some of the strategic challenges set out in this plan. Membership of the programme board includes Shropshire and Telford and Wrekin CCGs, Powys Local Health Board, Shropshire Doctors, a general practice representative, Shrewsbury and Telford Hospital NHS Trust, Shropshire Community Health NHS Trust, Shropshire and South Staffordshire Foundation Trust, Robert Jones and Agnes Hunt Foundation Trust, West Midlands Ambulance Service, Shropshire and Telford & Wrekin Councils, Shropshire and Telford & Wrekin Healthwatch, Montgomeryshire Community Health Council, patient representatives from each commissioning area. The programme is also developing strong links with the Joint Health Overview and Scrutiny Committee and with both Health and Wellbeing Boards and is commissioner led in line with NHS England planning guidance.

The creation of the programme demonstrates a recognition across the health and care system of the case for changes and a commitment to work together to create a sustainable future for healthcare for Shropshire and Telford & Wrekin. Programme support and governance structures have been put in place to ensure that the management of the programme meets best practice standards and there will be external assurance of the process and key products from the programme. This includes the involvement of the West Midlands Clinical Senate to review the clinical models, the formal assurance role of NHS England, OGC Gateway reviews at appropriate points throughout the programme and oversight by Shropshire and Telford and Wrekin Councils' Joint Health Overview and Scrutiny Committee.

Governance structures are also in place via the Health and Wellbeing Boards to address the Better Care Fund requirements. In addition to this further governance arrangements are in place in relation to the Urgent Care and Planned Care Working Groups

Arising from the clinical visioning work within the FutureFit programme plans are being developed for the creation of a clinical senate to provide system wide clinical leadership to the implementation of the vision set out in this document.

In relation to mental health modernisation governance is direct to CCG Governing Boards, along with this there is a regular structure of joint quality and contract monitoring meetings. Further to this there are learning Disability Partnership Boards in place which also feed into the CCG's Governing Boards as well as governance structures in the local Councils

The clinical vision for the FutureFit programme is supported by the Programme Board which has broad membership across

What governance processes are in place to ensure future plans are developed in collaboration with key stakeholders including the local community?

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the Local Health Economy. Following a further period of engagement the clinical vision will be presented to the CCG's and provider boards in the near future. The Future Fit Programme includes the following partners: • Patient Representatives • Healthwatch Shropshire • Healthwatch Telford and Wrekin • Montgomeryshire Community Health Council • NHS England Shropshire & Staffordshire Area Team • Powys Teaching Health Board • Robert Jones and Agnes Hunt Hospital NHS Foundation Trust • The Shrewsbury and Telford Hospital NHS Trust • South Staffordshire and Shropshire Healthcare NHS Foundation Trust • Shropshire Clinical Commissioning Group • Shropshire Community Health NHS Trust • Shropshire Council • Shropshire Doctors Cooperative Ltd ("ShropDoc") • Telford and Wrekin Clinical Commissioning Group • Telford and Wrekin Council • Welsh Ambulance Services NHS Trust • West Midlands Ambulance Service NHS Foundation Trust In addition to the stakeholders above, work on the Better Care Fund also involves voluntary sector partners via the respective voluntary sector forums. In addition to the engagement programmes already highlighted in this document in relation to the Better Care Fund, FutureFit and the development of this Strategic Plan, particular workshop sessions have been held with key providers to secure their input into the plan, alignment of vision and to agree the final plan for submission Our local Area Team, representing NHS England have been involved in the development and progress of all local plans and transformation work	

Approval of Plans Health and Wellbeing Boards are cited on the development of the Futurefit Programme and have signed off Better Care Fund Plans. Both Health & Wellbeing Boards have been kept appraised of the development of the CCGs' 5 year strategic plans. Shropshire's Health & Wellbeing Board and CCG Board considered a draft of the Strategic Plan at their respective meetings in June. Formal sign off will be given at the subsequent meetings in July Similarly in Telford & Wrekin the draft plan has been considered by the Boards and will be formally signed off by the CCG Board in July and the Health & Wellbeing Board in September. The Plan will also be presented to provider Boards over the summer	Who has signed up to the strategic vision? How have the health and wellbeing boards been involved in developing and signing off the plan?

Values and principles	
In 2013, Shropshire and Telford & Wrekin CCGs, alongside the main local providers and local authority partners, agreed a Health & Social Care Partnership Compact, which set out a vision and principles for collaborative working. This was incorporated into the Principles of Joint Working set out in the Future Fit Programme Execution Plan. Key principles were agreed which "have become, and must remain, central to the operational planning and delivery of transformational change across the health and social economy". These principles are: • The central role of attitudes, behaviours and relationships. • Healthy stakeholder organisations which are capable of large scale change. • Enduring full stakeholder involvement. • Clinical engagement at the heart of the change process. • Working across organisational boundaries. • Developing integrated teams. The following Principles of Collaborative Working are set out in the Compact: • We will seek authentic savings – making changes which reduce costs through higher quality, service redesign and real productivity. We will seek to avoid making changes which save costs in one part of the system only to result in equal or greater costs to another organisation. • We will share the financial risk of making agreed system-wide changes which form part of our work programme, using an open-book approach to assess the costs and benefits of system and service change to individual organisations with the aim of reallocating resources across the health and care system to reflect impacts arising from the changes. • We will make shared decisions about which major whole-system innovations to roll-out at scale, recognising that any innovation may not always favour all parties and that at times some individual sacrifice for the common good will be necessary. • We will share appropriate information and records where that facilitates improved outcomes for the people we serve. • We will take collective responsibility for making progress towards our shared strategic vision and will agree a shared set of objectives and measures of success through which we will individually and collectively hold ourselves to account.	Please outline how the values and principles are embedded in the planned implementation of the interventions

• We will commit our organisations to a programme of collaborative work, to be agreed through the Shropshire, Telford and Wrekin Chief Officers Group. We will provide the necessary resources to individual projects and programmes and ensure senior clinical and executive participation and leadership, usually through existing groups and structures. • We will share in the overall governance of the work, through individual boards and jointly through the Chief Officers Group. • We will share organisational plans and be transparent about budgets, costs, activity and utilisation data where that is required to enable the best joint decision making and the agreement of three-year financial strategies for each part of the health and social care system and for the system overall. • We will respect the need for individual organisations to pursue their own objectives alongside these whole system objectives. We recognise that aspects of the system will be subject to competition, whether through national policy or local decisions made by commissioners, and that this may in some circumstances limit the information which an individual organisation is willing or able to share. All efforts will be made to minimise the risk that this might compromise achievement of the objectives of this Compact. • We will remain mindful of the impact we may have on other providers within our wider health economy not represented in this compact agreement. • This Compact will support and complement the wider strategic role of Health and Wellbeing Boards in setting health and well-being strategies for Local Authority areas and overseeing achievement against them.	
The CCGs published a document setting out the feedback from the Call to Action. At the associated conference a set of principles were developed for the Futurefit programme which capture the feedback from the public: • Patients are at the heart of everything we do. • All factors have been taken into account. • All decisions must be based on accurate or best-available information. • There is shared confidence that problems and issues will be addressed. • Decisions will be objective and rational, but also compassionate. • Processes will be transparent. • Decisions will be based on shared principles. • There must be two-way, honest and accurate communication with affected people. • Easily understandable language must be used. • Everyone affected by a decision must have an equitable opportunity to be involved in helping shape the decision.	Is there a clear 'you said, we did' framework in place to show those that engaged how their perspective and feedback has been included?

• A decision must attempt to address the problem for as many people as it can. • Any risks arising from the decision must be identified and mitigated as far as possible. • There must be access to specialist advice to help make the decision. Ongoing monitoring must be in place to ensure the outcome of a decision is an expected.	

Appendix A: Plan on a page

We envisage a system where, through working together, we have created a pattern of services that offer excellence in meeting the distinctive and particular needs of the rural and urban populations of Shropshire and Telford & Wrekin.

System Objective
A service pattern that will attract the best staff and be sustainable clinically and economically

System Objective
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System Objective
A service which supports care closer to home and minimises the need to go to hospital

System Objective
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System Objective
A pattern of service which ensures a positive experience of care

System Objective
A service pattern which is developed in full dialogue with patients, public and staff and which feels locally owned

Delivered through: Clinical models

Whole system models of care describing whole patient journeys. Clinically led design with strong patient engagement.

Delivered through: Workforce

Workforce engagement, support and development central to our change programmes. Redesigning roles to meet the needs of new patterns of service delivery with staff working across different care settings.

Delivered through: Change Management

Using change management methodology for system and process improvement, which support continuous learning and development.

Delivered through: Shifting finance, shifting focus

Commissioning and contracting models which support the delivery of new clinical models and patterns of service delivery and which reflect the whole patient journey and support a re-focus of care away from a

Delivered through: Managing risks/working together

Taking collective responsibility for making progress towards our shared strategic vision

Overseen through the following governance arrangements

- FutureFit
- Health & Wellbeing Boards (Better Care Fund)
- Planned Care Working group
- Urgent Care Working Group
- Possible development of a clinical senate
- System Resilience Group

Measured using the following success criteria

- 3.2% improvement in PYLL
- Improving the health related quality of life for those with LTC
- 15% improvement in unplanned hospital admissions
- Increase the number of people entering IAPT services by 15% by March 15
- Increase the level of recovery for those accessing IAPT services to 50% by March 15
- 10-15% improvement in patient experience of Hospital care
- Increase by 20% people with COPD referred into a rehabilitation programme
- Increase the dementia diagnosis rate to 67% by March 15
- Reduce permanent admissions of older people to residential and nursing care
- Increase the proportion of older people who are still at home 91 days after discharge
- Most effective use of resources
- Equitable access to the full range of services
- Improved staff recruitment , retention and satisfaction

System values and principles

We value above all else the extent to which our collective efforts will achieve real improvements in services for the people we serve. We recognise that everything we do will be achieved through our staff, stakeholder partners, with the help and support of patients, their carers and the general public and volunteers. We will demonstrate the high esteem in which we hold people, and the respect we have for them, by leading in accordance with the principles set out in the Concordat we have collectively signed up to. In particular, we will make sure that there is. a clear clinical vision for change that inspires those involved in delivering it.

Principles: Home is normal. The level of care should match the level of need and unnecessary escalation of care should be avoided. A commitment to 7 day working as part of an integrated local health economy approach. Recognition that a commitment to quality and safety is paramount for clinicians. The need to get the system right for the next 10-20 years.

NHS Shropshire and NHS Telford and Wrekin
Clinical Commissioning Groups

A summary of our 5 Year Strategic Plan

2014/15 through to 2018/19

An overview of our five year strategic plan

- In June 2014, all Clinical Commissioning Groups (CCGs) submitted a draft five year strategic plan to NHS England
- This is a joint strategic plan shared by both the Shropshire CCG and Telford and Wrekin CCG
- The plan describes in some detail the system vision for the next 5 years and has been developed in consultation with our main provider organisations

An overview of our five year strategic plan

- The strategic plan is based on three core areas of activity
  - NHS Future Fit
    - A review of hospital services
  - Better Care Fund
    - Joint service development and planning across health & social care
  - Mental Health Modernisation
- The operational plan is the detailed document that contains the actions that will deliver the three core areas of CCG business over the first 2 years of the 5 year plan

The NHS belongs to the people A CALL TO ACTION

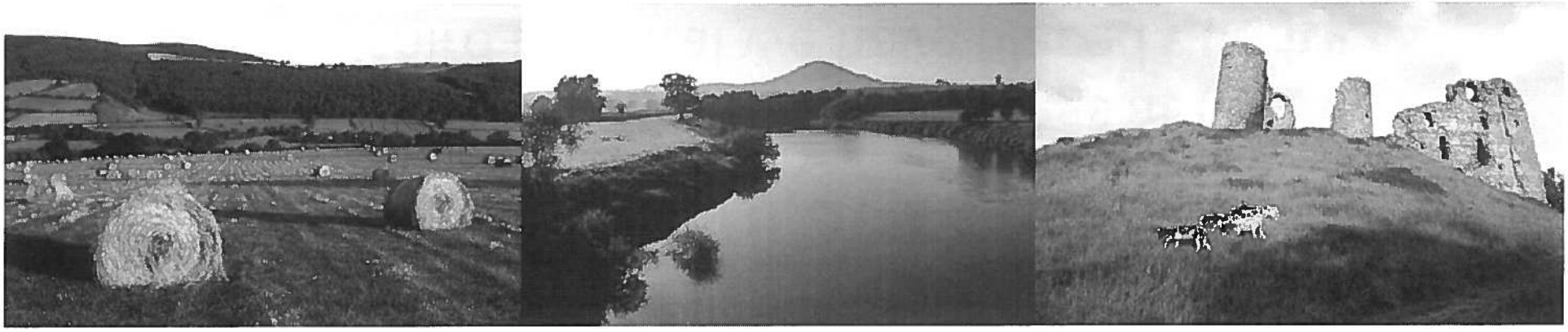
NHS

National challenges

- Our population is getting older
- People with long term health problems, such as diabetes and cancer, are living longer
- Quite rightly, our population wants the highest quality healthcare

Our local challenges

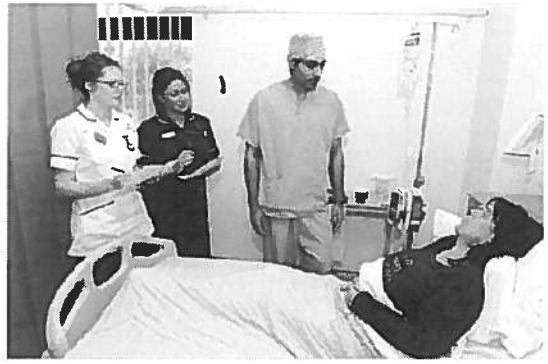
- We celebrate the fact that the life expectancy of older people has improved markedly
- In Shropshire, Telford and Wrekin the population of over 65's has increased by 25% in just 10 years!
- We have one of the largest and most rural inland counties of England
- And a high population of older people spread across a large rural area with long travelling distances to hospitals
- So we need to develop a comprehensive range and increased scale of community based health services



Specific healthcare challenges

- After the Francis Inquiry into failings at Mid Staffordshire Hospital we have placed **quality** firmly at the top of our agenda
  - This means we will ensure quality is built into every aspect of the local healthcare system
- The clinical and financial sustainability of our local acute hospital services is a concern
- The capacity of our community based services needs to be developed
- 'Parity of Esteem' – mental health needs to be a focus in everything we do

Workforce challenges



- There is a national recruitment challenge for the NHS in recruiting and retaining doctors and nurses
- Doctors' training is now more specialist and advances in medical technology mean that there are less people with the right skills for every specialism
- This is combined with an ageing workforce and the need to establish a more community centred workforce
- Our rural profile and issues of access and travel distances also adds to the challenge
- We have shortages of medical staff in A&E services, stroke, medicine, critical care and anaesthetics

NHS England resource vs demand

The funding gap is projected to be around £30bn by 2020/21.

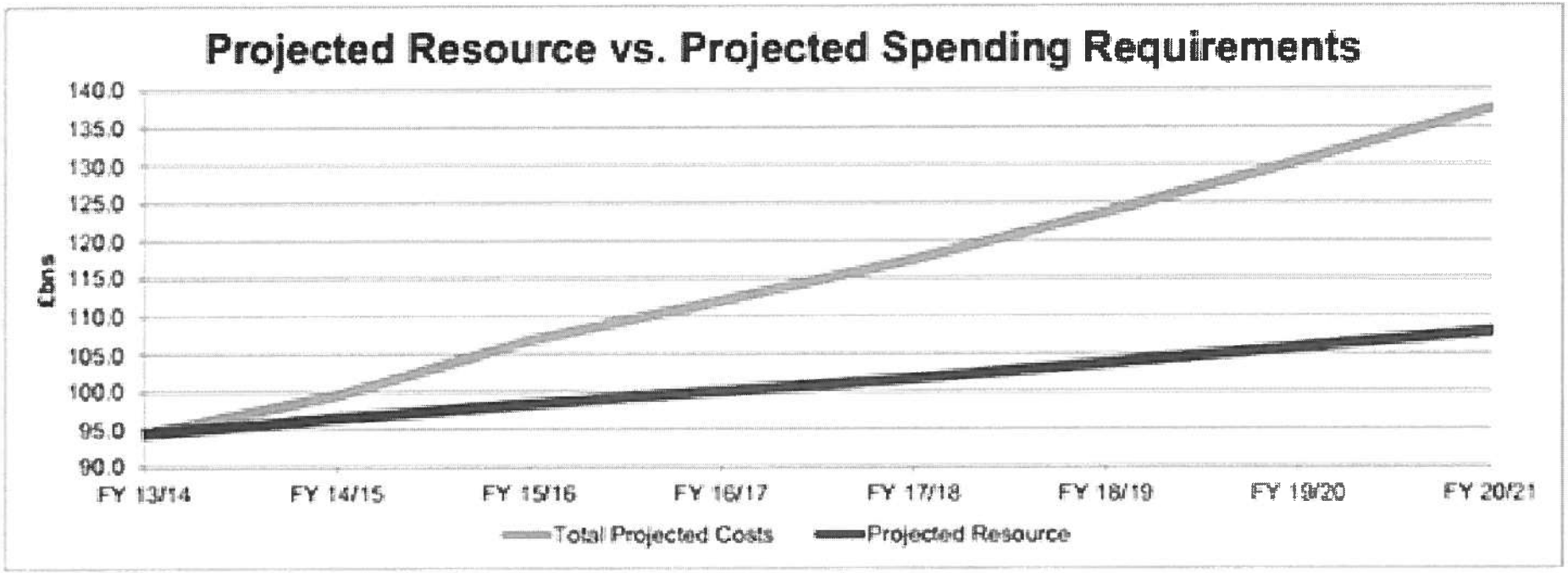


Figure 44 - Graph showing projected resource versus projected spending requirements to 2020/21

Financial challenges

- The need for investment in the latest equipment, medicine and staff with the right skills and experience
- Rising inflation – so services cost more
- Diminishing availability of specialists
- Question over viability of sub specialisms
- Greater demands on services from ageing population, health problems and lifestyle

Our system vision

'We envisage a system where, through working together, we have created a pattern of services that offer excellence in meeting the distinctive and particular needs of the rural and urban populations of Shropshire and Telford & Wrekin'

Delivering the vision

futurefit
Shaping healthcare together

Call to Action Conference Nov 2013

Patients, doctors, nurses and NHS staff agreed

Hospitals can and should be used differently

Opportunities for more people to manage their own health or receive care closer to home

It is possible to redesign and enhance services that can offer excellence in meeting the different needs of the rural and urban populations of this area

Change is needed to improve health outcomes, experience and safety for patients

Any changes should be led by clinicians with full involvement of patients and communities

futurefit
Shaping healthcare together

NHS

- A review of all hospital services – acute and community-based
- Led by clinicians with patient involvement throughout
- Final clinical model developed by more than 300 clinicians and patients – approved in June 2014
- Governed by a programme board that involves all key stakeholders

futurefit
Shaping healthcare together

NHS

	Acute Care	LTC / Frailty	Planned Care
Prevention	Make every contact count Whole economy long term strategic prevention programme	Targeted prevention	Information / Self care
Patient Empowerment	Access to reliable info about signposting and self care.	Self management. Care and EOL plans with shared decisions.	Access to reliable info re self care, local services and direct access
Advocacy and Continuity	Integrated care record	Key worker	Pathway navigation
Partnership Care	Timely specialist support to generalist in Urgent Care Centre	GP led care with specialist support and education	Tiered pathway driven care with GP and specialist at defined points. Feedback and education as the norm
Levels of Care (see diagram)	One Emergency Centre 'Some' Urgent Care Centres	Low, medium and high medical input care settings	Single Diagnostics and Centre for medium and high level procedures
Integrated Teams	SPA to access integrated community services	Integrated multi-disciplinary teams	Teams integrated around service

Whole system synergies

Better Care Fund

- The Better Care Fund is an opportunity to transform the local health and social care landscape.
- Committed to focus on four overarching principles:
  - Prevention
  - Early intervention
  - Building community resilience
  - Independent living
- An opportunity to develop the capacity of services in the community

Mental Health Modernisation

- "No health without mental health"
  - delivering high quality services with a focus on recovery
  - establishing clear waiting time limits
  - tackling inequalities in access.
- We are committed to developing parity of esteem to "put mental health on a par with physical health, and close the health gap between people with mental health problems and the population as a whole" (Department of Health, November 2013)
  - to ensure that mental health services are given the same focus as physical health services
  - The aim of which is to ensure that local agencies work together to improve care provision for those experiencing a mental health crisis.

Improving quality and outcomes

- Quality
  - We have effective systems in place to monitor the quality of health services across Shropshire, Telford and Wrekin but there is still much to do and we need to work in partnership to deliver positive patient experiences
- Health Inequalities
  - Tackling health inequalities is a priority for both CCGs each has it's own challenges whether that is urban deprivation or rural isolation we need to work together to challenge these inequalities and improve patient care
- Working in partnership
  - Both CCGs have a robust and resilient approach to partnership working with the local councils and voluntary sector organisations and they are committed to continuing these positive relationships to enhance the necessary work to continuously improve patient care
- Engagement
  - Both CCGs have mechanisms for engaging with their member GP practices and ensuring clinical expertise is at the heart of decision making this is combined with a dedicated approach to bringing patients and public into the shaping of healthcare for the whole of Shropshire, Telford and Wrekin.

Our strategic plan in summary

NHS

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Delivered through: Shifting finance, shifting focus

Commissioning and contracting models which support the delivery of new clinical models and patterns of service delivery and which reflect the whole patient journey and support a re-focus of care away from a hospital based model100

Delivered through: Managing risks/working together

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- Most effective use of resources
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System values and principles

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System Objectives

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Delivering the system objectives

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Delivered through: Managing risks/working together

Taking collective responsibility for making progress towards our shared strategic vision

Delivery governed by…

Overseen through the following governance arrangements

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System values and principles

We value above all else the extent to which our collective efforts will achieve real improvements in services for the people we serve. We recognise that everything we do will be achieved through our staff, stakeholder partners, with the help and support of patients, their carers and the general public and volunteers. We will demonstrate the high esteem in which we hold people, and the respect we have for them, by leading in accordance with the principles set out in the Concordat we have collectively signed up to. In particular, we will make sure that there is. a clear clinical vision for change that inspires those involved in delivering it.

Principles: Home is normal. The level of care should match the level of need and unnecessary escalation of care should be avoided. A commitment to 7 day working as part of an integrated local health economy approach. Recognition that a commitment to quality and safety is paramount for clinicians. The need to get the system right for the next 10-20 years.

To find out more….

- http://www.shropshireccg.nhs.uk/resources
- http://www.telfordccg.nhs.uk/publications

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD

24th SEPTEMBER 2014

CCG QUALITY PREMIUM 2014/15

REPORT OF NHS TELFORD AND WREKIN CLINICAL COMMISSIONING GROUP

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

The 'quality premium' is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing health inequalities.

The quality premium paid to CCGs in 2015/16 will reflect the quality of the health services commissioned by them during 2014/15. The payment is based on six measures that cover a combination of national and local priorities. These are:

- Reducing potential years of life lost through causes considered amenable to healthcare and addressing locally agreed priorities for reducing premature mortality (15% of quality premium);
- Improving access to psychological therapies (15% of quality premium);
- Reducing avoidable emergency admissions (25% of quality premium);
- Addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in 2014/15 and showing improvement in a locally selected patient experience indicator (15% of quality premium);
- Improving the reporting of medication-related safety incidents based on a locally selected measure (15% of quality premium);
- A further local measure that should be based on local priorities such as those identified in joint health and wellbeing strategies (15% of quality premium).

All of the measures except avoidable emergency admissions include the ability for CCGs and local partners to set either partially or fully the level of improvement to be achieved. These together with the additional local measure, need to be agreed by individual CCGs with their Health and Wellbeing Board and with the relevant NHS England Area Team.

2. RECOMMENDATIONS

That the Board agreed the quality premium targets for the Telford & Wrekin Clinical Commissioning Group (CCG) as set out in Section 3 (Impact of Action) of this report under each of the key measures.

3. IMPACT OF ACTION

- **Reducing potential years of life lost through causes considered amenable to healthcare and addressing locally agreed priorities for reducing premature mortality**

A 3.2% reduction in PYLLs has been established based on the 2012 (calendar year) figures. The baseline used will be the 2013 year end outturn and the payment based on the reduction achieved in 2014.

- **Improving access to psychological therapies**

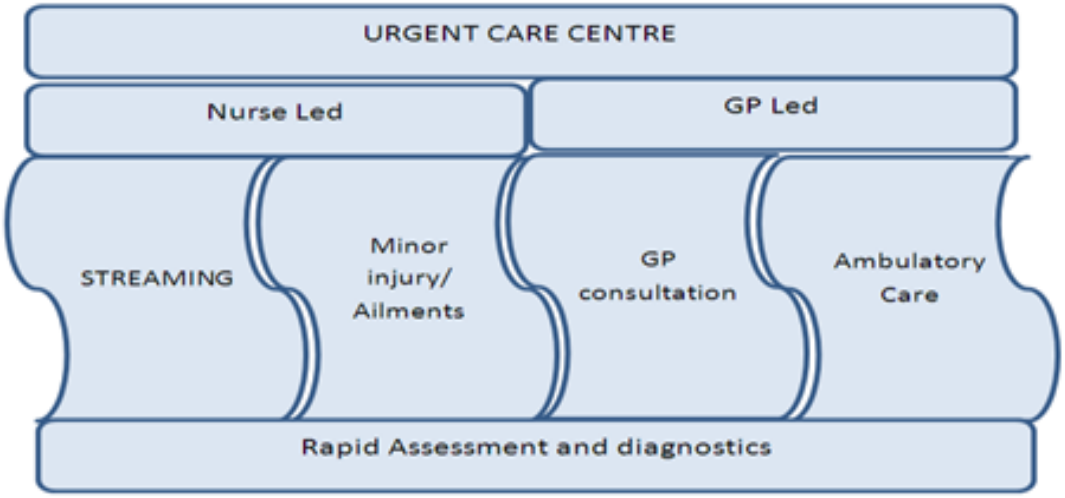
- Equity of access to psychological therapies
- 'Parity of Esteem', granting equal priority to mental health as to physical health

- **Reducing avoidable emergency admissions**

There are several priority projects that will contribute towards a successful admissions avoidance programme:

- Better Care Fund (BCF)
- Urgent Care Centre
- Redesign of local primary and community healthcare offer as part of the urgent care system
- Avoidable Admissions Enhanced Services
- WMAS 'see and treat'

The Urgent Care Centre models differ slightly across the country but they are mainly predicated on four functions: streaming; treatment of minor ailments and injuries; GP consultation; and ambulatory care; all underpinned by rapid assessment and treatment, illustrated in the diagram below.



Urgent Care Centres work cooperatively and in partnership with secondary care acting, in some cases, as multidisciplinary teams.

Clear pathways will be in place to deliver community-based care as an alternative to admission.
Effective primary to secondary care ambulatory care assessments and diagnostics will be delivered within the acute medical unit (AMU).

Reductions in emergency admissions measured in a number of ways:

- Reductions in the overall number of avoidable emergency admissions
- Reductions in the number avoidable admissions of patients who are 65+ years
- Reductions in 0-1 day Length of Stay

➢ **Addressing issues identified in the 2013/14 Friends and Family Test** (FFT), supporting roll out of FFT in 2014/15 and showing improvement in **a locally selected patient experience indicator**

The indicator chosen in the CCG's 5-year strategic planning document provided to the Area Team is for hospital inpatients, and the improvement should be 4 per cent year on year over 5 years.

E.A.5	The proportion of people reporting poor patient experience of inpatient care
Baseline	158.6
2014/15	152.3
2015/16	146.2
2016/17	140.3
2017/18	134.7
2018/19	129.3

Table from 5-year strategic planning template, submitted to NHS England on 14th April 2014.

- **Improving the reporting of medication-related safety incidents based on a locally selected measure**

- Analysis of medication safety incidents at a local and national level allows risks to be identified and communicated to healthcare providers
- Improving medication incident reporting and learning will increase patient safety.
- Improved reporting to the National Reporting and Learning System (NRLS) will ensure that local learning is cascaded to a national level

- **Reducing Smoking at Time of Delivery (SaToD)**

In England in 2012/13, the percentage of mothers smoking at delivery was 12.7 per cent. In Telford and Wrekin, this figure was 22.4 per cent.

The target for 2014/15 for Telford and Wrekin is a reduction in numbers of mothers SaToD to 20%. It is hoped that this will improve the life chances of children born in Telford and Wrekin.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	All
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	No	*No*
	Will the proposals impact on specific groups of people?	
	Yes	*Borough-wide impact*
TARGET COMPLETION/DELIVERY DATE	*31st March 2015 – This is a yearly target and is reported through the CCG Planning Performance Quality subgroup of the Board*.	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	*The maximum quality premium payment for a CCG will be expressed as £5 per head of population, calculated using the same methodology as for CCG running costs.*
LEGAL ISSUES	No	N/A
EQUALITY & DIVERSITY	Yes	*The delivery of the quality premiums will enhance the outcomes for patients within the defined areas.*
IMPACT ON SPECIFIC WARDS	Yes	*Borough-wide impact*
PATIENTS & PUBLIC ENGAGEMENT	No	*No there has been no specific engagement around the quality premium. These have been established based on CCG priority areas.*
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	*Opportunity is to improve the patient outcomes across the areas defined.*

PART B) – ADDITIONAL INFORMATION

1. INFORMATION

- **Reducing potential years of life lost (PYLL) through causes considered amenable to healthcare and addressing locally agreed priorities for reducing premature mortality (actions apply to CCG and Public Health)**

The table below provides a summary of the top causes of PYLL for Telford and Wrekin for the period 2010-2012. The table demonstrates that cardiovascular diseases (CVD) and cancers are the most significant contributor to PYLL, accounting for more than 74% of the total. These are key Health and Wellbeing Board priorities given the significant impact on life expectancy.

NHS Telford and Wrekin CCG	**PYLL from causes considered amenable to healthcare (2010-12)**	
Condition (ICD10 group)	**Potential years lost**	**% of total PYLL**
Ischaemic heart disease (Coronary Heart Disease)	4,675	33%
Neoplasms (cancer)	4,075	29%
Cerebrovascular diseases (Stroke/ Transient Ischaemic Attack)	1,803	13%
Respiratory diseases	941	7%
Total PYLL	**14,186**	

The CCG has had early discussions with Local Authority Public Health on how to work collaboratively to achieve this indicator, taking into account the priority areas of coronary heart disease (CHD); stroke; cancers (bowel and breast predominately); and respiratory. Two recent publications have helped inform initial discussions. The first; “Living Well for Longer” (NHS England April 2014), highlights some of the high impact interventions to reduce premature mortality. The second, “Our ambition to reduce premature mortality" (NHS England December 2013), provides a framework and toolkit resource to commissioners.

Together, the CCG and Public Health have undertaken a gap analysis of current commissioning arrangements and drawn up a joint plan that is cross-referenced with the diagnosis (ICD-10) codes used to record the causes considered amenable to healthcare.

- **Improving access to psychological therapies (action applies to the CCG)**

The Department of Health is keen to ensure that all patients have the same equity of access to mental health services as those requiring access for physical health problems – i.e. Parity of Esteem. In 2009 a new initiative was developed to improve access to care which was called Improving Access to Psychological Therapy (IAPT). IAPT is a national target to ensure that people experiencing anxiety and depression have access to talking therapies, in particular Cognitive Behavioural Therapy (CBT). There are two elements to the target:

- 15% of the population with anxiety and depression will have accessed IAPT services by April 2015;
- 50% of those people accessing therapy will have reached recovery (as defined nationally).

The CCG provides quarterly reports to NHS England to ensure compliance with the target. The service is provided by South Staffordshire & Shropshire NHS Foundation Trust.
At the end of 2013/14 the percentage of people accessing the service was 9.8 per cent: this exceeded the target of 9%.

- **Reducing avoidable emergency admissions (action applies to the CCG)**

Develop and implement new pathways from GPs and West Midlands Ambulance Service (WMAS) for potential admissions for identified conditions including Urinary Tract Infections; Respiratory conditions; Falls; and End of Life care. Target population: those with long term conditions or ambulatory care needs.

Develop and implement Ambulatory Care pathways with Shropshire Community Trust, GP, Council and hospital staff (primary and secondary care interface) to complete rapid assessment and diagnostics and return home with appropriate treatment and support. These pathways would support the acute specialist interventions to manage escalating Long Term Conditions (LTCs), as well as the conditions identified above.

- **Addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in 2014/15 and showing improvement in a locally selected patient experience indicator (action applies to the CCG)**

- **Reducing the number of patients reporting a poor hospital experience**

The NHS Friends and Family Test is part of a systematic approach to improving patient experience and is based on one simple question (would they would recommend hospital wards, accident and emergency units to a friend or relative based on their treatment) that ensures that local hospitals and the public get regular, up to date feedback on what patients think about

their services. It provides a mechanism to identify poor performance and encourage staff to make improvements where services do not live up to the expectations of patients. This leads to a more positive experience of care for patients.

The indicator chosen in the CCG's 5 year strategic planning document provided to the Area Team is for hospital inpatients and A&E and the percentage improvement should be 4% year on year over 5 years (see chart in impact section). Additionally, the CCG is looking for an improvement on the target average score for positive responses from 75% in 13/14 to 80% in 2014/15. This is generally aligned to Shropshire CCG's targets.

In 2013/14 our main acute provider (Shrewsbury & Telford Hospitals) has struggled with responses to the FFT, particularly in A&E. The CCG is in continual dialogue with the Trust and Area Teams to explore how the capture rate and score can be improved. Currently, the Trust has had a successful 1-month pilot in the use of volunteers when capturing the data and this will now be rolled out for a longer period. This has already had a positive impact on the scores.

The Robert Jones & Agnes Hunt NHS FT is already among the top 5 trusts nationally.

- **Improving the reporting of medication-related safety incidents based on a locally selected measure (action applies to the CCG)**

Research evidence indicates that 5% of prescription items issued in general practice contain errors. 0.18% contain serious errors.

Between January and December 2013:
2,744,347 prescription items were dispensed in Telford. If we assume a 5% error rate, there were 137,217 errors. If we assume a 0.18% serious error rate, there were 4,940 serious errors.

Only 10 medicines related safety incidents were reported to the CCG between April-December 2013.

A Patient Safety Incident (PSI) is any unintended or unexpected incident, which could have or did lead to harm.

Medication errors are PSI incidents where there has been an error in the process of prescribing, preparing, dispensing, administering, monitoring or provision of medicines advice. These can be divided into two categories:-
1. Error of commission e.g. wrong medicine or wrong dose
2. Error of omission e.g. omitted dose or failure to monitor

Proposal

During 2014/15 the CCG will work closely with GP practices, Community Pharmacies and Care Homes across Telford to improve medication-related incident reporting and learning.

The CCG currently receives on average 3.25 medication-related safety incidents reports from primary care per quarter. The CCG will increase reporting by at least 100% during 2014/15 and will commit to receiving and learning from a minimum of 7 incident reports during Q4 2014/15.

- **A further local measure that should be based on local priorities such as those identified in joint health and wellbeing strategies: Mother's Smoking at Time of Delivery status (actions apply to CCG and Public Health)**

Reducing Smoking at Time of Delivery (SaToD)

Smoking remains one of the few modifiable risk factors in pregnancy. It can cause a range of serious health problems, including lower birth weight, pre-term birth, placental complications and perinatal mortality. Babies from deprived backgrounds are more likely to be born to mothers who smoke, and to have much greater exposure to second-hand smoke in childhood.

The following actions will be taken forward in 2014/15:

- Increased contract with North 51 (smoking cessation provider) until end of March 2015
- Develop an 'opt out' referral from sonographers at 20 week scan
- Look at having a stop smoking service presence at the consultant-led sessions at PRH
- Check phone numbers for clients are the same on all databases
- Develop resources for professionals to give smoking mothers-to-be about issues such as
  - Wanting babies to sleep through the night
  - Low birth weight
  - Babies going through withdrawal symptoms
- Hospital Stop Smoking Service to continue to deliver on the midwife training
- To be part of a pilot to improve the system and process of electronic referrals (one of only two in the country)
- To improve the data from SaTH to CCG and Public Health on smoking at booking and smoking at delivery
- Periodically check data on those recorded as SATOD and those supported to quit at delivery by the stop smoking service
- Develop a local marketing and communications plan managed through the Smoking in pregnancy working group, with input from both the CCG and Public Health.

2. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

Please see main report above.

3. PREVIOUS MINUTES

N/A

4. BACKGROUND PAPERS

Quality Premium: 2014/15 guidance for CCGs - NHS England/Commissioning Development/Commissioning Policy and Primary Care 13 March 2014

Report prepared by Nicky Wilde, Interim Deputy Executive Lead for Commissioning and Quality Telephone: 01952 580418

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD

24th SEPTEMBER 2014

PHARMACEUTICAL NEEDS ASSESSMENT BRIEFING

REPORT OF: HELEN ONIONS, CONSULTANT IN PUBLIC HEALTH, TELFORD & WREKIN COUNCIL, HITESH PATEL, PHARMACEUTICAL ADVISER, NHS TELFORD AND WREKIN CCG

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

Health and Wellbeing Boards (HWB) have a legal duty[1] to publish revised Pharmaceutical Needs Assessments (PNA) for their area by 1st April 2015. The process requires HWB Board sign-off and a period of public consultation beforehand. This report outlines the approach and process taking place for the PNA refresh in Telford and Wrekin.

2. RECOMMENDATIONS

The Board is requested to endorse the PNA refresh process described in this report.

3. IMPACT OF ACTION

- The PNA, which is part of the wider Joint Strategic Needs Assessment, will be used to make decisions on which services, including public health services, need to be provided by local community pharmacies
- In addition, the PNA will be used by NHS England when deciding if new pharmacies are needed, in response to applications by businesses, including independent owners and large pharmacy companies

[1] Part 2, Regulation 5 of NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	Potentially all Health and Wellbeing priorities can be influenced by the role of community pharmacy as a key provider of primary health care services.
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	Yes	• Improving the health and wellbeing of our communities and addressing health inequalities
COMMUNITY IMPACT **(cont.)**	Will the proposals impact on specific groups of people?	
	Yes	Local pharmacy has a key role in providing primary care services within our local communities.
TARGET COMPLETION/DELIVERY DATE	➢ The draft PNA will be prepared to start the 60 day public consultation period on 24/11/2015 ➢ The refreshed PNA will be presented to the HWBB on 11/03/15 and published by the end of March 2015 ➢ See Appendix I for a detailed timeline for the PNA process	
FINANCIAL/VALUE FOR MONEY IMPACT	No	
LEGAL ISSUES	Yes	Statutory provisions requiring the Pharmaceutical Needs Assessment are outlined in the main body of this report at Part A paragraph 1 and Part B paragraphs 1.1 and 1.2. Further, in addition to adhering to the general principles for an effective consultation process, the consultation (in addition to the content of the PNA) must adhere to the rules set out in the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.
EQUALITY & DIVERSITY	Yes	There is evidence that community pharmacy has a key role to play in health inequalities as often pharmacies are the first point of call for those requiring support who may not have engaged with other health services.

IMPACT ON SPECIFIC WARDS	No	None – community pharmacies are located throughout the borough.
PATIENTS & PUBLIC ENGAGEMENT	Yes	➢ Public consultation and engagement is a specific requirement of the PNA process. ➢ As part of this a Telford and Wrekin survey of community views on pharmacy services is now live[2] (see link). The survey runs until 11th October 2014. ➢ The 60 day public consultation on the draft PNA is due to take place between 22/11/14 and 22/01/15.
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	None

[2] http://www.elesurvey.co.uk/servlet/survey.PreviewSurvey?surveyId=612244&pwd=3b39&TestMode=Yes&ARGS=-576259144

PART B) – ADDITIONAL INFORMATION

1.1 Background

- Community pharmacies are a valuable and trusted public health service. The scale of daily contacts with the public means there is real potential to use community pharmacy teams more effectively to improve health and wellbeing and to reduce health inequalities.
- From 1st April 2013, Health and Wellbeing Boards (HWB) in England assumed the responsibility[3] to publish and keep up-to-date a statement of the needs for pharmaceutical services of the population in its area, through Pharmaceutical Needs Assessment (PNA).
- PNAs have been used historically by the NHS to make decisions on which NHS-funded services need to be provided by local community pharmacies. Now following transition of public health services to local authorities, PNAs should also be used to assess the contribution of community pharmacies to local public health programmes.
- In addition, PNAs will be used by NHS England when deciding if new pharmacies are needed, in response to applications by businesses, including independent owners and large pharmacy companies. Applications are keenly contested by applicants and existing NHS contractors and can be open to legal challenge if not handled properly.

1.2 Expectations for Health and Wellbeing Boards

- HWBs have a legal duty[4] to check the suitability of existing PNAs, originally compiled by primary care trusts (PCTs), and publish supplementary statements explaining any changes.
- Each HWB will need to publish its own revised PNA for its area by 1st April 2015. This will require board-level sign-off and a period of public consultation beforehand.
- HWBs need to ensure that the NHS England Area Teams have access to their PNAs.
- Failure to produce a robust PNA could lead to legal challenges because of the PNA's relevance to decisions about commissioning services and new pharmacy openings.

1.3 Key Elements of PNA

- PNAs should include pharmacies and the services they already provide, including dispensing, providing advice on health, medicines reviews and local public health services, such as stop smoking, sexual health and support for drug users.
- PNAs should also consider other services, such as dispensing by GP surgeries, dispensing appliance contractors, and services available in neighbouring HWB areas that might affect the local need for services.

[3] Section 128A of NHS Act 2006, as amended by Health Act 2009 and Health and Social Care Act 2012

[4] Part 2 of National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013

- PNAs should examine demographics of the local population, across the area and in different localities, and their health and wellbeing needs.
- PNAs should consider gaps that could be met by providing more pharmacy services, or through opening more pharmacies. It should also take account of likely future needs.

1.4 Refreshing the Telford and Wrekin PNA

The Telford & Wrekin PNA was originally published by the PCT in February 2011. A core group (including the CCG Pharmaceutical Adviser and the Council's Consultant in Public Health and Senior Research & Intelligence Officer) began working on the PNA refresh plan in April 2014. A steering group has been established and will be meeting on a two monthly basis during 2014/15 to ensure that the refreshed PNA is prepared for the Health and Wellbeing Board in March 2015. The group includes representatives from key HWB organisations, including: the CGG, the Council, NHS England Shropshire and Staffordshire Area Team, the Local Pharmaceutical Committee and Healthwatch Telford & Wrekin. The purpose and aims of the Telford and Wrekin PNA Steering Group are to:

- Coordinate the update of the Pharmaceutical Needs Assessment (PNA) in line with current legislation
- Oversee the overall process for updating the PNA within the required timescale
- To agree the statement of the needs for pharmaceutical services in Telford and Wrekin
- To agree and oversee the process for assessing the current provision of pharmaceutical services by pharmacies, appliance contractors and dispensing practices within Telford and Wrekin (and neighbouring areas where appropriate)
- To ensure that accurate maps identifying the premises where services are provided are produced
- To agree and oversee the process required for the statutory consultation with all relevant parties as laid out in the regulations
- To develop a framework for subsequent assessments and supplementary statements
- To take into account any further legislation that may impact on the PNA

The terms of reference of the steering group, which includes the membership, are shown in Appendix I. A timeline has been produced for key milestones in the process, this includes: a public consultation phase and briefing dates for relevant Boards and Committees (see Appendix II).

1.5 Wider links

There is a key requirement for PNAs to be aligned with other plans for local health and social care. The Telford and Wrekin PNA will be strongly aligned to the Health and Wellbeing Strategy and associated priorities and will be an integral part of the wider JSNA process.

The PNA also has relevance to the work of the Better Care Fund and the wider NHS services reconfiguration Futurefit work programme. Specifically, the PNA should support these programmes by defining community pharmacy current and future needs and provision.

2 IMPACT ASSESSMENT – ADDITIONAL INFORMATION

Please see section 4 above for detailed information on impacts associated with this work.

3 PREVIOUS MINUTES

There are no previous minutes – this is the first PNA report to the HWB.

4 BACKGROUND PAPERS

None.

Report prepared by Helen Onions, Consultant in Public Health
Telephone: 01952 381028

APPENDIX I

Telford and Wrekin Pharmaceutical Needs Assessment

Steering Group Terms of Reference

1 Membership

Name	Role/Title	Organisation
Helen Onions	Consultant in Public Health (chair)	Telford & Wrekin Council
Paul Thomas	Senior Research & Intelligence Officer	Telford & Wrekin Council
Lynne Deavin	LPC Business Development Officer	Shropshire Local Pharmaceutical Committee
Kate Ballinger	Patient/Public Representation	Healthwatch Telford & Wrekin
Dr A Egleston	Dispensing Doctors Representative	GP Wellington Road, Newport
Ruth Bolderston	Assistant Contracts Manager	Shropshire and Staffordshire Area Team
Jacqui Seaton	Head of Medicines Management	NHS Telford & Wrekin CCG
Manir Hussain	Chair – Pharmacy Local Professional Network	NHS England Area Team
Hitesh Patel	Pharmaceutical Adviser	NHS Telford & Wrekin CCG

2 Reporting and Governance Arrangements

PNA developments will be reported as follows:

- Jacqui Seaton/Hitesh Patel will report to CCG Governance Board
- Manir Hussain/Helen Onions will report to Area Team Primary Care Quality Group
- Manir Hussain will report PNA development to the Area Team
- Helen Onions/Jacqui Seaton/Hitesh Patel will report to the Strategic Commissioning Group and Health & Wellbeing Board
- Kate Ballinger will report PNA development to Healthwatch representatives where necessary

3 Purpose and Aims of the PNA Steering Group

- Coordinate update of the Pharmaceutical Needs Assessment (PNA) in line with current legislation.
- Oversee the overall process for updating the PNA within the required timescale.
- To agree the statement of the needs for pharmaceutical services in Telford and Wrekin.
- To agree and oversee the process for assessing the current provision of pharmaceutical services by pharmacies, appliance contractors and dispensing practices within Telford and Wrekin (and neighbouring areas where appropriate).
- To ensure that accurate maps identifying the premises where services are provided are produced.
- To agree and oversee the process required for the statutory consultation with all relevant parties as laid out in the regulations.
- To develop a framework for subsequent assessments and supplementary statements.
- To take into account any further legislation that may impact on the PNA.

4 Frequency of Meetings / Communications

- The group will meet as deemed necessary (2 monthly). Wherever possible email will be used to communicate ongoing PNA development.
- Through the development phases the Public health lead and Medicines Management lead will coordinate the PNA development.
- Specific meetings around public consultation and formal consultation will be led by the communications team (LA and CCG).
- Other stakeholders will attend meetings only as necessary
- A formal meeting/communication will be arranged to agree a final draft PNA prior to consultation.
- Hitesh Patel will coordinate communication with the LPC during the PNA development. (LPC meeting updates will be scheduled as necessary)
- Hitesh Patel will coordinate communication with Wellington Road Medical Practice, Newport during the PNA development.
- Public engagement and consultation will be coordinated with support from Healthwatch Telford & Wrekin and local CCG patient group representatives.

5 . Conflicts of interest

Member	**Conflict of interest**
Helen Onions	None
Paul Thomas	None declared
Lynne Deavin	LPC Business Development Officer representing interests of all community pharmacies in Telford and Wrekin.

	No financial interest in any community pharmacy in Telford and Wrekin.
Kate Ballinger	None declared
Dr A Egleston	Dispensing doctor practice representative from Wellington Road Medical Practice, Newport.
Ruth Bolderston	None declared
Jacqui Seaton	None
Manir Hussain	None declared
Hitesh Patel	Brother (Mr Yogesh Patel) is current owner of Lawley Pharmacy, Lawley Bank, Telford. No financial interest in Lawley Pharmacy.

APPENDIX II

Telford & Wrekin Pharmaceutical Needs Assessment Timeline 2014/15 (Updated Sept 2014)

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Agree members of PNA steering group												
Agree PNA timeline and action plan												
Develop community pharmacy baseline profile (Survey for current provision)												
Local mapping by locality												
Establish PNA steering group		08.05.14										
Brief Strategic Commissioning Group		20.05.14										
Locality analysis of priorities and health needs (linking PNA with LA/CCG priorities/health needs)												
Brief LPC on PNA progress and proposed timeline												
Brief NHS E Primary Care Quality Group			17.06.14									
Patient / Public engagement and consultation						01.09.14	13.10.14					
Update CCG Board				08.09.14								
Health & Wellbeing Board Briefing Report						24.09.14						
Brief Local Pharmaceutical Committee				1.07.14								
Brief Local Medical Committee						24.09.14						
Finalise PNA draft for consultation (including sig off from steering group)								17.11.14				
Consultation starts (60 days)								24.11.14				
Consultation ends										22.01.15		
Meeting to consider consultation responses and amend draft PNA										27.01.15		
Finalise draft of PNA for consideration by Health and Wellbeing Board											02.02.15	
Final draft document approved by PNA steering group to be put for consideration by Health and Wellbeing Board											10.02.15	
Health and Wellbeing Board consider draft PNA together with outcome of consultation and decide on a version to be approved and published (legal comment deadline 20.02.15, democratic services deadline 27.2.15)												11.03.15
PNA Published												31.03.15