Shropshire Council
Legal and Democratic Services
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

Date: 13 November 2014

Committee:
Health and Wellbeing Board

Date: **Friday, 21 November 2014**
Time: **8.30 am**
Venue: **Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND**

You are requested to attend the above meeting.
The Agenda is attached

Claire Porter
Corporate Head of Legal and Democratic Services (Monitoring Officer)

Members of Health and Wellbeing Board

Karen Calder (Chairman)
Ann Hartley
Lee Chapman
Professor Rod Thomson
Stephen Chandler
Karen Bradshaw
Dr Caron Morton (Vice Chairman)
Dr Helen Herritty
Dr Bill Gowans
Paul Tulley
Jane Randall-Smith
Graham Urwin
Jackie Jeffrey

Your Committee Officer is:

Karen Nixon Committee Officer
Tel: 01743 252724
Email: karen.nixon@shropshire.gov.uk

AGENDA

1 Apologies for absence

To receive apologies for absence.

2 Minutes (Pages 1 - 6)

To approve as a correct record the Minutes of the meeting held on 10 October 2014 which are attached.

Contact Karen Nixon on 01743 252724.

3 Public Question Time

To receive any questions, statements or petitions from the public, notice of which has been given in accordance with Procedure Rule 14.

4 Disclosable Pecuniary Interests

Members are reminded that they must not participate in the discussion or voting on any matter in which they have a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

5 Future Fit Programme Update (Quality & Performance) (Pages 7 - 30)

A report is attached.

Contact Dr Caron Morton, Accountable Officer Shropshire CCG, Tel 01743 277580

6 Better Care Fund Update - Shropshire (Quality & Performance) (Pages 31 - 36)

A report is attached.

Contact Stephen Chandler, Director of Adult Services, Tel 01743 253704

7 Launch Year of Physical Activity 2015 (For Decision/Endorsement) (Pages 37 - 50)

A report is attached

Contact Miranda Ashwell, Public Health Programme Lead, Physical Activity Tel 01743 253935.

8 Children's Trust Update (For Decision/Endorsement) (Pages 51 - 78)

A report is attached.

Contact Karen Bradshaw, Director of Children's Services, Tel 01743 254201.

9 Mental Health (For Information)

A report will follow.

Contact Dr Julie Davies, Shropshire CCG, Tel 01743 277500.

10 Crisis Care Concordat Update (for Information)

A report will follow.

Contact Dr Julie Davies, Shropshire CCG, Tel 01743 277500.

11 Neighbourhood Life (For Information)

A presentation will be made.

Contact George Candler, Director of Commissioning, Tel 01743 255003 or Miranda Ashwell Tel 01743 253935.

12 Health & Wellbeing Strategy - Refresh Process (For Information)

A presentation will be made.

Contact Prof Rod Thomson, Director of Public Health, Tel 01743 253934.

13 Next Steps Towards Primary Care Co-Commissioning (For Information) (Pages 79 - 126)

A document published by NHS England on 10 November is attached for information.

Contact Dr Caron Morton, Accountable Officer, Shropshire CCG, Tel 01743 277580 or Graham Urwin, NHS England, Tel 0300 7900 233 ext 3495.

Shropshire Council

Committee and Date

Health and Wellbeing Board

21 November 2014

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 10 OCTOBER 2014
9.30 AM - 12.10 PM

Responsible Officer: Karen Nixon
Email: karen.nixon@shropshire.gov.uk Tel: 01743 252724

Present
Councillor Karen Calder (Chairman)
Councillors Lee Chapman, Professor Rod Thomson, Stephen Chandler, Dr Caron Morton (Vice Chairman), Dr Bill Gowans, Paul Tulley, Jane Randall-Smith and Rachel Wintle (substitute for Jackie Jeffrey)

Others present:
Penny Bason, Charlotte Cadwallader, Paul Cooper, Gerald Dakin, Alastair Findlay, Peter Gillard, Amanda Holyoak, Madge Shineton, Sam Tilley and Dave Tremellen.

53 **Apologies**

53.1 Apologies for absence were received from Karen Bradshaw, Ann Hartley, Helen Herritty, Jackie Jefferies and Graham Urwin.

53.2 Rachel Wintle substituted for Jackie Jefferies (VCSA).

54 **Minutes**

RESOLVED:

54.1 That the minutes of the meeting held on 29 August 2014 be approved as a correct record and signed by the Chairman.

54.2 That the minutes of the meeting held on 11 September 2014 be approved as a correct record and signed by the Chairman, subject to it being amended that Dr Julie Davies substituted for Paul Tulley and not Dr Caron Morton as indicated.

55 **Public Question Time**

There were no public questions.

56 Disclosable Pecuniary Interests

Members were reminded that they must not participate in the discussion or voting on any matter in which they had a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

57 Preventive Mental Health (For Decision)

57.1 The Director of Public Health confirmed that the report entitled 'Improving Access to Psychological Therapies – The Shropshire Model' which had been previously circulated, by Professor Patrick Pietroni had been withdrawn from the agenda and would not be considered at the meeting.

57.2 It was explained that due to the recent publication of a document entitled 'Achieving Better Access to Mental Health Services by 2020' by the Department of Health (DoH), which was circulated at the meeting for information only, plus a short briefing paper by Officers, (again for information only) which was also circulated giving background, key points and some information about funding – copies attached to the signed minutes – the original report by Professor Patrick Pietroni had been withdrawn.

57.3 It was agreed that the implications of what had recently been disseminated by central Government would have to be considered by everyone before the Board looked at this. It was also noted that this item would be deferred to a future meeting for discussion once it had been to the Clinical Advisory Panel.

57.4 Very briefly, the DoH document put mental health on the same footing as other physical mental health services as far as access and treatment were concerned. It also introduced targets, similar to physical health targets and put an emphasis on improving liaison psychiatry services, better resolution team services and more developed CAHMS services. It was underpinned by the National Health Service Concordat. It was understood that new monies were to be announced shortly; a lot of which would be 'freed up' from elsewhere. It was generally agreed that it was vital that the implications of the targets and funding were understood.

57.5 Paul Cooper, Commissioning and Service Redesign Lead - Mental Health and Learning Disabilities, CCG, spoke about the challenges facing rural Shropshire and also about street triage for people in crisis.

57.6 It was agreed that a conversation needed to be had publicly around all of this to highlight changes and educate everyone involved.

58 Crisis Care Concordat (For Decision)

58.1 Paul Cooper, Commissioning and Service Redesign Lead - Mental Health and Learning Disabilities, CCG, introduced and amplified a report (copy attached to the signed minutes) on the publication of a national concordat regarding improving care for people experiencing mental health crisis and the expectation that a local

concordat with an associated action plan would be produced and implemented with oversight for the Health and Wellbeing Board.

58.2 A summary of the background to and key points within the concordat was included and there was a summary of the current position for Shropshire Services against the standards and recommendations for the next steps.

58.3 A discussion ensued about concerns around crisis care and the use of Place of Safety Suites. It was pleasing to note that because of the hard work undertaken recently that concern had dropped, but officers assured they would not become complacent and would continue to meet regularly with the Police to monitor this.

58.4 An observation was made that there did not appear to be any input from the Probation Service thus far and that perhaps they should be included in the local agreement when drawn up. This was agreed.

RESOLVED

a) That the contents of the report be noted.

b) That the development of a multi-agency mental health crisis care concordat for the population of Shropshire be supported.

c) That the establishment of a task and finish group to facilitate the development of a local concordat and associated action plan for presentation to/approval from the Health & Wellbeing Board be approved.

d) That a progress report on the concordat be made to the Health and Wellbeing Board on 21st November 2014, prior to its final submission to the Department of Health.

59 Health and Wellbeing Delivery Group Report to Board (For Decision)

59.1 A report (copy attached to the signed minutes) highlighting the issues raised at the Health and Wellbeing Delivery Group either for information, endorsement or decision that had not been addressed as their own item at the Board was introduced and amplified by the Health and Wellbeing Co-ordinator.

59.2 In discussing the Health and Wellbeing Strategy Refresh, it was agreed that this should take into consideration the engagement of the Call to Action and Future Fit programme and key programme priorities. It was agreed that a report be made back to the Delivery Group on 7 November, to include a timeline and details of who was doing what and when. Subject to the foregoing it was

RESOLVED:

a. That arrangements for the Shropshire Peer Challenge in January 2015 be welcomed and noted.

b. That the process of refreshing the Health and Wellbeing Strategy as set out in paragraph 1.3.4 of the report and detailed in points 1 to 7 be approved and that work be progressed on the Communication and Engagement Strategy, with Healthwatch as a clear driver.

c. That in taking Working with the Community Safety Partnership (CSP) further, it was agreed that the CSP should be invited to a future meeting of the Health & Wellbeing Board (H&WB) to discuss key areas of joint interest such as Mental Health and Substance Misuse at the 20 February 2015 H&WB meeting, including the following 3 agenda items;

   i. Evidence (JSNA and the Community Safety Strategy)
   ii. Alcohol, drugs and tobacco – impact on health, services and commissioning
   iii. Mental Health – impact on anti-social behaviour & parenting: available services; and section 136.

d. That progress with work around Organ Donation be approved.

60 **Future Fit Update (Quality & Performance)**

60.1 Dr Caron Morton, Accountable Officer, Shropshire CCG, gave a verbal update to the Board on the progress of Future Fit.

60.2 The Evaluation Panel appointed by the CCG Board had held a number of meetings since June 2014. At the conclusion of its last meeting, the Panel made recommendations to the Board. The Board had considered these recommendations and agreed both a Long List of Options and a set of Evaluation Criteria to be used in determining a Short List.

It was briefly noted that;

- Greenfields sites – were currently being evaluated
- Urgent Care Centres (UCC's) – numbers were not specified yet
- Womens and Children's Centre – the current location was not a fixed site

It was noted that Powys was also now engaged and held strong views that they should have their own UCC or a border UCC which was accessible for residents.

60.3 Next steps would be engaging the community and clinicians. Two general public events were planned for the end of October 2014 in Telford and Shrewsbury and these would be backed up by at least 6 engagement events and numerous other meetings, such as using the local authority Local Joint Committees (LJC's). The Chair highlighted that Health Officers should communicate with the Council's Communications Team, who could assist with this aspect, which was welcomed.

60.4 A question was raised regarding funding the decisions of the Future Fit programme. It was confirmed that no final decision had been made on Future Fit and it was not possible to confirm funding arrangements. However it was likely that funding may come from a combination of sources. Above all, it was stressed that it was important that any funding was affordable and sustainable in the long-term.

61 Annual Safeguarding Report (Quality & Performance)

61.1 The Board considered a report – copy attached to the signed minutes – providing an introduction and context for the Shropshire and Telford & Wrekin Safeguarding Adults Board Annual Report 2013/14.

61.2 Concern was expressed at the delays around assessments and the potential backlogs that may occur relating to Deprivation of Liberty Safeguards. It was therefore agreed that an update be made back to the Health and Wellbeing Board in 6 months' time on this.

RESOLVED: That the content of the report be noted alongside the Safeguarding Adults Board Annual Report 2013-14. Particular attention was paid to the information highlighted in the report concerning the Supreme Court's decision in March 2014 concerning Deprivation of Liberty Safeguards (DoLS).

62 Better Care Fund Update (Quality & Performance)

62.1 The Director of Adult Services gave an update on the submission of the final Better Care Fund Submission – a copy of which is attached to the signed minutes. Informal feedback thus far confirmed that the plan was open and transparent and contained good metrics. The next stage would be the assurance process, which would involve the Director of Adult Services. The level of analysis was phenomenal and it was highlighted that this would need to be borne in mind in future. There were 4 ratings that could be achieved; 1; Approved, 2: Approved with support, 3: Approved with conditions or 4: Not approved. Shropshire's formal rating was still awaited.

62.2 The Chair thanked everyone for their hard work on this and requested that when clarity was received that a copy of the final submission be distributed to all partners.

RESOLVED:

a) That the Health and Wellbeing Board noted and acknowledged the input from all partner organisations including statutory and non-statutory provider organisations, the Voluntary and Community Sector, and the independent sector in the development of this plan and acknowledged that all partners had demonstrated an on-going commitment to work together to deliver better outcomes for the people of Shropshire;

b) That the Health and Wellbeing Board noted and acknowledged the Better Care Fund submission (as attached to the report) and the ongoing effort to gain assurance.

c) That once approved, a copy of the Final Better Care Fund submission be distributed to all partners.

63 Care Bill (For Information)

63.1 The Director of Adult Services gave a PowerPoint presentation on the Care Act and Care and Support Reforms 2015 and 2016 – copy attached to the signed minutes. In introducing and amplifying the presentation he explained there would be a phased implementation in two main stages; April 2015 and April 2016.

63.2 It was noted that the Care Act contained provisions covering Adult social care reform, Care standards, Health education and research and Market oversight and managing provider failure. The emphasis moving forward will be person centred, asset based care.

63.3 Initial consultations had concluded and the final guidance and regulations were to be published the week commencing 13 October 2014. Preparations for implementation had begun at national, regional and local, Shropshire level. Funding streams had been identified and the impact of the care reforms identified, not only for the Council, but for the voluntary sector too. This was going to produce a big shift in arrangements for the future.

RESOLVED: That the presentation be noted.

64 Health Scrutiny Update (For Information)

64.1 The Chairman of the Health and Adult Social Care Scrutiny Committee appraised the Health and Wellbeing Board of some of the recent activity of his scrutiny Committee and also that of the Shropshire and Telford and Wrekin Joint Health Overview and Scrutiny Committee, which was duly noted.

Signed …… (Chairman)

Date:

Health and Wellbeing Board
21st November

FUTURE FIT PROGRAMME UPDATE

Responsible Officer Caron Morton/
Mike Sharon – Programme Director
Email: caron.morton@shropshireccg.nhs.uk Tel: 01743 277580

1. Summary

1.1 The purpose of this report is to request Sponsor support of key Programme decisions.

1.2 The Programme Execution Plan sets out that, whilst the Programme Board has authority to take all decisions relating to the management of the Programme, certain specified key decisions also require the explicit support of Programme Sponsors following approval by the Programme Board.

1.3 In order to avoid undue delay, the Programme is proceeding on the assumption that work should continue on subsequent stages of the Programme pending confirmation of support by Sponsors.

1.4 Please see the attached documents Appendix A (Future Fit - Executive Summary) and Appendix B (Future Fit – Long List and Evaluation) in order to consider the recommendations below.

2. Recommendations

2.1 This process has already been taking place in relation to the Programme Execution Plan itself, and Sponsors are now requested **to endorse:**

a) **The Long List of Options for delivering the Clinical Model**

b) **The Evaluation Criteria to be used in evaluating the Long List and determining a Short List.**

3. Risk Assessment and Opportunities Appraisal
(NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

3.1 The Future Fit Programme and the Health and Wellbeing Board work to reduce inequalities and take into account issues listed above.

4. Financial Implications

4.1 The Future Fit Programme's financial implications will be discussed at a later date following key decisions.

5. Background

5.1 Background information can be found at http://www.nhsfuturefit.co.uk/ .

6. Additional Information

n/a

7. Conclusions

n/a

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) Karen Calder (Portfolio Holder – Health)
Local Member All
Appendices Appendix A: Executive Summary Appendix B: FF Long List and Evaluation

Development of Long List and Evaluation Criteria

1 Executive Summary

The Evaluation Panel appointed by the Board has held a number of meetings since June. At the conclusion of its last meeting the Panel agreed the following recommendations to the Board. The Board has now considered these recommendations and agreed both a Long List of Options and a set of Evaluation Criteria to be used in determining a Short List.

1.1 Long List

The Panel agreed to recommend a long list of eight options (see over) comprising:

i) A 'do minimum' option (as required by the Treasury);

ii) Seven options for the location of the Emergency Centre and the Diagnostic & Treatment Centre (all of which deliver the approved clinical model); and

iii) A range of between four and seven Urgent Care Centres which should ideally be co-located with Local Planned Care facilities and Community Units, and should be scaled to serve local need.

The Panel noted the potential for further UCCs to be developed in Powys but felt it was beyond its remit to include a formal recommendation on the location of facilities in Powys.

The Panel also suggested that, whilst recognising the clinical and logistical rationale of co-locating UCCs with existing acute and community facilities, travel analysis should be undertaken to determine whether there are alternative and/or additional locations in Shrewsbury and Telford which could provide significantly better UCC access for the respective urban populations than existing acute hospital sites.

Programme Board accepted the proposed Long List and the Panel's other recommendations.

Recognising the recent development of a Women and Children's Centre at Princess Royal Hospital, Telford (PRH), the Board also agreed that the potential to locate consultant-led obstetrics either at the Emergency Centre (EC) or at PRH should be considered as a variant to options which do not locate EC at PRH.

1	**Do Minimum** - Provider & Commissioner efficiency strategies implemented but no major service change. **Existing dual site acute services (including A&E).**		**Four community hospitals and MIUs** providing services as currently.
2	**EC with UCC & LPC at RSH; ***	**DTC with UCC & LPC at PRH;**	**Two to five further UCCs ideally co-located with LPCs & CUs**
3	**EC with UCC & LPC at PRH;**	**DTC with UCC & LPC at RSH;**	
4	**EC with UCC at new site; ***	**DTC with UCC & LPC at PRH; UCC & LPC at RSH;**	
5	**EC with UCC at new site; ***	**DTC with UCC & LPC at RSH; UCC & LPC at PRH;**	
6	**EC & DTC with UCC & LPC at RSH; ***	**UCC & LPC at PRH;**	
7	**EC & DTC with UCC & LPC at PRH;**	**UCC & LPC at RSH;**	
8	**EC & UCC with DTC at new site; ***	**UCC & LPC at PRH & RSH;**	
** the potential to locate consultant-led obstetrics either at the Emergency Centre or at PRH should be considered as a variant to these options.*			

1.2 Evaluation Criteria

The Panel agreed a set of four criteria appropriate for shortlisting purposes only, and agreed to meet again at the end of September to review the criteria as confirmed by Board and to develop them in further detail.

The Panel noted that these four criteria (and their associated measures) are a subset of the overall benefits sought by the Programme and which a preferred option will need to demonstrate that it can deliver. The rationale for this subset is that it is intended to be amenable to objective differentiation between options.

The proposed criteria are:

ACCESSIBILITY FOR PATIENTS	QUALITY OF CARE
a) Total miles travelled **b)** Total time travelled **c)** Net gain (loss) by area (overlaid with Index of Multiple Deprivation) **d)** Comparison against average national travel times to A&E **e)** Impact on ambulance services	**a)** Change in number of people who are more than 45 minutes from an Emergency Centre (potential to allow for differential Ambulance access should be explored) **b)** Ability to recruit & retain key clinical staff **c)** Extent of consultant delivered high acuity services **d)** Potential for better enabling partnership working

DELIVERABILITY	AFFORDABILITY
a) Timescale for delivery (the shorter, the better) allowing for phasing of benefits **b)** The amount of disruption for existing services (the less, the better) **c)** Ability to flex in response to future service needs beyond Future Fit (the greater, the better) against 3 scenarios **d)** Extent of remaining backlog maintenance	**a)** Can be accommodated within projected future resources **b)** Net revenue cost impact

The Board approved the criteria and confirmed the need for further work to be undertaken on the detail of how the criteria should be measured.

Mike Sharon

Programme Director

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Development of Long List and Evaluation Criteria

Report to:	**Programme Board**
Subject:	**Development of Long List and Evaluation Criteria**
Report by:	**Mike Sharon, Programme Director**
Date:	**17th September 2014**

1 Executive Summary

The Evaluation Panel appointed by the Board has held a number of meetings since June, and a report of these follows. At the conclusion of its last meeting the Panel agreed the following recommendations to the Board. The Board has now considered these recommendations and agreed both a Long List of Options and a set of Evaluation Criteria to be used in determining a Short List.

1.1 Long List

The Panel agreed to recommend a long list of eight options (see over) comprising:

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The Panel noted the potential for further UCCs to be developed in Powys but felt it was beyond its remit to include a formal recommendation on the location of facilities in Powys.

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Programme Board accepted the proposed Long List and the Panel's other recommendations.

Recognising the recent development of a Women and Children's Centre at Princess Royal Hospital, Telford (PRH), the Board also agreed that the potential to locate consultant-led obstetrics either at the Emergency Centre (EC) or at PRH should be considered as a variant to options which do not locate EC at PRH.

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The proposed criteria are:

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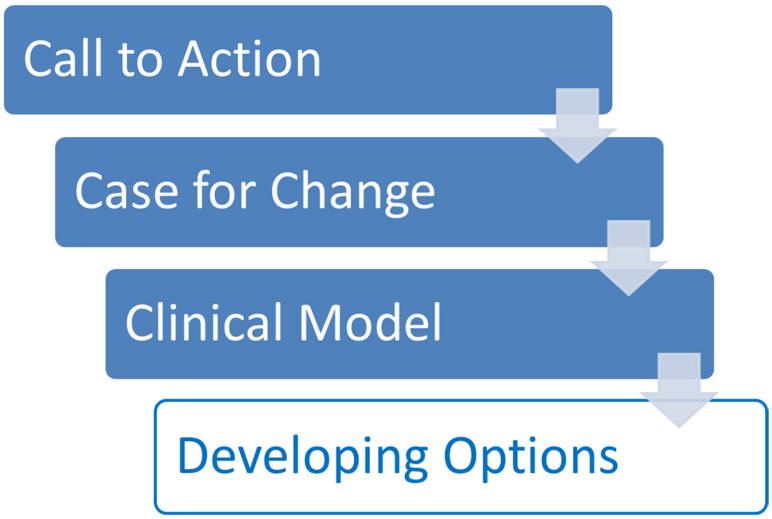
DELIVERABILITY	AFFORDABILITY
a) Timescale for delivery (the shorter, the better) allowing for phasing of benefits **b)** The amount of disruption for existing services (the less, the better) **c)** Ability to flex in response to future service needs beyond Future Fit (the greater, the better) against 3 scenarios **d)** Extent of remaining backlog maintenance	**a)** Can be accommodated within projected future resources **b)** Net revenue cost impact

The Board approved the criteria and confirmed the need for further work to be undertaken on the detail of how the criteria should be measured.

2 Introduction

The work of the Clinical Design workstream to define the future model of care was completed in May and was subsequently approved by Programme Board. The focus of the Programme then turned to the identification of options for how the clinical model of care might be delivered. The process for undertaking this work, in line with national guidance, was approved by the Board in May. This included the appointment of an Evaluation Panel (Appendix A) to prepare recommendations for the Board.



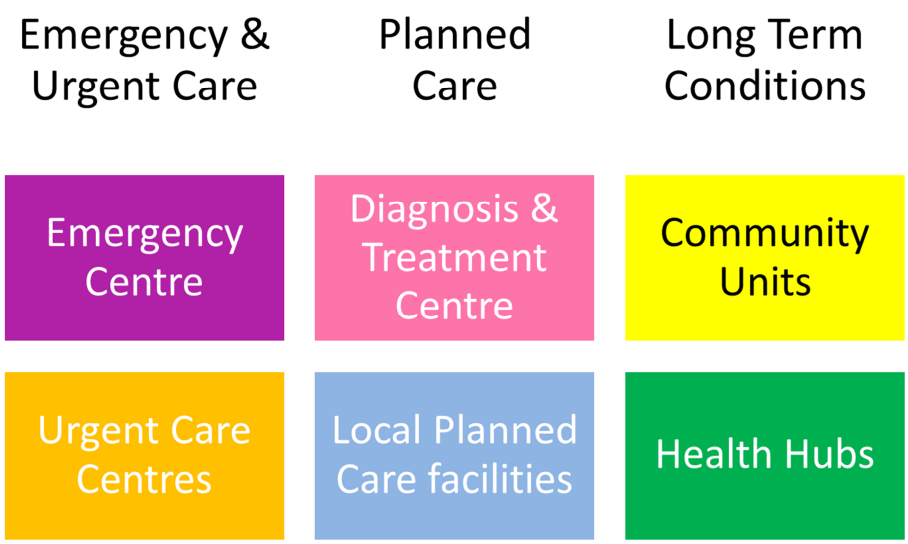
The purpose of this report is to present to the Board the Evaluation Panel's recommendations on a Long List of options and on the Evaluation Criteria to be applied in reducing that Long List to a Short List. The report also described the process the Panel went through to reach those recommendations.

3 Long List of Options

The development of the Long List comprised three key tasks:

- Generating ideas;
- Engaging the Community and Clinicians, and;
- Describing the Long List.

At the outset of its first meeting, the Panel was presented with background demographic and geographic information to inform the generation of ideas, and the nature of the various physical components of the model were described.



3.1 Generating Ideas

The Panel was presented with an overview of the options development process (see over), and an option was defined as 'a unique combination of the number, location and co-location of the model's components'.

It was pointed out by panel members that the model was open to interpretation. It was also pointed out that the clinical model highlighted the need for, for example, integration between social care and health, integrated health records, a more empowered community and that these were not guaranteed to happen. This was recognised and panel members were asked to state their assumptions in developing the options.

The Panel was then asked to work individually, in groups and then in plenary on developing a range of possible options. At this stage the panel was asked not to constrain their thinking and was asked to think innovatively about possible solutions.

Individuals were asked to set out location of model components on maps. Groups were asked to record their discussion and the rationale for proposing or discarding options.

In total, some 41 ideas were generated, all of which contained one Emergency Care centre and varying combinations of numbers, locations and co-locations of the other components of the model.

The location of components generally assumed that they would be located in the larger population centres both in Shropshire and, less frequently, in Wales. In some cases, however, other locations were proposed - most frequently for Local Planned Care services and Health Hubs. In one case, other locations for Urgent Care Centres were suggested.

The Emergency Centre (EC)

The emergency Care centre location was proposed in one of three locations, PRH site, RSH site or new build on another site. The new site was always placed on the A5, either on the Shrewsbury ring road or on a site between Shrewsbury and Telford.

In some cases the Emergency Centre was co-located with the Diagnostic and Treatment Centre and, in others, they were on separate sites.

The Urgent Care Centres (UCC)

The number of UCCs proposed ranged between one and eight with an average of six locations proposed. Most but not all ideas assumed a co-location of the EC with a UCC. Once idea proposed only a single UCC co-located with EC.

The geographical spread of UCCs was wide including proposed new locations in the north and south of the county, in Powys, and in the centre of Telford. Most ideas, however, had UCCs in one of the existing hospital sites and/or in some or all of the existing Community Hospital/MIU locations. Again, most ideas proposed the co-location of UCCs with other services such as Local Planned Care, Community Units and Health Hubs.

Diagnostic and Treatment Centres (DTC)

Nearly all ideas proposed a single DTC. However, one proposed five DTCs as well as five Local Planned Care Centres (LPCs), and another proposed three DTCs. Half of the ideas proposed a new build EC also proposed a co-located new build DTC.

Across all ideas, excluding that with five DTCs, a total of four sites were proposed for the DTC. These were:

- New site EC
- PRH
- RSH
- Oswestry

In cases with a DTC on an existing hospital site most ideas did not co-locate the DTC with the EC. This occurred more frequently as an option for the PRH site than for the RSH site.

1. Drivers
2. Ideas
3. Long List
4. Short List
5. Preferred Option
• Workshop 1
Generating Ideas
• Workshop 2
Proposing Criteria
• Public Engagement
• Workshop 3
Weighting Criteria
• Workshop 4
Evaluating Options
• Public Engagement
• Appraisal
Financial
Non-financial
• Public Consultation
• Decision
• Outline Business Case(s)
An infinite range of ways to implement the model needs to be reduced to a provisional long list of around 12.
Criteria for evaluating the long list also need to be drafted.
Following extensive engagement the long list & evaluation criteria are confirmed by Board, and descriptions of the options developed.
Agreed criteria are then weighted and the options scored against the criteria.
A recommended short list is proposed to Board.
Following confirmation of the short list, options are further developed alongside more engagement on the model and the agreed list.
The detail of this stage is yet to be agreed by Board.
A preferred option emerges from the appraisal process – and subject to various approvals – that option will be subject to Public Consultation and fully developed within one or more Outline Business Cases.
Parameters
Key Benefits
Clinical Model
Demography
Parameters

Community Units (CU)

The number of CUs proposed ranged from 0 to 11 with most ideas proposing five, six or seven. CU locations were widespread, most often in exiting Community Hospital locations but also including existing hospital sites (although not on a new site EC). In some cases CUs were located in Wales. CUs were nearly always co-located with other services.

Health Hubs (HH)

Health Hubs did not feature in some ideas. The maximum number proposed was fourteen.

HHs represent probably the widest geographical spread of all of the components of the model, with HHs proposed in some areas without any other components of the model. Although some HHs were proposed as standalone, the majority of HHs were co-located with other facilities such as community units. A minority of ideas showed HHs co-located with the EC, together with other services.

Local Planned Care (LPC)

Local Planned Care facilities did not feature in all ideas. The maximum number proposed was ten with most options proposing six or seven

LPCs showed a broad geographical spread and were usually co-located with UCCs and CUs. A small number had LPCs as standalone units

The key issues discussed in plenary session were:

Access

This was believed to be one of the most important factors to be taken into account when developing options. Some argued that ease of access was more important for planned care than for the Emergency Centre to which travel was more likely to be by ambulance.

There was also a debate on whether services should be made more accessible even if that meant that they were adequate rather than excellent. This was not generally supported.

Access for the population living in Wales was felt to be a particular concern which is why some contributors had placed some facilities in Wales.

The ability of populations to access peripheral providers would need to be taken into account in any travel time modelling.

There was also a discussion about the variability of public transport. It was accepted that public transport was largely absent form many parts of the County and that even where it did exist in more urban areas it could not necessarily be relied upon for travel to healthcare facilities when this was needed because it was too infrequent or had stopped too early.

Achieving a natural clustering of services

Most members of the Panel had taken a view that it would be preferable to achieve a clustering of services in population centres to make services as accessible as possible and to achieve a critical mass of services in a single location.

Making best use of existing facilities

Groups reported that making effective use of existing facilities was an assumption underpinning most of the options. However, it was pointed out that making the best use of existing facilities did not necessarily mean that they should be used for the same purpose or that they could not be sold to provide funding for facilities in another location.

In this context the use of Robert Jones and Agnes Hunt was raised as an issue. It was suggested that either its work could be moved to the DTC or that its existing capacity could be used to provide all elective orthopaedic provision in the County.

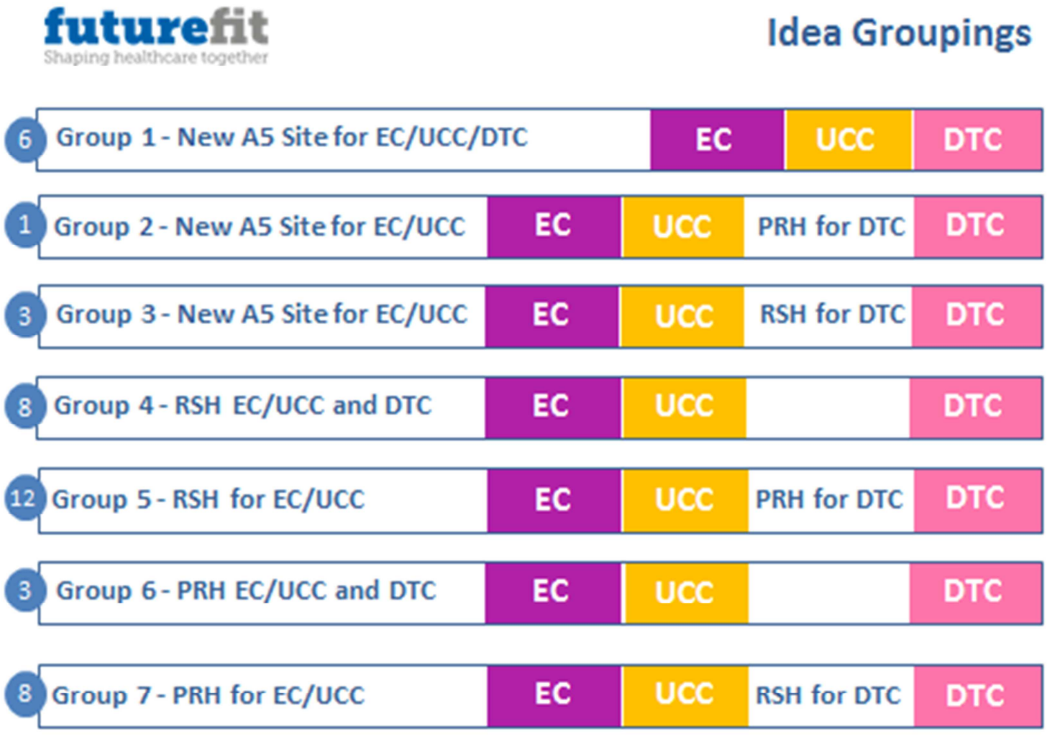
Finance

It was recognised by panel members that the affordability of options would become an issue. However, in general this had not been used as an overriding consideration when options were being developed.

Politics

It was also recognised by some panel members that political considerations could play a part in determining future consideration of options. There was a desire that politics should not be a determining factor in options development or evaluation and generally this had not been a factor taken into account in the development of options.

Following this first Panel workshop, the Programme Office was asked to synthesise the ideas generated. Whilst there was a great deal of diversity in proposals for the more local components of model, there was a clearly discernible set of idea groupings in relation to EC and DTC. These are summarised in the table below (the number on the left indicates the frequency with which that grouping was proposed).



3.2 Engaging the Community and Clinicians

Following this initial generation of ideas by the Panel, a series of further clinical design discussions were initiated. Key conclusions from these discussions were:

i) Co-location of DTC with EC is not essential although it may be desirable from the perspective of workforce efficiency;

ii) Acute patients admitted to the Emergency Centre could be transferred to a sub-acute/community facility when clinically appropriate (this can often benefit patients and relatives if the right rehabilitation and re-ablement culture is in place more locally) but transfers during an acute stay should not be factored into service planning;

iii) Should there be a failure to find a deliverable local option this needn't deny all aspects of the model. A theoretical (but not desirable) alternative would be use of out of County ECs which also supported enhanced UCCs in County;

iv) DTC should operate for 3 sessions (morning, afternoon, evening) and for 7 days a week supported by a large specialist staff – overnight it would be covered by a small generalist staff;

v) UCCs should be open 16 hours/day co-located with OOH GP services;

vi) Staffing would comprise Nurses, Enhanced Nurse Practitioners and GPs plus prompt remote support from Acute specialists;

vii) Co-location of UCCs with LPCs is desirable and with CUs, too, in rural areas;

viii) There are advantages in using existing community facilities;

ix) For a rural population of c.50k it would be possible to extend the range of services currently provided in MIUs so long as there are adequate diagnostics (X-ray and ultrasound), near-patient testing and IT (including telemetry);

x) Shrewsbury and Telford should each have a UCC/LPC given their populations;

xi) Further UCC/LPCs (along with CUs) should be based around some or all of the existing MIUs (minimum 2) to take advantage of existing facilities and build on current services.

In addition to these clinical discussions, public engagement activities in August included four deliberative events and a stratified telephone survey of 1000 people. These activities are the subject of a separate report but their key outputs were presented to the Panel to inform its identification of a long list of options.

3.3 Describing the Long List

At two further workshops in September, the Evaluation Panel reviewed its initial ideas and received further information in relation to:

i) Summary of Clinical Discussions

ii) Public Engagement feedback

iii) Access Analysis

iv) Emergency Centre Feasibility Study key findings

v) Activity Modelling.

At the second workshop the Panel was invited to consider an emerging long list which reflected its initial ideas and subsequent clinical discussions. This was offered as a starting point but not as a constraint, and the Panel (working in groups) was asked to identify their own lists and to specify their rationale for these. The key points then discussed in plenary session were as follows:

i) It was agreed by all groups that options with out-of-county Emergency Centres should be excluded due to excessive access times for patients and the referral complexity for GPs (creating a further risk for patients);

ii) After extensive discussion it was concluded that rather than specify a fixed number of UCCs (with CUs/LPCs), each option (other than the required 'Do Minimum') should have a range of four to seven UCCs. It was noted that, in the original panel ideas, the average number of UCCs proposed was six, and that this was echoed in subsequent clinical discussions (which also suggested a minimum of four);

iii) Although each UCC would be scaled to reflect its local catchment (whilst maintaining a common service offer), there was some feeling that Shrewsbury and/or Telford populations warrant more than one UCC each. The modelling of alternative and/or additional locations in Shrewsbury and Telford was agreed (within the overall range of four to seven);

iv) There was some feeling that the exact location of UCCs might vary in each option, depending on the location of the EC in that option; and.

v) Whilst the Panel recognised the potential for UCCs to be developed in Powys, it felt that it was beyond its remit to propose locations in Powys.

As a result of these discussions, the Panel agreed to recommend a long list of eight options (see over) comprising:

iv) A 'do minimum' option (as required by the Treasury);

v) Seven options for the location of the Emergency Centre and the Diagnostic & Treatment Centre (all of which deliver the approved clinical model); and

vi) A range of between four and seven Urgent Care Centres which should ideally be co-located with Local Planned Care facilities and Community Units, and should be scaled to serve local need.

The Panel noted the potential for further UCCs to be developed in Powys but felt it was beyond its remit to include a formal recommendation on the location of facilities in Powys.

The Panel also suggested that, whilst recognising the clinical and logistical rationale of co-locating UCCs with existing acute and community facilities, travel analysis should be undertaken to determine whether there are alternative and/or additional locations in Shrewsbury and Telford which could provide significantly better UCC access for the respective urban populations than existing acute hospital sites.

1	**Do Minimum** - Provider & Commissioner efficiency strategies implemented but no major service change. **Existing dual site acute services (including A&E).**		**Four community hospitals and MIUs** providing services as currently.
2	**EC with UCC & LPC at RSH; ***	**DTC with UCC & LPC at PRH;**	**Two to five further UCCs ideally co-located with LPCs & CUs**
3	**EC with UCC & LPC at PRH;**	**DTC with UCC & LPC at RSH;**	
4	**EC with UCC at new site; ***	**DTC with UCC & LPC at PRH; UCC & LPC at RSH;**	
5	**EC with UCC at new site; ***	**DTC with UCC & LPC at RSH; UCC & LPC at PRH;**	
6	**EC & DTC with UCC & LPC at RSH; ***	**UCC & LPC at PRH;**	
7	**EC & DTC with UCC & LPC at PRH; ***	**UCC & LPC at RSH;**	
8	**EC & UCC with DTC at new site; ***	**UCC & LPC at PRH & RSH;**	
** the potential to locate consultant-led obstetrics either at the Emergency Centre or at PRH should be considered as a variant to these options.*			

Once the Board has determined a final Long List, it will then be necessary to prepare a brief description of each option to inform the subsequent short-listing process. These descriptions will directly address each of the evaluation criteria.

Whilst this work is being undertaken, there will also be a further series of public engagement activities to gather public feedback on the long list. A report on these activities will be provided to the Evaluation Panel before it evaluates the long list.

4 EVALUATION CRITERIA

In parallel with the development of a long list of options, the Panel was also charged with proposing a set of Evaluation Criteria for use in differentiating between options. It was highlighted to the Panel that these criteria need to be:

- Grounded in what has been agreed to date as part of the Programme (the Clinical Model; the Case for Change; the Programme Objectives)
- 'Co-produced' with patients, public and clinicians
- Agreed by constituent boards to help bind collective decision making
- Capable of balancing financial considerations with a thorough assessment of how to best meet the needs of all the people served by the Future Fit economy , urban and rural.

For the criteria to do what is required of them, they also need to be:

- Clearly defined
- Measurable or at least capable of being informed by 'marker measures' that are measurable.

At the outset of its initial deliberations, the Panel discussed and agreed two important matters:

- The difference between a criterion that has value in discriminating between options (evaluation criteria) and one which has value in determining later on whether what was done worked in delivering, for example, better health (benefits realisation criteria). This is particularly relevant in the case of Future Fit as the options are all, in principle, capable of delivering the Clinical Model (except the 'do minimum' option). This means that it would not be possible to differentiate between them in relation to some of the quality improvements that the model is intended to deliver…..whereas it is vital that having chosen one and implemented it we seek to measure whether it is actually delivering that quality improvement.
- The advantages of carefully specified criteria in ensuring that comparative assessment is well grounded and well informed by relevant evidence (measurable) and that the decision-making process is less open to capture by the 'politics, history and habit' that the public response to Call to Action specifically asked Future Fit to avoid .

The Panel began its deliberations about criteria with three core inputs:

- The objectives of the FutureFit Programme as defined in the Programme Execution Plan and agreed by the Programme Board as well as each of the constituent boards and the Joint HOSC;
- The headings for option evaluation criteria that are suggested in guidance by the Department of Health; and
- A set of 21 statements /principles that had been drawn by the Clinical Design Group from the Clinical Model which was agreed at the Programme Board in June 2014.

Members of the Panel were then asked individually and then in small groups to undertake the following considerations:

- Which of the list of 21 derived from the Clinical Model could be developed as a criterion, and if so would it be an option evaluation criterion or a benefits realisation criterion (or both)?
- Given the objectives for Future Fit, were there any important option evaluation criteria that were needed but which didn't arise from the list of 21?
- Which of the criteria were most important in differentiating between options intended to deliver the Clinical Model? (their 'top 5')

- How might the criteria be measured?

The conclusions of each group were shared with the whole Panel and debated. Members were encouraged throughout to voice any questions or observations about the exercise. They were asked to approach the task mindful of the fact that they were the people who ultimately would be asked by the Programme Board to score options against these criteria.

The Panel reached some initial agreement on potential high–level criteria that were most important and relevant. They were able to make some specific recommendations on some of the sub-headings or 'markers' that might be amenable to measurement for the top three criteria though they asked for further work to be done on these by the Programme Office prior to further consideration in September.

The subsequent development of the criteria by both the Panel and the Programme Office was informed by:

- Public engagement activities;
- Discussion in the Assurance and Impact Assessment workstreams; and
- Review against standard DH benefit criteria and recommended areas for impact assessment.

As a result, a comprehensive list of criteria and supporting measures was provided to the Panel. This was subsequently reduced by the Panel to a list of four criteria appropriate for shortlisting purposes only, and it was agreed to meet again at the end of September to review the criteria as confirmed by Board and to develop them in further detail.

The Panel noted that these four criteria (and their associated measures) are a subset of the overall benefits sought by the Programme and which a preferred option will need to demonstrate that it can deliver. The rationale for this subset is that it is intended to be amenable to objective differentiation between options.

The panel also noted that the proposed criteria should be presented in a way which demonstrates a clear focus on the perspective of patients.

No measures are proposed which directly address the quality of planned care (as opposed to urgent and emergency care) because it is assumed that accessibility is an appropriate proxy for this given the evidenced impact of distance on patient utilisation of planned care services (e.g. radiotherapy).

The proposed criteria are:

ACCESSIBILITY FOR PATIENTS **f)** Total miles travelled **g)** Total time travelled **h)** Net gain (loss) by area (overlaid with Index of Multiple Deprivation) **i)** Comparison against average national travel times to A&E **j)** Impact on ambulance services	**QUALITY OF CARE** **e)** Change in number of people who are more than 45 minutes from an Emergency Centre (potential to allow for differential Ambulance access should be explored) **f)** Ability to recruit & retain key clinical staff **g)** Extent of consultant delivered high acuity services **h)** Potential for better enabling partnership working
DELIVERABILITY **e)** Timescale for delivery (the shorter, the better) allowing for phasing of benefits **f)** The amount of disruption for existing services (the less, the better) **g)** Ability to flex in response to future service needs beyond Future Fit (the greater, the better) against 3 scenarios **h)** Extent of remaining backlog maintenance	**AFFORDABILITY** **c)** Can be accommodated within projected future resources **d)** Net revenue cost impact

Mike Sharon

Programme Director

futurefit
Shaping healthcare together

APPENDIX A

EVALAUTION PANEL ATTENDEES

17 JUNE 2014

ORGANISATION	Invited	Attended
Shropshire Clinical Commissioning Group	**Dr Julian Povey, Clinical Director of Performance and Contracting**	**Dr Julian Povey, Clinical Director of Performance and Contracting**
Telford & Wrekin Clinical Commissioning Group	**Chris Morris, Exec Lead for Nursing and Quality**	**Chris Morris, Exec Lead for Nursing and Quality**
Powys Local Health Board	**Victoria Deakins, Lead Therapist for North Powys**	**Victoria Deakins, Lead Therapist for North Powys**
Shrewsbury and Telford Hospital NHS Trust	**Mr Mark Cheetham, Scheduled Care Group Medical Director**	**Debbie Vogler, Director of Strategy – AM** **Mr Mark Cheetham, Scheduled Care Group Medical Director - PM**
Shropshire Community Health NHS Trust	**Dr Emily Peer, Assistant Medical Director & GPSI**	**Dr Emily Peer, Assistant Medical Director & GPSI**
Shropshire Patient Group	**Pete Gillard**	**Pete Gillard**
Telford & Wrekin Health Round Table	**Christine Choudhary**	
Healthwatch Shropshire	**Vanessa Barrett**	**Vanessa Barrett**
Healthwatch Telford & Wrekin	**Martyn Withnall**	**Kate Ballinger**
Shropshire Council	**Kerrie Allward**	**Andy Begley**
Telford and Wrekin Council	**Liz Noakes, Assistant Director and Director of Public Health**	**Liz Noakes, Assistant Director and Director of Public Health**
West Midlands Ambulance Service NHS FT	**Sue Green, Director of Nursing & Quality**	**Sue Green, Director of Nursing & Quality**
Welsh Ambulance Services NHS Trust	**Heather Ransom, Head of Service & Resourcing**	
Robert Jones & Agnes Hunt Hospital NHS FT	**John Grinnell, Director of Finance**	**John Grinnell, Director of Finance**
South Staffs & Shropshire Healthcare NHS FT	**Lesley Crawford, Director of Mental Health**	**Lesley Crawford, Director of Mental Health**
LMC/GP Federation	**No nominee**	
Shropshire Doctors' Cooperative Ltd	**Ian Winstanley**	
NHS England Shropshire & Staffordshire Area Team	**Liz McCourt, Head of Assurance**	

2 SEPTEMBER 2014

ORGANISATION	Invited	Attended
Shropshire Clinical Commissioning Group	**Dr Julian Povey, Clinical Director of Performance and Contracting**	**Dr Julian Povey, Clinical Director of Performance and Contracting**
Telford & Wrekin Clinical Commissioning Group	**Chris Morris, Exec Lead for Nursing and Quality**	**Chris Morris, Exec Lead for Nursing and Quality**
Powys Local Health Board	**Victoria Deakins, Lead Therapist for North Powys**	**Victoria Deakins, Lead Therapist for North Powys**
Shrewsbury and Telford Hospital NHS Trust	**Mr Mark Cheetham, Scheduled Care Group Medical Director**	**Mr Mark Cheetham, Scheduled Care Group Medical Director**
Shropshire Community Health NHS Trust	**Dr Emily Peer, Assistant Medical Director & GPSI**	**Dr Emily Peer, Assistant Medical Director & GPSI**
Shropshire Patient Group	**Pete Gillard**	**Pete Gillard**
Telford & Wrekin Health Round Table	**Christine Choudhary**	**Christine Choudhary**
Healthwatch Shropshire	**Vanessa Barrett**	**Carole Hall**
Healthwatch Telford & Wrekin	**Martyn Withnall**	**Jane Chaplin**
Shropshire Council	**Kerrie Allward**	**Kerrie Allward**
Telford and Wrekin Council	**Liz Noakes, Assistant Director and Director of Public Health**	**Liz Noakes, Assistant Director and Director of Public Health**
West Midlands Ambulance Service NHS FT	**Sue Green, Director of Nursing & Quality**	**Sue Green, Director of Nursing & Quality**
Welsh Ambulance Services NHS Trust	**David Watkins, Locality Manager**	**David Watkins, Locality Manager**
Robert Jones & Agnes Hunt Hospital NHS FT	**John Grinnell, Director of Finance**	
South Staffs & Shropshire Healthcare NHS FT	**Lesley Crawford, Director of Mental Health**	**K Mansell**
LMC/GP Federation	**Jessica Sokolov**	
Shropshire Doctors' Cooperative Ltd	**Ian Winstanley**	
NHS England Shropshire & Staffordshire Area Team	**Liz McCourt, Head of Assurance**	
Montgomery Community Health Council	**Observer status only**	
Shropshire HOSC	**Observer status only**	**Gerald Dakin**
Telford & Wrekin HOSC	**Observer status only**	

9 SEPTEMBER 2014

ORGANISATION	Invited	Attended
Shropshire Clinical Commissioning Group	**Dr Julian Povey, Clinical Director of Performance and Contracting**	**Dr Julian Povey, Clinical Director of Performance and Contracting**
Telford & Wrekin Clinical Commissioning Group	**Chris Morris, Exec Lead for Nursing and Quality**	**Chris Morris, Exec Lead for Nursing and Quality**
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Shropshire Community Health NHS Trust	**Dr Emily Peer, Assistant Medical Director & GPSI**	**Dr Emily Peer, Assistant Medical Director & GPSI**
Shropshire Patient Group	**Pete Gillard**	**Pete Gillard**
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Healthwatch Shropshire	**Vanessa Barrett**	**Vanessa Barrett**
Healthwatch Telford & Wrekin	**Martyn Withnall**	**Kate Ballinger**
Shropshire Council	**Kerrie Allward**	**Andy Begley**
Telford and Wrekin Council	**Liz Noakes, Assistant Director and Director of Public Health**	
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Welsh Ambulance Services NHS Trust	**David Watkins, Locality Manager**	**David Watkins, Locality Manager**
Robert Jones & Agnes Hunt Hospital NHS FT	**John Grinnell, Director of Finance**	**John Grinnell, Director of Finance**
South Staffs & Shropshire Healthcare NHS FT	**Lesley Crawford, Director of Mental Health**	
LMC/GP Federation	**Jessica Sokolov**	**Jessica Sokolov**
Shropshire Doctors' Cooperative Ltd	**Ian Winstanley**	
NHS England Shropshire & Staffordshire Area Team	**Liz McCourt, Head of Assurance**	
Montgomery Community Health Council	**Observer status only**	
Shropshire HOSC	**Observer status only**	**Gerald Dakin**
Telford & Wrekin HOSC	**Observer status only**	**Derek White**

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Health and Wellbeing Board
21st November 2014

BETTER CARE FUND UPDATE - SHROPSHIRE

Responsible Officer: Stephen Chandler
Email: Stephen.chandler@shropshire.gov.uk

1. Summary

1.1 In order to establish whether Better Care Fund plans should be approved a consistent assurance methodology has been nationally adopted. The Nationally Consistent Assurance Review (NCAR) was designed to provide an appropriate rating for each plan based on both its quality as an approach and its suitability to the local context.

The four key elements to the review were:

- Standardised plan review by external review experts
- Local delivery risk review by Area Teams with HWBs and Regional colleagues
- Moderation by central team informed by Area Team and Regional colleagues
- National calibration by NELCSU and BCF Task Force

1.2 This report advises the Board on the Shropshire NCAR outcome as 'Approved with Support' and provides a definition of this status and what this means in terms of the response required.

1.3 Finally it summarises the actions that are required over the coming months to address the areas for improvement identified through the NCAR process.

2. Recommendations

2.1 That the Health and Wellbeing Board:

1 Note and acknowledge the NCAR process and current status;
2 Note and agree the plan for updating the BCF Plan in line with NCAR recommendations;

REPORT

3. Background

3.1 The Better Care Fund (BCF) was introduced in June 2013 as a way to provide an opportunity for local areas to transform local services so that people received better integrated care and support.

3.2 The Shropshire Health and Wellbeing Board established a working group who developed the local Better Care Fund plan through the Autumn 2013 and Spring 2014. Workshops with the Health and Wellbeing Board and other stakeholders through this time supported this development and a plan was submitted in April 2014.

3.3 The Shropshire plan/submission did not receive full assurance from NHS England and the Local Government Association (LGA) with concerns around our stakeholder involvement and a lack of clarity around our shared local vision; the 'golden thread'. However, concerns arose nationally that the submitted BCF plans as a whole did not demonstrate actual cost savings and reduction in pressure on acute services.

3.4 In July 2014 new and more detailed guidance was published with significant changes and updates and a request for all local areas to resubmit their plans by 19th September 2014.

3.5 The revised Better Care Fund (BCF) planning guidance, issued on 25 July, set out some key changes to the requirements of the BCF. These included:

- P4P now linked to reducing emergency admissions only; expectation that plans will set a minimum target of 3.5% reduction in emergency admissions
- Expectation of stronger plans
- Clear vision and schemes that will deliver the vision
- The case for change
- A plan of action
- Strong governance
- Alignment with acute sector and wider planning
- Protection of Social Care
- Engagement

3.6 During the summer of 2014 the BCF plan was refreshed to reflect the new guidance and a draft version of this was presented to the HWBB on the 11th September, following which updates were made and approved by the Chair of the HWBB for submission to NHS England and the LGA on the 19th September. The final version of the BCF Plan was presented to the Board on 10th October 2014.

3.7 In order to establish whether plans should be approved, NHS England and the LGA adopted a consistent assurance methodology, designed to provide an appropriate rating for each plan based on both its quality as an approach and its suitability on the local context. The Nationally Consistent Assurance Review (NCAR) methodology was developed with NHS England, LGA, Monitor and the TDA.

3.8 Following submission all plans were reviewed against the NCAR process. Shropshire's BCF Plan has been classified as '**Approved with Support'**. Please find attached a letter from Dame Barbara Hakin, National Director of Commissioning Operations at NHS England advising Shropshire H&WB Board of this outcome.

3.9 NHS England and the LGA define the classifications as follows:

- **APPROVED**:

No significant actions required. Plan is of sufficient quality to move forward to implementation with no actions required.

- **APPROVED WITH SUPPORT**:

Plan has some actions that are required but these do not represent a fundamental flaw in the approach or a material concern and can be resolved by a clarification of additional required information by the end of November

- **APPROVED SUBJECT TO CONDITIONS:**

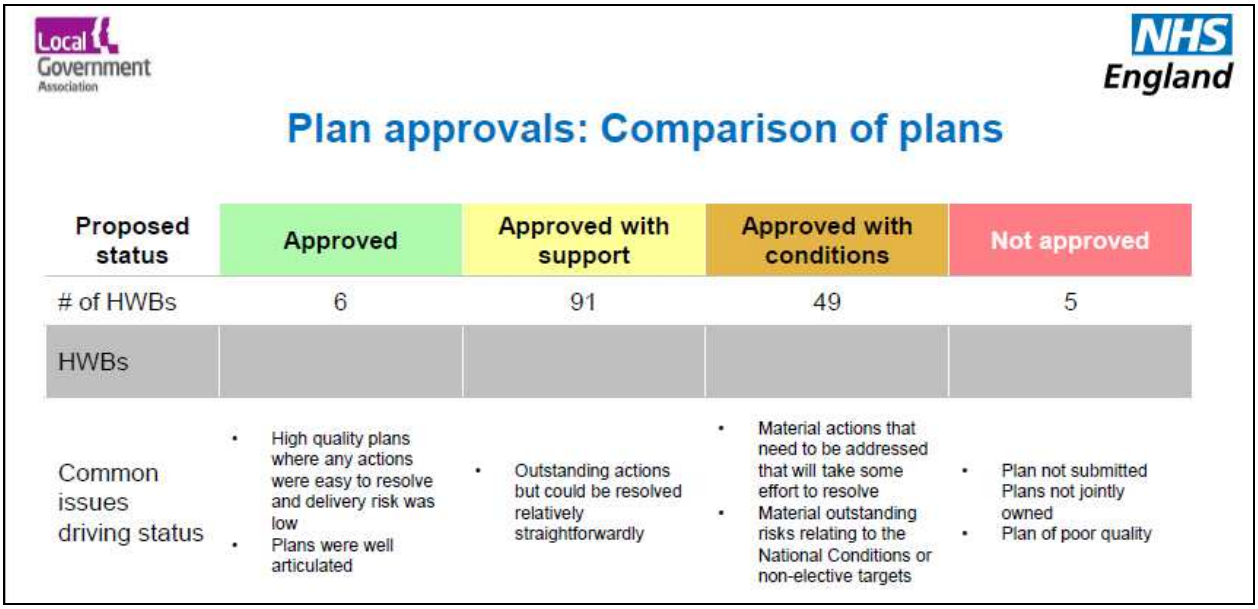
Whilst the fundamental approach is deemed suitable there are specific challenges that need to be addressed before proceeding to implementation. In particular:

  - A material concern about the ability to deliver the National Conditions
  - A material concern about the credibility of the non-elective target, given either current performance or the provider engagement in this plan
  - The volume of corrective actions or unmitigated risks in the plan being such that a significant level of further work is required before they can be assured

- **NOT APPROVED:**

Plan falls short of key criteria either because it is not signed-up to by all parties or the fundamental approach is flawed.

3.10 A list detailing the full NCAR outcomes for all Health & Wellbeing areas can be found on page 28 of the **attached document** - NCAR Results and Analysis, in summary:



Proposed status	Approved	Approved with support	Approved with conditions	Not approved
# of HWBs	6	91	49	5
HWBs				
Common issues driving status	• High quality plans where any actions were easy to resolve and delivery risk was low • Plans were well articulated	• Outstanding actions but could be resolved relatively straightforwardly	• Material actions that need to be addressed that will take some effort to resolve • Material outstanding risks relating to the National Conditions or non-elective targets	• Plan not submitted Plans not jointly owned • Plan of poor quality

3.11 The letter from Dame Barbara Hakin and subsequent correspondence from the NHS Local Area Team (LAT), who ongoing support and oversight of the BCF Plan has been delegated to, sets out the next steps and arising from this approval category. They are detailed in the attached document – 'Process Chart for 'Approved with Support' NCAR Outcome' and can be summarised as follows:

- **29th October 2014** – H&WB areas receive letter notifying assurance category and named point of contact (NHS England Relationship Manager)

- **14th November 2014**– H&WB area to agree with LAT Relationship Manager what evidence and information will be submitted to mitigate risk areas and when this will be submitted through the completion of the Template E Action Plan.

- **28th November 2014** – H&WB areas to have submitted their further information/evidence for review and sign-off with NHS England LAT Relationship Manager

- **5th December 2014** - NHS England LAT recommend to BCF Taskforce that they seek Programme Board approval to move area(s) to fully approved category

- **8th December 2014 -** Fully 'approved' outcome letters to be issued to H&WB areas.

3.12 The detailed actions that are required to mitigate risk areas are detailed in tab 2 of the attached document - Shropshire NCAR Outcome Report. A detailed action plan has been developed to address these actions; in the main the action required is relatively straightforward, with many simply requiring sections to be reworded to provide greater clarity or fields in the templates being populated differently to comply with the formatting rules.

3.13 There are some areas that require further action and those actions can be summarised as follows:

Ref	Action Required	Notes	By When
1	Aggregate lines of the expenditure plan and show how they contribute to achieving the linked performance measures.	Although much work was completed to show the benefits that will be delivered through the transformation schemes, the link to the performance measure was not always explicit. The scheme descriptors are being reviewed to make this linkage more explicit.	28/11/2014
2	Update the vision section to better articulate the overarching vision	The view of the NCAR Team is that the vision section of the BCF Plan currently reads as an 'Executive Summary' rather than a vision. This will be rewritten to describe the overarching vision of the Better care Fund – which aligns to the H&WB Vision	28/11/2014
3	Partnership Agreement	The plan was submitted with a list of principles from which a 'Partnership Agreement' will be developed. The NCAR Team is looking for further clarity or an indication of when there will be. Work has started to develop the Partnership Agreement, but given the significance of this piece of work, and the sign off required from the CCG, LA & H&WB Boards we will resubmit the BCF with the progress to date and a clear	Detailed plan by 28/11/2014 Partnership agreement in place by March 2015

		set of timescales of when this work will be concluded.	
4	Describe what 7 Day Services look like for Shropshire and how the plan will achieve this	Although the plan detailed what progress has been made towards implementing 7 Day Services in Shropshire, it did not start from the position of explain what services are required over 7 days and why so that we can show the incremental progress towards this. This section will be rewritten to describe this.	28/11/2014
5	Describe the Information Governance (IG) frameworks and how they provide assurance that appropriate IG controls are in place.	Although the plan detailed that IG controls are in place insufficient detail was provided in this section. This section will be re-written to describe the joint frameworks in greater detail.	28/11/2014
6	Show how intelligence/evidence relates to and has informed the plan	Although the evidence is shown throughout the plan – more work is required to ensure that the linkage is explicit. Review the scheme descriptors and case for change section to ensure that the evidence base is made explicit.	28/11/2014
7	Review scheme descriptors and update them to include the level of detail found in the ICS descriptor.	Although it was acknowledged that schemes were at varying stages of development the NCAR Team pointed to the ICS scheme descriptor and highlighted this as the standard for all other scheme descriptors. All scheme descriptors will be updated to reflect the comments – although acknowledging that at times this will still only include a plan for when further detail will be available.	28/11/2014

4. Conclusions

n/a

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)

Letter from Dame Barbara Hakim re: Shropshire's NCAR Outcome	Letter from Dame Barbara Hakim re: Shı
Shropshire NCAR Outcome Report	Shropshire NCAR Outcome Report
Process Chart for 'Approved with Support' NCAR Outcome	Process Chart for 'Approved with Suppc
Link to the Better Care Fund NCAR Results and Analysis – October 2014	**http://www.england.nhs.uk/wp-content/uploads/2014/11/bcf-ncar-results-analysis.pdf**

Cabinet Member (Portfolio Holder)

Cllr Karen Calder

Local Member

All

Appendices

None

Health and Wellbeing Board
21st November 2014

LAUNCH YEAR OF PHYSICAL ACTIVITY 2015

Responsible Officer Miranda Ashwell, Public Health programme Lead
Email: @shropshire.gov.uk Tel: Fax:

1. Summary

"The benefits of regular physical activity to health, longevity, wellbeing and protection from serious illness have long been established. They easily surpass the effectiveness of any drugs or other medical treatment."

Sir Liam Donaldson, Chief Medical Officer, 2009

1.1 Physical inactivity is the fourth largest cause of disease and disability in the UK, leading to 37,000 premature deaths a year, more than all deaths from murder, suicide and accidents combined. One in four women and one in five men do less than 30 minutes of physical activity a week and are 'inactive'. We are now 25% less active than we were in 196's.If we don't act now we will be 35% less active by 2030.

1.2 Public Health England have published 'Everybody Active Every Day', an implementation and guidance reports which outlines the options for action by local government, NHS commissioners and providers, schools and colleges, business and the voluntary sector. All actions could yield real population level return on investment if delivered at scale and are based on existing policies or evidence-based NICE guidance.

1.3 This paper proposes that the Shropshire Health and Well-being Board adopt 2015 as the Year of Physical Activity to raise the profile of physical activity and to the roles and responsibilities partners in contributing to creating a more active society.

2. Recommendations

a) That the Health and Wellbeing Board make 2015 their 'Year of Physical Activity ' to address physical inactivity as a major risk to health.

b) That the approach of the 2015 Year of Physical Activity be based on 'Everybody Active Everyday' principles and structure (Appendix A attached).

c) That organisations assess their contribution to the physical activity agenda based on the 'Everybody Active Every Day' options.

d) That the Year of Physical Activity action be based on optimising opportunities across organisations, departments and services, within existing resources.

3. Risk Assessment and Opportunities Appraisal
(NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

Physical Activity is a key component of reducing health inequalities.

4. Financial Implications

None at this time.

5. Background

5.1 Key facts:

- Around one in two women and a third of all men in England are damaging their health through a lack of physical activity
- It is an unsustainable situation, and one that cost an estimated £7.4 billion a year.
- Over one in four women and one in five men do less than 30 minutes of physical activity a week, so are classified as 'inactive'1
- Physical inactivity is the fourth largest cause of disease and disability in the UK. It leads to 37,000 premature deaths a year: more than all deaths from murder, suicide and accidents combined.
- Just 51% of children, reach the daily recommendations for young people. Physical fitness in children is decline by 9% per decade.
- In comparison to 1961 levels, we are now 24% less active. If we don't act now, we will be 35% less active by 2030.

5.2 If current trends continue, the burden of health and social care will destabilise public services, and take a real toll on quality of life for individuals and communities

5.3 How active should we be?

5.3.1 The four UK Chief Medical Officers recommend at least:

- Adults: 150 minutes per week of moderate physical activity in bouts of 10 minutes or more. Older adults to include balance and co-ordination exercise.
- 5-18 yrs. should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day.
- Physical activity should be encouraged from birth, particularly through floor-based play and water-based activities. Children of pre-school age who are capable of walking unaided should be physically active daily for at least 180 minutes (3 hours).
- All ages should minimise the amount of time spent being sedentary (sitting) for extended periods. Sedentary behaviour is a separate and independent risk factor for health.

5.4 Recent Key documents:

Everybody Active Everyday (Public Health England) Sept 2014

Provides the evidence and implementation guidance for intervention for the physical environment, social environment, community-wide interventions, group interventions, one-to-one interventions and life course interventions

Start Active, Stay Active (Dept. of Health): A report on physical activity for health from the four home countries' Chief Medical Officers giving recommended levels for physical activity and sedentary behaviour across the whole life course

Tackling Physical Inactivity report by All-Party Commission on Physical Activity, 2014. Describes and makes recommendations to achieve cultural and individual behaviour changes required to address the "toxic tide of inactivity":

– Population wide communication: young people , parents, health , social care and education professionals

– Designing activity back into everyday lives, though active towns, workplaces through active travel, active recreation (streets, parks, green spaces)workplaces

– Making physical activity a lifelong habit: active schools

– Proving success; development of standardised measures of physical activity.

Moving More, Living More (HM Government) 2014: the Physical Activity Olympic and Paralympic Legacy for the Nation reiterates

- the ambition to increase the number of adults taking at least 150 minutes of exercise per week and reduce the number taking less than 30 minutes per week, year on year.
- The necessity of working across government and sectors to ensure physical activity no longer occupies a silo in any one department

Department of Transport consultation on Cycling Delivery Plan October 2014

Cycling Delivery Plan (10 yrs.) (formerly the Cycling and Walking Delivery Plan and still covering walking as active travel) is out to public consultation for four weeks at: https://www.gov.uk/government/consultations/cycling-delivery-plan-informal-consultation

- Sets an ambition to double the number of cycling stages and increase percentage of children 5-10 yrs. walking to school from 48%to 55%

NICE PH Guidance 44 May 2013.Physical Activity: brief advice for adults in Primary Care

Provides recommendations for identifying inactive adults, delivering brief advice, incorporating brief advice in commissioning, systems to support brief advice and providing information and training

NICE public health guidance 54 Sept 2014 Exercise referral schemes to promote physical activity

Provides recommendations for Exercise referral for people who are sedentary or inactive and have a health condition or other health risk factors.

Sport England Get Healthy Get Active Fund

Sport England's new £5m 'Get Healthy Get Active' fund for local projects launched October 2014

http://www.sportengland.org/funding/our-different-funds/get-healthy,-get-active/

6. Additional Information

n/a

7. Conclusions

See recommendations above.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) Everybody Active Every Day option summary
Cabinet Member (Portfolio Holder) Karen Calder
Local Member
Appendices Appendix A: 'Everybody Active Everyday' principles and structure.

Public Health England

Everybody Active, Every day

Implementation and evidence guide Sept 2014

- Option given are those actions with the strongest evidence base and most potential for implementation within the current climate.
- Actions run across the life course.
- Many action's are existing policy that has been or will be implemented, others are evidence based NICE guidance.
- All could yield real population-level return on investment – if implemented at scale.
- 4 Themes cover creating a social movement, professional skills and knowledge, active environment , individual change at scale

A. Active Society :creating a social movement
Options for Action

Local Government	Local leadership to increase physical activity and reduce physical inactivity through HWB Boards. Include in JSNA, Health and Wellbeing plans. Connections made to local Spatial and neighbourhood plans, Transport plans, Community Sports and physical activity plans, CCG Strategic Plans and Economic regenerations	Work with Local Enterprise partnerships, and local Chambers of trade to integrate physical activity through active travel and workplace health into economic growth and infrastructure planning	Implement national standards for the Workplace Wellbeing Charter Supports local business to take part, particularly supporting action to increase physical activity in workplaces
NHS Commissioners	Integrate ambition to increase physical activity through clinical commissioning pathways into the NHS strategic plan and delivery action plans	Clinical Commissioning groups to demonstrate local leadership to activate professionals to promote physical activity in clinical care e.g. local physical activity champions in primary and secondary care	National leadership emphasising the potential return on investment for individuals and at population level
NHS providers	Integrate physical activity into clinical assessments, and techniques such as motivational interviewing into patient care and support	Support local physical activity champions in primary and secondary care	Integrate active lifestyle messages into every service so every contact counts

A. Active Society :creating a social movement
Options for Action

Schools and Higher Education	Consistently promote the benefits of healthy lifestyles across the curriculum at primary, secondary and higher education levels	Promote campaigns for cycling and walking to school, college, university	Engage local community groups /orgs to maximise imaginative use of school college or uni. Facilities such as playing fields, gyms, dance halls, swimming pools
Businesses and Employers	Lead by example in implementing evidence-based interventions to promote physical activity in the workplace, including work-based NHS Health Checks, and encourage walking and cycling to work and other forms of active travel and physical activity in the workplace	Sports and leisure providers promote engagement and participation among populations with highest levels of inactivity, especially women, disabled and ethnic minorities	
Voluntary and Community Sector	Take community leadership on promoting physical activity , especially in ethnic minorities, faith and disable communities and organisations	Promote understanding of physical activity in an integrated way with mainstream messaging eg leadership of Breakthrough Breast Cancer and Macmillan is a good model in promoting physical activity to reduce cancer risk	

B. Moving Professionals: using networks
Options for Action

Local Government	Local Government Improve competency and skills of health and social care staff to support people , including integration of key skills around physical activity for older people	Commissioning training programme for staff to promote increased physical activity in early years	Integrate physical activity into workforce development programmes and staff training
NHS Commissioners	Require training of provider staff of the role of physical activity in the care pathway and opportunities for maximising patient care	Incorporate a requirement for brief interventions training in physical activity provider contracts	
NHS providers	Ensure all health and social care staff are trained and assessed in their competence in brief interventions and motivational interviewing techniques	Create an environment which values making every contact count approach	

B. Moving Professionals: using networks
Options for Action

Schools and Higher Education	Schools/teacher training to train education staff to understand link between Health and wellbeing and educational attainment, and ensure they have skill sort deliver PHSE effectively	Universities to work with partners to understand potential role of physical activity across undergraduate curriculum, form healthcare, planning and engineering	Medical royal colleges, chartered Associations, professional/accrediting bodies to integrate understanding of , and skills to support physical activity into post-graduate training to support professionals as they develop tin their careers	Review training needs of transport professionals in order to ensure a consistently high standard of provision of walking and cycling infrastructure on the Strategic and Local Road network
Businesses and Employers	Provide learning and development , volunteering and skills development opportunities for all staff to develop their physical literacy and build physical activity into their daily lives	Support staff volunteering in community physical activity projects for examples as community sports coaches	Sports and leisure providers ensure all staff have comprehensive diversity training and where appropriate additional training to facilitate activity for people with disabilities and impairments	
Voluntary and Community Sector	Integrate prevention methods into training of volunteers and staff so every contact counts	Support training and development for community and faith leaders to energize and activate their communities to be active every day at all ages	Utilise the support available for volunteer physical activity facilitators, such as Walking for health initiative, or Active, Connected Engaged neighbourhoods (ACE)	

C. Active Lives: creating the right environment
Options for Action

Local Government	Align the Health and Wellbeing Strategy informed by JSNA and Local Plans (e.g Community Plans) .LEP plans should make public health a priority in strategic planning and investment choices to deliver healthier environments	Develop coordinated cross sector approaches to promote walking, cycling, active transport and active play, including choice of new housing, education and health care site developments, for all ages, through effective use of the Local Plan, strategies such as Dept. of Transport 'Door to Door' Strategy to enable active travel as part of community everyday life.	Deliver multi-component sport leisure , outdoor activity based on insight/co-creation that are attractive to whole community (all ages)	Use regulatory/statutory frameworks (e.g. Local Plan)licensing and assessments to design health inclusive (e.g. age-friendly) environments that promote physical activity, social interaction and a feeling of safety and security	To put active transport plans in place for all settings and implement schemes to help staff and visitors to maximise active travel
NHS Commissioners	Integrate requirement for active travel plans into pre-qualifying questionnaire stage of procurement	In capital investment strategies and delivery plans integrate active travel planning and the promotion of physical activity			
NHS providers	To put active transport plans in place for all settings and implement schemes to help staff, patients and visitors to maximise active travel	Look to provide other opportunities for physical activity in everyday activity such as activating stairwells, promoting activity through corporate challenges, sports leagues, fun runs etc			

C. Active Lives :creating the right environments
Options for Action

Schools and Higher Education	Design playground to enhance physical activity	Integrate active travel (including supporting facilities such as changing rooms, secure cycle stores, showers/drying facilities) into school/higher education capital investment strategies and delivery plans as core requirements	Support and encourage cycle training for children to keep them safe on roads
Businesses and Employers	Increase physical activity opportunities in the working day through support for active travel, or for evidence-based workplace approaches	Participate in the Public Health Responsibility Deal and Workplace Wellbeing Charter to learn and share best practice	Participate in the national Cycle to Work scheme and support adults to take up cycling classes and opportunities to increase their safety on the roads
Voluntary and Community Sector	Have active travel pans and policies for staff, volunteers and users	Increase physical activity opportunities in the working days, through support for active travel, or evidence based workplace approaches	

D. Moving at scale: making us active everyday
Options for Action

Local Government	Embed the physical activity standard evaluation framework into the commissioning of any physical activity intervention , and align these with DH 'Lets Get Moving' report	Support education and early years settings with implementing NICE guidance and recommendations of physical activity for children and young people, Similarly with wider services to support active older people	Implement integrated behaviour change programmes at population level to increase healthy lifestyles, promote wellbeing and reduce the burden of disease. This should include measures to prevent cognitive decline in later life	Work with NHS commissioners to ensure that physical activity risk assessment in clinical care pathways leads to appropriate interventions for those receiving the NHS Health Check and those eon Chronic Disease registers
NHS Commissioners	Ensure pathways are in place to support healthy weight and diet for children, promote physical activity to children and young people	Utilise community pharmacy tams to support people at every age to lead healthy lifestyles through opportunistic advice on physical activity	Commission services that integrate prevention, mental wellbeing, lifestyle modification and that address for signpost to support on social determinants of health as part of all clinical care pathways, such as physical activity throughout the care pathway for cancer.	Embed the physical activity standard evaluation framework into commissioning of any physical activity intervention
NHS providers	Integrate health advice into every health and social care contact and in al care pathways	Using NICE guidance on behaviour change , process and training to make every contact count		

D. Moving at scale: making us active everyday
Options for Action

Schools and Higher Education	Promote understanding and dissemination of the evidence base and through higher education support the development of the new and emerging evidence base		
Businesses and Employers	Lead by example, being advocates for the evidence base for physical activity in the workplace to support staff to be active in their own lives and ambitious business travel standards that promote active travel		
Voluntary and Community Sector	Lead by example, being advocates for the evidence base for physical activity in the workplace to support staff and volunteers to be active in their own lives		

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Health and Wellbeing Board
21st November 2014

CHILDREN'S TRUST REPORT TO THE HEALTH AND WELLBEING BOARD

Responsible Officer **Karen Bradshaw**
Email: Karen.bradshaw@shropshire.gov.uk Tel: 01743 254201

1. Summary

1.1 Where appropriate the Children's Trust implements decisions and actions highlighted in HWB Strategy and as required by the Health and Wellbeing Board. This report aims to highlight issues raised at the Children's' Trust either for information, endorsement or decision.

1.2 For Information:

1.2.1 **SEND REFORMS** As of 1 September 2014 the Children and Families Act came into force and arrangements for supporting children with special educational needs and disabilities (SEND) in school and further education have changed. These changes are designed to simplify arrangements for identifying and supporting children with SEND by ensuring:

- **Greater participation** - a clear focus on the participation of children, young people and parents in assessment, decision-making and planning
- **Better outcomes** - a strong focus on high aspirations and improving outcomes for children and young people
- **Better joint working** - a commitment to joint planning and commissioning between services to ensure close co-operation between education, health and social care
- **Improved transition between phases** - a 0-25 year process that will improve transition between early years, school and further education and training environments

1.2.2 The main changes are that:

Education, health and care plans replace educational statements and learning disability assessments -

From September 2014 health providers, social care and education providers will work with families to co-produce education, health and care plans (EHCPs) .EHC plans will have the same legal status as educational statements, and can continue up to the age of 25 if it's agreed that the young person needs more time to complete their education or training. In Shropshire the pathway and processes are in place and are working to the new regulations. In addition to writing new plans for children and young people with SEND, Local Authorities are required to convert all existing Educational Statements to EHCPs by March 2018. Shropshire currently has 2000 Statements of SEN representing 4.1% of the school population; the National figure is 2.8%. It is therefore recognised that this will be a significant challenge to the Shropshire Council. A small team of officers have been recruited, funded through the SEND reforms grant, to manage the conversions. In line with government requirements Shropshire's conversion plan has been published on the Local Offer.

1.2.3 **SEND Support replace School Action and School Action Plus-**
Schools will continue to identify children who need additional support and will use a graduated approach to ensure that children's individual needs are being identified, addressed and reviewed appropriately. This will be known as 'Special Needs Support'. Shropshire schools have had extensive guidance and support in respect of the reforms and are clear about their new responsibilities.

1.2.4 **The Local Authority are required to publish a 'Local Offer' -**
This will detail services available for children in the local area It will provide a 'one-stop shop' for advice, support and information for children and young people with SEND, and their families. In Shropshire we have uploaded our initial Local Offer pages and appointed a co-ordinator (funded through the reforms grant) to progress this work.

1.2.5 **From September, local authorities must make information, advice and support available that covers disability, education, health and social care -**
This should be available directly to young people, as well as parents/carers, building on current services. Currently our Information, Advice and Support Service (formerly known as Parent Partnership) are meeting this requirement primarily signposting to services they are unable to deliver themselves; however along with other Local Authorities this area requires development and we are currently in the process of a commissioning exercise to ensure we are able to provide this service.

1.2.6 For the past 12 months there has been extensive work undertaken in order to ensure that Shropshire is able to undertake all the requirements of the reforms. The SEND 0-25 strategic board provides governance and a number of sub groups have been working through the requirements on an operational level; these will continue until we are secure in our new practice. Representatives from education, health, social care, children and adult services, parent carer organisations and commissioning are involved at both a strategic and operational level. A particular strength of our work over the past year is through joint working, relationships and practice has been strengthened as a result.

1.2.7 In order to address the areas that where we are less advanced, an action plan has been developed based upon the DfE Implementation response that each LA is required to submit each term. This will inform on our risk status.

1.3 For Decision: The Disabled Children's Charter

1.3.1 In light of the recent detailed work as part of the SEND reforms the Children's Trust has recommended that the Health and Wellbeing Board signs the Disabled Children's Charter.

1.3.2 The Charter states that the **Health and Wellbeing Board** is committed to improving the quality of life and outcomes experienced by disabled children, young people and their families, including children and young people with special educational needs and health conditions. We will work together in partnership with disabled children and young people, and their families to improve universal and specialised services, and ensure they receive the support they need, when they need it. Disabled children and young people will be supported so that they can lead ordinary lives.

1.3.3 The Charter has 7 key objectives and 'by *[date within 1 year of signing the Charter]* our Health and Wellbeing Board will provide evidence that:
1. We have detailed and 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

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

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

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

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

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

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

1.4 For Information:

1.4.1 **Children and Young People's Whole System Event** (WSE) – The WSE will bring together in one room young people (50% of attendees) along with senior public sector and business figures. The purpose is to ask a question and through a series of discussions and activities come up with a number of actions that will deliver a clear a measurable benefit for young people in that community.

1.4.2 The key difference is that the event will not result in objectives and outcomes but a small number of actions that those in the room can commit there and then to deliver.

1.4.3 The first WSE will take place on December 1st where will be time to explore the possibilities that arise from sharing our ideas and enthusiasms and build on our local assets. The day will lead to action, so there will be a short follow-up workshop to support working together on whatever actions are decided at the event.

1.5 For Information:

1.5.1 **CAMHS Update –**
Background

1.5.2 This report provides information in relation to the current position of Tier 3 CAMHS in Shropshire. CAMHS are Child and Adolescent Mental Health Services in place to treat mental illness. Tier 3 refers to the stage in the 4-tier CAMHS model that is specialist multi-disciplinary support. Children and young people accessing CAMHS have a mental illness of a persistent, pervasive nature.

1.5.3 Over recent years, several reviews of CAMHS have been undertaken to inform the development of the service. Through commissioners working in partnership with the current provider, local authority and public health colleagues CAMHS services have been re-modelled with the aim of achieving better outcomes for service users.

1.5.4 A revised service specification has been written and agreed, with input from partners, for tier 3 CAMHS. A redesign of the CAMHS referral pathway has been implemented, with all referrals going through Compass, the single point of access. Senior Primary Mental Health workers are located in Compass, alongside Early Help Social workers and Targeted Youth Support workers.

1.5.5 Governance and reporting mechanisms have been strengthened with weekly reports on waiting times and referral rates sent to commissioners and formal monthly reporting to the CCG's Contract Review Board and Clinical Assurance Panel.

1.5.6 Whilst the new model of service delivery has been implemented there continue to be issues in relation to some specific areas of the service pathway. Commissioners meet regularly with the service provider in order to identify resolutions to the issues and enable further improvement to take place.

Current Position

1.5.7 Clinical Commissioning Group commissioners from Telford & Wrekin and Shropshire meet every month with the service provider, Shropshire Community Health Trust (Shropcom), to monitor delivery against the Service Development and Improvement Plan for Tier 3 CAMHS (SDIP). The SDIP has been developed in order to track progress against the required areas of improvement. The service is continuing to improve. However, there are still some key areas of concern. These are detailed below.

1.5.8 Referral process and waiting times
All referrals for Tiers 1 to 3 CAMHS are received through a single point of contact service called Compass. In order to further improve the referral process an electronic referral form has been developed and once fully implemented we expect to see further improvements to the referral process.

1.5.9 Between December 2013 and February 2014, inappropriate referrals to Tier 3 CAMHS totalled between 30 and 45 per month. Since March 2014, after the introduction of Compass, inappropriate referrals to Tier 3 have never been higher than 1 per month and 5 of the last 9 months have seen no inappropriate referrals to the service. This has been a significant improvement since the introduction of the new service model.

1.5.10 Waiting times to access the Tier 3 CAMHS service continue to be unacceptably high. Commissioners are working closely with the service provider to understand the reasons behind the long waiting times. Action is being taken to ensure that waiting times are reduced.

Service delivery

1.5.11 Commissioners are working with the service provider to address existing issues in relation to improving some areas of service delivery. This includes the need for the provider to develop contingency arrangements to mitigate against the issues that could potentially arise through day appointments being cancelled due to rest time required following out of hours calls for consultants the night before. There is also a need to improve shared care arrangements with GPs for service users who are more stable.

1.5.12 The service continues to have some consultant posts covered by Locums following two unsuccessful recruitment rounds.

Next steps

1.5.13 Commissioners will continue to work closely with the provider to ensure the Tier 3 CAMHS service improves in order to ensure the requirements of the service specification are met.

1.6 For Information: Developing a Comprehensive Model of Support on Emotional Health & Wellbeing for Children, Young People and Families in Shropshire

1.6 To ensure a wide understanding of the development of mental health support and services for children and young people in Shropshire, the Children's Trust has developed a document that

draws together the work being undertaken from universal tier 1 through tier 4. Shropshire has developed strong working practices for our universal provision, Think Good, Feel Good; is further developing early help provision that includes targeted support; and there has been a proactive response to a number of reviews of the CaMHS service in recent years and subsequent service specification development for tier 3 CaMHS. Please see **Appendix A** for the Final DRAFT version for discussion by the Health and Wellbeing Board.

REPORT

3. Risk Assessment and Opportunities Appraisal

(NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

3.1 The work of the Health and Wellbeing Board impacts on Health Inequalities; and all work being undertaken by the Board's work streams considers impact on health inequalities.

4. Financial Implications

4.1 There are no immediate financial implications associated with this report.

5. Background

5.1 The Health and Wellbeing Delivery Group (formerly the Health and Wellbeing Executive) meets monthly – 6 weekly and is responsible for the delivery of the Health and Wellbeing Strategy and the Better Care Fund.

6. Additional Information

n/a

7. Conclusions

n/a

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) Cllr. Karen Calder
Local Member
Appendices Appendix A – Developing A Comprehensive Model of Support on Emotional Health & Wellbeing for Children, Young People and Families in Shropshire.

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Developing A Comprehensive Model of Support on Emotional Health & Wellbeing for Children, Young People and Families in Shropshire

DRAFT V6

November 2014

Contents

Foreword
(Karen Bradshaw, Prof Rod Thomson, Dr Julie Davis & Cllr Ann Hartley)

In Shropshire we believe that good mental health for all is the cornerstone of a happy and healthy society and improvements to our mental health can have an immediate and long term positive impact on local communities.

Good mental health is a key outcome for our Health and Wellbeing Strategy and the Children, Young People and Families Plan. It is also central to the work we do on safeguarding our children. To achieve good mental health we need to work together across organisations and sectors to empower local people to make good decisions for their own health, to work with schools to provide the framework and curriculum for building strong and resilient children, to work with our own services and the voluntary and community sector to support families when they need extra support, and to work with our health services so that children and families can access the right kind of service and support at the right time for their mental health needs.

We would be failing our children and future generations if we did not focus our efforts on improving emotional wellbeing and resilience through concerted efforts at every level. As a community of leaders we recognise that an effective strategy is based on good joint working; on involving our local communities, families and children; as well as providing the right services and resources. If we are to achieve our vision we will work through local communities supporting them to take part in activities that promote wellbeing, build life skills, improve social networks and intervene when problems emerge.

1. Introduction

This document sets out the context in which we work and demonstrates the requirement for an overarching strategy that brings together how we work collectively to support the development of good mental health within our communities, schools and families. This starts with self-help and a prevention focus at a universal level for all children and families with additional support when needed provided by a range of targeted services and programmes.

The strategy does this through:

1. Description of our current position
2. Description of our current need
3. Provides an update on work to date following two reviews
4. Description of current services and programmes and their responses to date
5. Sets out the vision for the future and how we will deliver that

The document uses a population based approach to support the prevention agenda of Shropshire Council and its partners. It incorporates key recommendations from two local reviews and the subsequent actions that have taken place. We acknowledge it is work in progress and there is more to do.

The strategy is a key part of the wider vision that is driving change for even better health and wellbeing for children and young people in Shropshire. It supports the work on locality based services for children, young people and parents, including Family Solutions, the COMPASS, and new programmes such as the Family Nurse Partnership. Mental wellbeing will be a central element of the

work on parenting, part of children's services delivery and our workforces in Early Help, Children's Centres, school nursing and health visiting who are all key to the early identification and delivery of universal and targeted prevention programmes around mental wellbeing.

We intend to maximise opportunities with our current and future commissioning responsibilities around school nursing, FNP and health visiting to make sure mental health knowledge and skills are central to every professional's role. We will work with the voluntary sector and adult services to ensure there is better joint working between adult and children's services.

We want to de-mystify mental health and provide programmes of support that build confidence, self-esteem and resilience. For children and young people this will mean availability of community based programmes with better access to services and support to prevent problems escalating, it will also mean a greater synergy with adults services so that professionals working with parents with existing problems can make sure support is provided for children.

Improving the emotional health and wellbeing of children and young people across Shropshire is a priority of the local Health and Wellbeing Board, for the Children's Trust, the Health Champions and for members of our Local Youth Parliament. It is a central component of our work programmes linked to the Safeguarding Board and is driven forward through the joint efforts of Shropshire Council, the clinical commissioning group, our young people, the voluntary sector and our public services.

Good mental health has been recognised as an important local issue in different forums; through CCG and Local Authority reviews, in local statistical information, in feedback from schools, professionals and young people's groups. As such it is a key action in the Shropshire's Children, Young people and Families Plan 2014 governed by the Children's Trust who have the responsibility of ensuring it is achieved. It is a key element of the Early Help Strategy 2013.

Our vision is taken from the **Health and Wellbeing Board Strategy Shropshire Flourishing Lives (2012): Improve the emotional wellbeing and mental health of children and young people by focussing on prevention and early support.**

This strategy sets out a graduated model with prevention as the building block that underpins high quality efficient mental health provision for those children and young people who need access to and support from services. The primary goal is for better emotional and mental health and wellbeing for all our Shropshire children.

Our aims reflect our approach:

Aim 1	To ensure that more of our children have better wellbeing and good mental health **Outcome:** Ensuring the emotional wellbeing of children Good mental health will support all Outcomes
Aim 2	To reduce the number of children who develop mental health problems **Outcome:** Ensuring the emotional wellbeing of children
Aim 3	To commission high quality services for those children who develop mental health problems **Outcome:** Ensuring the emotional wellbeing of children Good mental health will support all Outcomes

The commissioning and delivery of high quality mental health and wellbeing services is an investment that will lead to population health gains and financial savings both in the medium and long term. The evidence base for mental health is strong and over the past decade there have been a plethora of strategies, studies and programmes that demonstrate the long term impact of intervening. This is especially relevant in the early childhood and in the teenage years.

Mental health problems starting in childhood are common and can result in wide ranging and longer term problems such as poorer educational attainment and negative relationships. Other long term effects include poor employment prospects and additional mental and physical health conditions in later life. One in ten children (three in in every class) aged between 5-16 years has a clinically diagnosable mental health problem. Just over half have a conduct disorder and the remainder will have an emotional disorder or severe attention deficit hyperactivity disorder. It is well documented that 50% of those with lifetime mental illness will experience symptoms by age 14 years.

The expanding body of evidence demonstrate clinical, social and financial benefits of different interventions across the age ranges and in different settings. Early identification and intervention can make real differences to the outcomes for children in the short term and longer term.

Some examples of potential savings are taken from the Mental Health Promotion and mental illness prevention: The economic case (Knapp et al, 2011):

- Social and emotional learning programmes results in returns of £84 for each £ invested
- School based interventions to reduce bullying result in returns of £14 per £ invested
- Parenting interventions for families with conduct disorder result in returns of £8 per £ spent
- Early detection of psychosis results in £10 for every £ spent with savings in year 2

Supporting carers and parents during pregnancy and the early years is known to impact on the mental health of children and young people. A secure parent/child relationship contributes to a positive attachment and helping to create emotional resilience in children. As children get older support for parents and carers is just as important through parenting programmes. Settings such as schools, colleges and the voluntary sector provide real opportunities to build social and emotional resilience of children and young people through interventions covering to develop self- esteem, social and emotional skills and reduction of risk taking behaviours.

Schools are part of the universal provision to support emotional health and wellbeing for CYP. The evidence base for the role of schools in supporting mental health of children and young people is strong. Findings from DfE research report in 2013 highlight that 'children with higher levels of emotional, behavioural, social and school well-being on overage have higher levels of academic achievement and are more engaged in school, both concurrently and in later years.'

What we know from work done around education and health is that:

- Resilient and healthy children have higher achievement and attainment rates
- Children with a strong sense of worth who are resilient in their early childhood and adolescence are more likely to become healthy adults
- Higher attainment improves longer term chances of education, employment prospects
- Improved behaviour helps staff to provide positive learning experiences

What Does the Data Tell Us?

In developing this strategy we have deliberately chosen not to bombard the reader with lists of indicators but have carefully chosen a mixture of high level population data to illustrate prevalence. We compliment this with individual service and programme data to show how we are progressing and where we need to improve. This is linked to our aims and objectives.

Tier 1 – Prevention What do we know about data on children & young people's mental health and how are we responding?

- There are approximately 68,000 children in Shropshire aged 0-19 years.
- In a typically sized class of 30 children, it is estimated that 3 will have an emotional or mental health need.
- Looked After Children and those with disabilities are more likely to have mental health problems than other children.
- 66% of pupils in Shropshire attend a school where there is at least one Tier 1 prevention programme (TaMHS).
- 87% of pupils from the most deprived areas of Shropshire attend a school where there is at least one Tier 1 prevention programme (TaMHS) in place.

Tier 2 – What do we know about data on children & young people who need some support?

- It is estimated that around 4,000 young people aged 5-16 years old in Shropshire have a mental health problem requiring some level of specialist treatment at any one time.
- Overall all the top 5 referrals to Tier 3 CAMHS were for depression, anxiety, anger/aggression, ADHD and Autism/Asperger's respectively. There were differences between referrals for girls and boys, with girls more likely to be referred for depression and anxiety and boys more likely for anger/aggression, ADHD and Autism. Girls were less likely to be referred for ADHD and Autism; instead the fourth and fifth most likely reason for referral for girls was deliberate self-harm and self-harming behaviour.

Tier 3 – What do we know about data on children and young people who need specialist treatment

- Overall there were around 1,150 children and young people referred to Tier 3 specialist Camhs in 2012-2013
- There were a similar percentage of referrals to Tier 3 CAMHS services for both boys and girls, but the age distribution between genders varied with significantly more girls referred aged 15-16 (33.2%) and significantly more boys aged 05-09 (37.4%).
- There were significantly more referrals to Tier 3 CAMHS from the most deprived areas (23.8%) compared to the most affluent (16.8%).
- A significantly higher percentage of referrals to Tier 3 CAMHS came from GPs (67.9%) compared to other agencies referring.
- The highest percentage of reasons for discharge was inappropriate referrals of which a significant percentage was made by GPs.
- The self-harm figures for Shropshire show the rates are higher than the national average for the period 2011/2012 but lower for the period 2013/2014.

- In Shropshire the rate of admissions for to hospital from self-harm for people aged 0-17 years old was significantly higher in 2011-12, at 151.8 per 100,000, which accounted for 93 admissions. In 2012-13 the rate per 100,000 was 299.7 which were similar to the national average; however this measured young people aged 10-24 years old and is therefore not comparable with the 2011-12 figure.
- There were 9 suicides in young people aged 19 years and under between 2007-2011 of which slightly more were in boys than in girls.

Feedback From Local Young People, Schools and Clinical Colleagues

To supplement the high level and service data we have also listened to feedback from children and young people, different clinical groups, CaMHS practitioners and education colleagues.

Ongoing consultation with key groups of young people in Shropshire has highlighted that young people believe good mental health is essential to health and wellbeing. A recent event held by the Members of Youth Parliament focused on 'improving mental health' and Our Local Health Champions programme has identified mental health and wellbeing as a priority for 2014/2015.

The annual Children's Trust Area Forums (2013) and (2014) gathered views of professionals from multiple agencies reinforced the importance of a retained focus on: "***ensuring that services for children are right, that children find the support they need when they need it and that mental health continues to be a concern when working with families with mental health and wellbeing of parents playing a key role in the life chances of children".***

At the same time the CAMHS service in Shropshire were reporting significant increases in referrals to Tier 3. GP's were also reporting problems accessing CAMHS services in a timely manner.

In addition schools reported long waits for access to a service and did not feel sufficiently supported and confident to address the range of mental health problems facing young people. Data analysis completed by Public Health, indicated that many referrals were related to behavioural problems, anger management, depression, anxiety, and school refusal.

1.2 The Shropshire Context

In the past two years there have been two separate reviews of CAMHS (Children, Adolescent, Mental Health Services) currently delivered through Shropshire's Community Mental Health Trust CAMHS covers two Local Authority areas and there are two Clinical Commissioning Groups with commissioning responsibilities. Significant changes have taken place in the past two years in the commissioning and provider bodies responsible for these services in terms of organisational structure and allocation of resources. Major changes have also taken place in the local authority. Both reviews identified strengths, good practice and challenges for the CAMHS service and for those organisations involved in the wider preventative model.

A series of recommendations for each review were included with clearly defined actions for the respective organisations in each local authority and health economy areas. Whilst there are some commonalities across Shropshire for service design there are distinct differences for each local

authority in relation to need, geography, demography and delivery of services. The recommendations formed the basis for many of the changes locally.

The Review picked out the following key points for commissioners and providers to address:-

1. Lack of a robust commissioning strategy for a Comprehensive CAMHS in Shropshire
2. Specialist Tier 3 CAMHS is seen as a service that works in isolation to the broader primary care services, education and social care
3. A concerted effort be made to increase capacity within the universal Tier 1 and Tier 2 services to start working in a preventative model and addressing needs much earlier
4. TAMHS (Think Good, Feel Good) should be rolled out to further increase capacity and awareness
5. Performance outcome measures should be developed that measure output

In addition a number of areas for improvement were identified:

- Data collection and needs assessment
- Understanding of pathways
- Understanding of criteria/threshold for the service
- Long waiting times
- Urgent referrals are not seen soon enough
- Issues with transition to adult mental health services

To supplement the review of Comprehensive Child and Adolescent Mental Health Services in Shropshire (CCAMHS) the Local Safeguarding Children's Board (LSCB) led the Back to Basics Review of Early Help (2012) which specified the need for changes in the provision of early help within the council's children's service area to ensure appropriate and timely responses to referrals to lower level mental health need. Feedback from those professionals responding to the review included the following points:-

- Overly bureaucratic processes
- Duplication of information (assessment and referral form)
- Professionals felt they did not have the expertise to complete the assessments
- Referrers found action plans difficult to complete as they want support for a child but don't know what this would entail
- Assessment forms taking too long to complete (4 hours)
- Early Help Advisers are useful but access is not always easy
- The processes 'feel like a barrier'

We also recognise that problems in children could be the result of many different reasons which may need different solutions. An example of this could be anxiety – this could be a result of environmental factors such as problems at home where there might be abuse, or it could be down to internal feelings of self-worth or isolation or bullying at school or parental divorce. Making the judgement about what it is due to will be important to determine on the right intervention. Ensuring there are a range of interventions in place for different needs is something we are working hard at.

2. The CAMHS Service in Shropshire

The structure and operation of CAMHS to an outsider can appear confusing and complex however it is often structured around a four tiered model. In very simplistic terms this can be illustrated by the diagram above. The local makeup of the service in Shropshire is an integral part of the Early Help Offer for Children and Young People and is illustrated in Appendix One

CAMHS in Shropshire is a multidisciplinary community based service designed to meet the mental health needs of children 0 to 18 years of age, (including those with learning disability), across Shropshire and Telford. The CAMHS service is part of Shropshire Community NHS Trust and consists of Shropshire CAMHS, Telford and Wrekin CAMHS and CAMHS Learning Disabilities. The multi-disciplinary team is made up of Mental Health Practitioners, Social Workers, Psychologists, Nurses, Psychiatrists, Occupational Therapists, Speech and Language Therapists and others. Depending on the level of identified need there are a number of service delivery options which may include:

- Offer of consultation to other agencies, assessments and interventions/treatment where there are concerns about a child's mental health and well being
- Assessment and advice through Early Intervention Teams, schools and special schools for children with learning disabilities
- Individual work with children, young people and their families using a variety of skills to meet the needs of a child and their family
- Responding to psychiatric emergencies
- Specialist behaviour modification is offered for children with learning disabilities who have extreme challenging behaviour.

For those children needing specialist services following diagnosis the service is able to provide the following:-

- Offer skilled emotional and mental health assessment and intervention to children and young people with moderate to severe mental health needs within agreed care pathways
- Actively case manage those children who are identified as high intensity users of CAMHS
- Provide care in a range of settings appropriate to the needs of children, young people and their families
- Involve parents/carers and children and young people by providing a range of opportunities for service users and their families to contribute to the service delivery process
- Work proactively with children and young people to avoid escalation to Tier 4 CAMHS
- Work in partnership with Tier 4 services and NHS England to facilitate the transition (step down) of children and young people back into the community where clinically appropriate and reduce lengths of stay in Tier 4 settings.
- Work closely with colleagues delivering Tier 2 services including Targeted Mental Health in Schools (TAMHS) in Shropshire and services providing support as part of an Early Help Offer. This shall include ‘step down’ support from Tier 3, signposting and advice

In addition the Reaching Out Service has been developed to deliver better outcomes for children and young people during a crisis situation when they may otherwise be admitted to a Tier 4 bed (commissioned by NHS England) by management by the outreach team within the home/community environment.

2.1 The Shropshire Model and the Vision for the Future

Understanding the wide range of programmes that make up and contribute to improving and maintaining mental health and wellbeing is quite challenging as there are so many organisations and professionals playing a role. CaMHS operates very differently from secondary acute adult mental health hospital care and from traditional services that look after children and young people's physical health.

When describing the local picture we have categorised services and programmes around four tiers of provision ranging through prevention (tier 1) to targeted (tier 2) and more specialist treatment services (tier 3) and highly specialist treatment services (tier 4). Our vision for the future is ensuring that we achieve a good level of mental health for all our children and more children and young people with mental health problems recover.

Tier 1 – estimated to be approximately 68,000 children in Shropshire. This includes universal services, projects, and programmes such as primary care, health visitors, early years providers, school staff, school nurses, pharmacists.

Professionals should be able to promote mental health and wellbeing, develop self-esteem and confidence, deliver programmes that develop skills and promote mental wellbeing, offer information and signpost, deliver a brief intervention.

Recognise what when a child may have developmental or mental health or behavioural problems that a universal approach cannot address.

Know what to do and where to go for additional support.

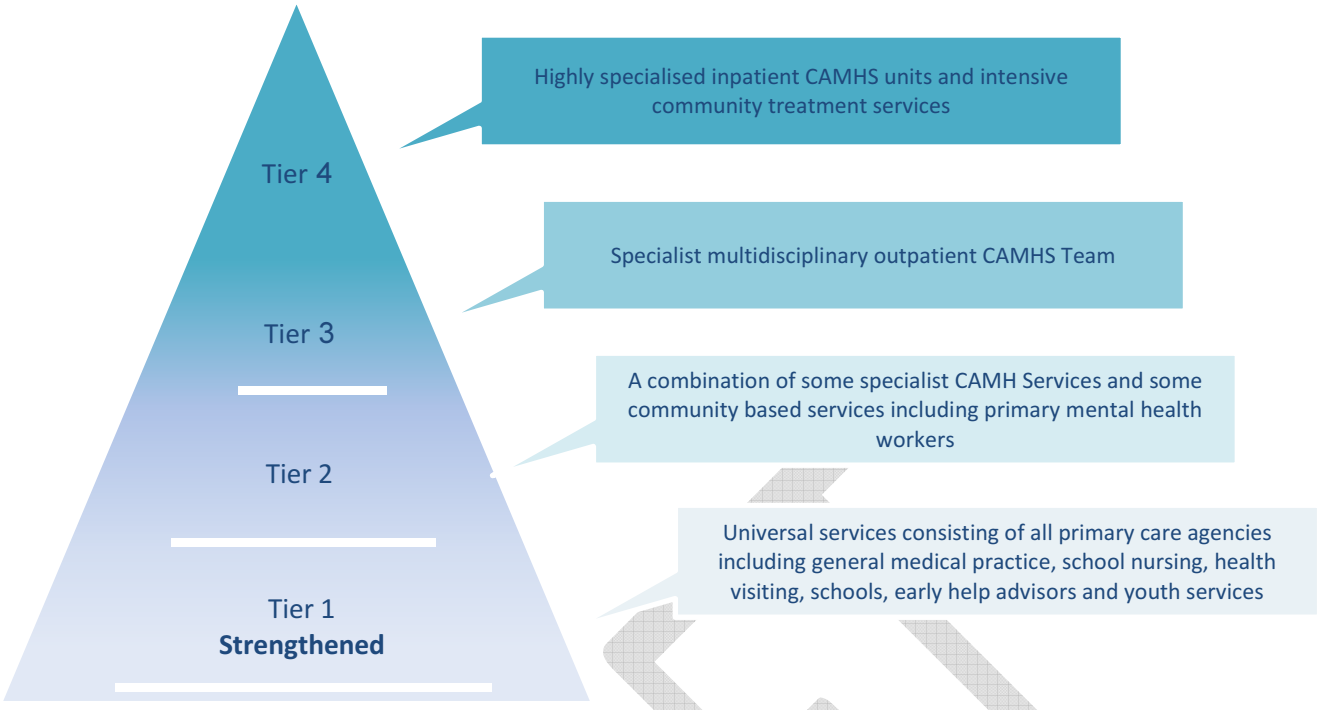
Tier 2 – estimated to be approximately 4,000 children in Shropshire. This includes more targeted projects, programmes and services such as targeted youth services, early help advisors, school nurses, educational psychologists, social workers, primary mental health workers, counselling services, targeted programmes in schools on mental health, psychologists, health visitors.

For children with milder problems where professionals work singularly as part of a wider workforce or in a specific setting.

Programmes can be developed in schools for children who are overly anxious, have poor attachment or who need one to one support over a period of time but who do not need a medical diagnosis. An assessment may be required with a specific intervention.
Targeted work also include that provided to specific groups of children and young people at risk of developing problems e.g. LAC (Looked After Children) or young offenders.

Tier 3 – estimated to be approximately 2,000 children in Shropshire. This includes specialist services: core CAMHS team, occupational therapist, social workers, family therapists (multi-disciplinary team), CAMHS learning disability teams, crisis home treatment teams preventing admissions, paediatric liaison teams. These services are often via a referral from a GP or sometimes from other agencies or schools.

Tier 4 – estimated to be small numbers of less than 20 per annum in Shropshire. This includes specialist mental health teams (in patient services and outpatient teams). Services are often provided on a regional basis. Other highly specialised services include medium secure units.



3. The Response to the Review of CAMHS in Shropshire

Shropshire Council, the CCG and the Local Safeguarding Board recognised the opportunity to commission children's services and programmes on mental health that are complimentary and based on local need that starts with wider universal mental health promotion and moves through to more specialised and intensive clinical support utilising and maximising the contributions of multiple partners. This approach has been adopted to respond to the actions in the review. At the same time changes were being made to the Children's Early Help offer and AMHS was seen as an integral part of this work.

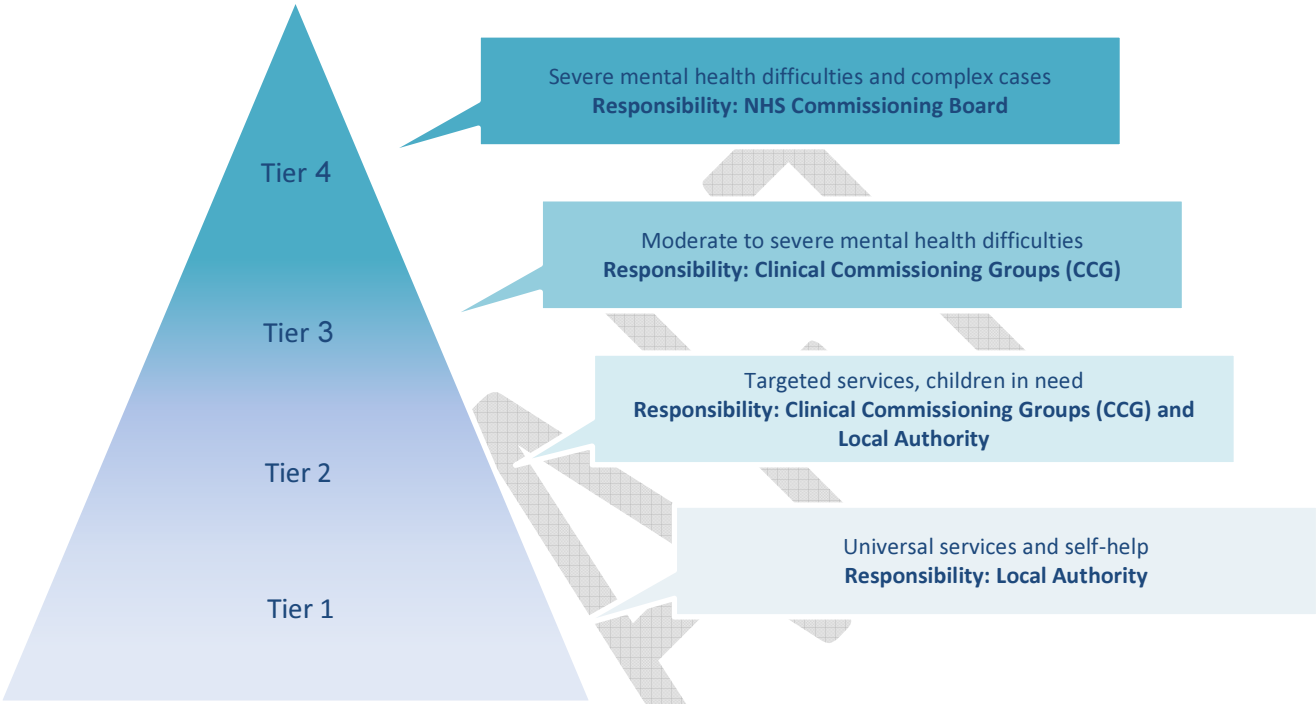
Having completed the reviews we have significantly strengthened our tier one and tier two provision which means we now have a much stronger prevention programme resulting in a Comprehensive CAMHS model. We have invested in additional resource at tier 1 in our local primary and secondary schools and redesigned services at tier 2 with additional investment in additional primary mental health workers at tier 2, a new referral route for GP's and improved multi agency assessment and triage co-locating teams from the NHS, social care and youth service.

3.1 Commissioning Responsibilities

Responsibility for commissioning of the different parts of the CAMHS pathway lie with different organisations, for Tier 3 the CCG is the lead commissioner and for Tier 2 and Tier 1 (universal provision and targeted) it is the local authority. The NHS Commissioning Board is responsible for Tier 4. To progress work across the pathway different working groups have taken forward key actions on each of Tiers led by a commissioner and in collaboration with the local provider. Progress is reported according to the respective governance arrangement for the commissioner, either into

the Children's Trust of Shropshire Council and the CAP within the CCG. In Shropshire mental health is a priority of the Health and Wellbeing Board and the Children's Trust where an overarching leadership role has been adopted to ensure progress is made towards a comprehensive approach to children's mental health and wellbeing.

Tier 4 Services are commissioned by the NHS Commissioning Board and links to these are made through the CCG. They are a crucial part of a local CaMHS service but are not discussed in this document as they are the responsibility of the NHS CB which was not in existence when the review was conducted.



4. Challenges Identified in the Review for Tier 3 Services:
Lack of a robust commissioning strategy for a Comprehensive CAMHS in Shropshire
Specialist Tier 3 CAMHS is seen as a service that works in isolation to the broader primary care services, education and social care

The Tier 3 CAMHS service provides specialist assessment, intervention and support to meet the emotional and mental health needs of children and young people who present with severe, complex, persistent and pervasive mental health issues

Significant progress has been made since the review across the pathway. There is now a new and revised service specification for Tier 3 CAMHS and the Reaching Out Service (ROS) across Shropshire and Telford.

The commissioner has worked jointly with colleagues from social care, primary care including GP colleagues and education to support the development and implementation of the single point of access for referrals to CAMHS. Our local GP's have had a clear role in its development.

There is now a specific development and improvement plan in place as well as a joint CQUIN for transition for 2014/2015 between CAMHS and Adult Mental Health Services (provided by Staffordshire and Shropshire Foundation NHS Trust). This will assist with transition.

Clear timescales for referrals are in place and improvements have been made in data collection and reporting. This now takes place weekly between commissioners and providers.

4.3 The Challenges Identified in the Review for Tier 2

A concerted effort be made to increase capacity within the universal Tier 1 and Tier 2 services to start working in a preventative model and addressing needs much earlier.

What have we done as a result?

Many of the changes proposed were linked to and complimentary to specialist services provided by CAMHS at Tier 2, 3 and 4. A substantial amount of work has taken place to develop the Early Help Model internally in the council but always in collaboration with partners. Changes have taken place with a newly devised strategy, work on thresholds, workforce capacity changes, updated referral and assessment processes and the creation of a single point of access to improve co-ordination and access. Various resources, interventions, and tools have been developed with system and team changes to provide additional Tier two capacity to meet the needs of professionals, parents and children.

This includes the implementation of a single point of coordination into Early Help and CAMHS known locally as COMPASS. Requests for support from professionals and families are processed in a timely fashion to ensure the right level of support is given. Strong inter-agency responses and co-location and joint working between Family Information Services, COMPASS for Early Help, Specialist CAMHS and Children's Social Workers ensure that those needing Tier 2 support will have access to and care from the right service at the right time.

COMPASS brings together and provides the following:

- a website with information, guidance, tools and resources (to replace the CAF and TAC plan),
- the Family Information Service
- call centre staff trained to receive calls from professionals, parents, carers
- access to social work consultation
- access to an early help resource panel
- a multi-disciplinary triage team of professionals from social work, CAMHS, youth workers
- additional support from ENHANCE (re-commissioned Tier 2 services)
- direct access to CAMHS where appropriate

This work should reduce demand on Tier 3 services and provide a more timely response for schools, GP's, children young people and parents.

In 2014 a new pathway for self-harm, guidance and risk assessment has been developed as a result of increased reporting of self – harm. The pathway has been developed to provide a consistent approach to early identification and support including information for young people and families. Developed in consultation with parents and young people self-harming it is currently being piloted together with a training resource for a dedicated Tier 2 programme in schools. Information, advice and guidance leaflets are also available.

4.4 Challenge Identified in the Review for Tier 1 – Universal Prevention TAMHS locally known as Thing Good, Feel Good, should be rolled out to further increase capacity and awareness

What have we done as a result?

Promoting Children's Emotional health and wellbeing and developing resilience across schools is the core aim of the 'Think Good, Feel Good' is a Shropshire wide schools based programme that started as a pilot programme in 2009. The programme uses a universal population based approach to for children and young people at Tier 1, and targeted support for those at Tier 2.

Initially aimed at school age children 5-16 years, their families and school staff the programme has now extended to reach under 5's and 16-19 year olds.

The programme adopts a whole school/ service approach with the following key objectives:-

- Increase awareness of mental health/mental ill-health
- Develop a common language that expresses thoughts and feelings
- Promotion and development of strategies to support mental health, build confidence self-esteem and resilience
- Improve communication and consultation with specialist services such as CAMHS
- Support schools to develop their role as commissioners to achieve positive mental health outcomes
- Provide training for school staff and partners to deliver targeted support intervention programmes supporting varying emotional needs within Tier 1 and Tier 2.
- Each school to have a core offer around a number of mental health related topics aimed at mentors, pastoral leads, teaching assistants

Schools and partner agencies are invited to attend centrally based multi-agency core training on issues such as self-harm, suicide prevention, domestic abuse, loss and bereavement, anxiety, anger management. The training increases the knowledge base of staff enabling them to recognise early signs and symptoms of need, provides practical examples of how to respond to the emotional needs of young people as well as tips and strategies on what to do and say following identification of need. The more in-depth intervention based training provides resources and clearly structured programmes that school based staff can deliver within the school setting to support a wide range of emotional needs. All of the training programmes that are delivered are evidence based, either nationally or internationally and are supported by high quality resources.

This work is supported on a multi professional basis by input from educational psychologists, primary mental health workers and school nurses. School nurses in their role as leads for the Healthy child Programme 5-19 years play a central role in supporting individual children's mental health needs and providing expertise to school staff on effective health improvement plans within the school setting. A recent review and action plan has highlighted the need for a named public health lead nurse on emotional health and wellbeing.

This work should ultimately reduce demand on Tier 2 services and Tier three services and increase universal provision as well as enabling schools and staff to develop a whole school approach to emotional health and wellbeing and to provide staff with the confidence to support children with low level mental health issues.

4.7 The challenge Around Performance and Outcomes
Performance outcome measures should be developed that measure output.

What have we done as a result?

Data analysis has been undertaken by the Public Health Intelligence Team looking at prevalence of Mental Health in children and young people, TAMHS provision and provision of the CAMHS Service. There were several purposes to this analysis:

- To understand the potential need for services in the local area
- To understand current service usage and provision in local services in the area
- To understand how people are accessing services and whether this is appropriate
- To identify where there are opportunities to reduce need for higher Tier services and where there are opportunities to prevent and reduce children having on going mental health issues and increase their well-being

In depth analysis of the CAMHS service data looked at all referrals into CAMHS within the financial year. This showed us why people came into the service, how they were referred and discharged with information about their age, gender and socio-economic status.

Prevalence estimates were calculated for Shropshire based on national prevalence and highlighted different mental health conditions in children at different age groups. This could then be compared with the information we had about mental health conditions and age groups from the CAMHS data to help us check estimated prevalence of condition against numbers in the service.

Early work on referral rates into CAMHS in relation to TAMHS provision in schools has been started. The number of Tier 1 and Tier 2 TAMHS interventions have been assessed on a school by school basis together with CAMHS data to identify referrals by school.

This helps us see the relationship between TAMHS provision and referral to Tier 3 CAMHS. Further work is needed on this to test for accuracy in the data being provided.

Data from the CAMHS service is now reported to the CCG on a weekly basis.

As a result of the COMPASS referrals to specialist Tier 3 in CaMHS have reduced.

5. Measuring Outcomes Linked to the Shropshire Children's Trust Plan

Action	Outcome	Strategic Links	What will improve	Measures
Ensure the implementation of a redesigned CAMHS (Child and Adolescent Mental Health Service) that incorporates clear pathways and is supported by TAMHS (Targeted Mental Health Service) across Shropshire.	• Ensuring the emotional wellbeing of children • Good mental health will support all Outcomes	• Healthy Child Programme • Health and Wellbeing Board Strategy • SSCB priorities	• Access to a comprehensive CAMHS and improved overage of preventative work through TAMHS. Children will be more resilient and happier.	• Delivery of the redesigned service. • Reduction in the referrals for specialist service. • Reduction in inappropriate referrals for specialist service.
Work with partners to promote the Shropshire Self-Harm Pathway; ensure that the pathway is promoted in schools and communicated to parents; ensure that the pathway is appropriately linked to service design, Tier two support, GP surgeries, the voluntary and community sector to ensure that the self-harm pathway supports the work they do with children and families.	• Ensuring the emotional wellbeing of children	• Shropshire Self-Harm Pathway • CAMHS Service • TAMHS • Early Help Strategy • SSCB	• Self-harm will reduce in Shropshire.	• Reduction in self-harm admittance to hospital (public health outcomes framework). • Work with schools to develop a reporting mechanism.
Conduct an Autism Needs Assessment for Shropshire that looks to understand prevalence, service need/demand, and current provision across all sectors.	• Ensuring the emotional wellbeing of children	• CAMHS Service • Early Help Strategy • Shropshire Adult Autism Strategy • SEND Action Plan • 0-25 Strategic Group • Autism Steering Group	• There will be a greater understanding of the support required for children with autism and their families and their needs as they transition to adulthood.	• Increase in support for families with a diagnosis of autism or behavioural disorder • Number of contacts for support via Early Help and Compass for behavioural concerns or autism
Ensure the signposting and roll out Solihull Parenting Programme across support agencies. Make appropriate links with parenting support initiatives.	• Ensuring the emotional wellbeing of children	• Healthy Child Programme • SSCB • Public Health/Making Every Contact Count	• Families will have greater access to parenting support. • Improved parental mental health.	• Number of parents accessing Solihull Parenting Programme

6. The Future – Actions to Help us Get to Where we Want to be		
Description of Action at Tier 1 - our prevention programme	**Lead Organisation**	**By When**
Refine and update the training package on Think Good Feel Good for schools	LA	Sept 2014
Fully evaluate the impact and outcomes of the Think Good Feel Good Programme in schools	LA	Sept 2014
Refine the Self Harm training package based on findings from the Self Harm project	LA	January 2015
Expand the programme of Think Good Feel Good into the 0-5 year old service areas	LA	October 2014
Continue to promote the public information on self-harm through leaflets and FIS	LA	Sept 2014
Develop a media campaign for the general public to dispel myths about mental health and raise awareness	LA	December 2014
Ensure the health champions and Members of Youth Parliament is linked to the TaMHS programme	LA/CCG	January 2015
Description of Actions at Tier 2 – targeted services and programmes	**Lead Organisation**	**By When**
Re-assess the current need, demand and capacity in tier 2 CaMHS services taking into account feedback from schools and the COMPASS model	LA working with Provider and CCG	Sept 2014

Assess the impact of the COMPASS and identify outcomes for those referred. Continue to develop the COMPASS ensuring sufficient capacity	LA working with CCG and Provider	Sept 2014
Ensure the model of COMPASS and the work on self-harm and Think Good Feel Good is complimentary (reduces demand) and ensure both areas of work are taken forward in parallel.	LA working with CCG and Provider	August 2014
Descriptions of Actions Tier 3 – Specialist treatment services	**Lead Organisation**	**By When**
Carry out a scoping exercise that explores the demand for extending hours of CaMHS provision (including weekend, and evening cover)	CCG	April 2015
Make improvements to 24 hour on call arrangements including scoping and review of current provision. Consider alternative provision and revision	CCG	April 2015
Provide regular performance reports on commissioned programmes in relation to tier 2 activity	LA working with Provider	Sept 2014
Develop and communicate clear pathways for diagnosis and management of conditions diagnosed and supported within CaMHS	Provider/CCG	TBC
Regularly report on outcomes from the service using the HONOSCA scores	Provider	TBC
Develop joint working protocols to support discharge of patients in tier 3 services from acute settings	Provider	

Descriptions of Actions for All Partners	Lead Organisation	By When
Continue to engage young people in the consultation on new resources linked to the programmes and services for children's mental health	All	Ongoing
Ensure young people have a strong voice in the commissioning of CaMHS services	LA and CCG	Ongoing
Ensure a pathway approach continues with commissioners and providers working collaboratively.	All	Ongoing
Scope the service requirements necessary for the Special Educational Needs and Disabilities Reforms	CCG and LA	Sept 2014
Develop jointly agreed outcomes for children and young people across all partners	Children's Trust	
Continue to be guided by local priorities of the Shropshire wide Safeguarding Board	All	Ongoing
Future Developments Across Children's and Young people's Service Areas		Timescales for Start Up
Redesign of Early Help Services into a locality model (covering Families Solutions, Early Help Advisors, Youth Support, Children's Centres) with a central referral hub (COMPASS)	LA	January 2015
Development of a Family Nurse Partnership programme in North Shrewsbury targeting first time young mums under 19 years. Two year visiting programme	LA with LAT and CCG	December 2014
Development of Community Parenting model that is based on need, evidence and urban/rural population (including a voluntary led programme)	LA	December 2014

Development of a healthy child pathway that spans 0- 19 years	LA with CCG and Provider	October 2014
Roll out of Self Harm Programme to schools	LA	March 2015
Work collaboratively with Maternity Services on the development of a public health midwife role (focus on healthy lifestyles)	LA/CCG and with Maternity Services	January 2015
Expand the schools based programme covering SRE/Eat More Move More/CHAT	LA with schools	July 2014
Roll out of newly designed school nursing service with core offer and three innovative practice sites (based on full healthcare needs assessment and review)	LA with provider and schools	October 2014
Ensure there is a smooth transition of Health Visitor Commissioning Responsibilities to the Local Authority	LA/LAT/ with CCG and provider	October 2015

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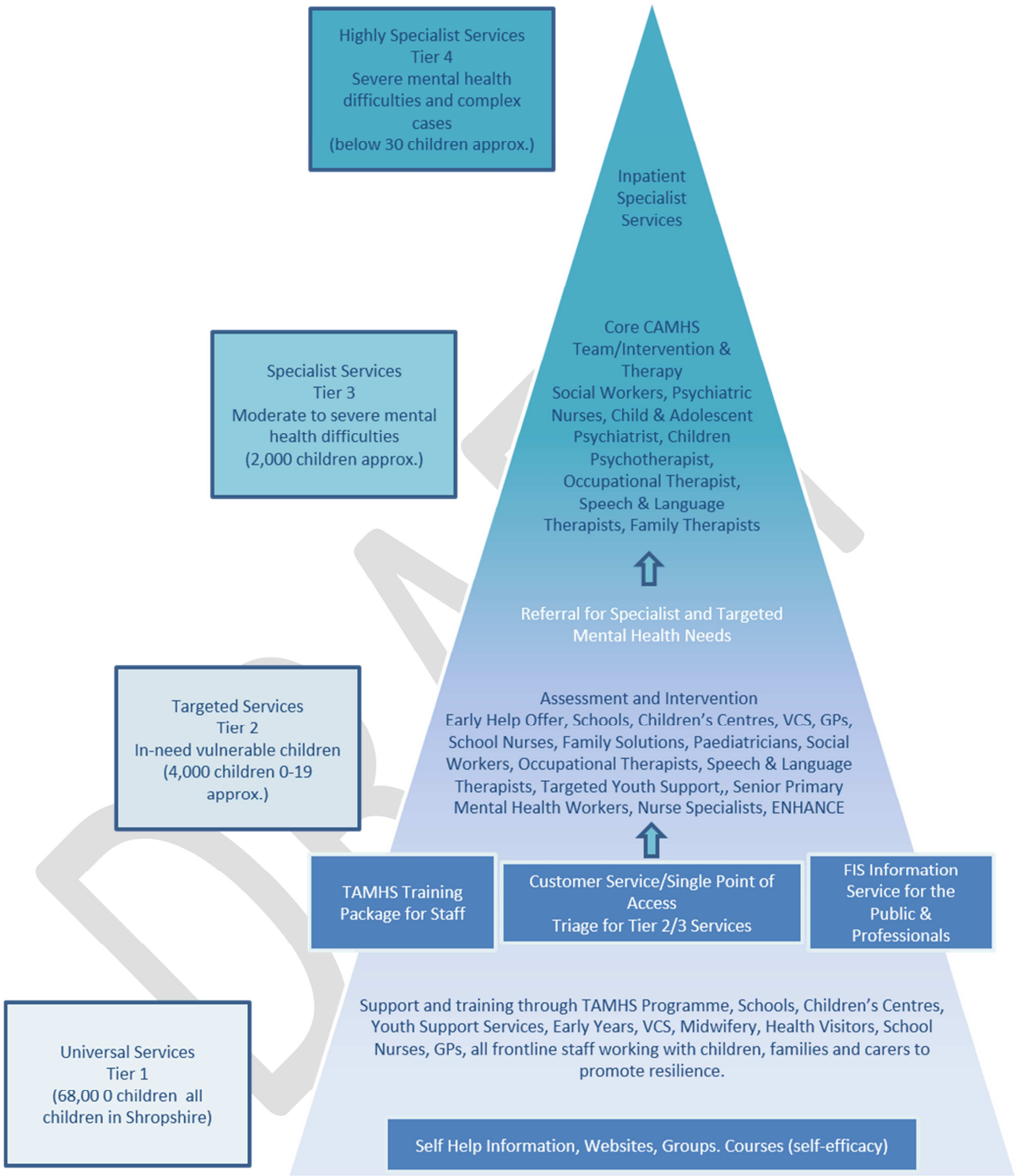
The Shropshire Think Good Feel Good Programme

Shropshire's Health & Wellbeing Strategy (2013)

Appendix 1: Shropshire's Single Point of Access for Children's Services



NHS England

Next steps towards primary care co-commissioning

November 2014

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Next steps towards primary care co-commissioning

First published: November 2014

Prepared by: Ian Dodge, National Director: Commissioning Strategy

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Foreword by Amanda Doyle and Ian Dodge

"General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain … Steps we will take include … [giving] GP-led clinical commissioning GPs more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services".

The NHS Five Year Forward View, October 2014

The introduction of co-commissioning is an essential step towards expanding and strengthening primary medical care.

Co-commissioning is recognition that clinical commissioning groups (CCGs):

- are harnessing clinical insight and energy to drive changes in their local health systems that have not been achievable before now;

but

- are hindered from taking an holistic and integrated approach to improving healthcare for their local populations, due to their lack of say over the commissioning of both primary care and some specialised services; and

- are unable to unlock the full potential of their statutory duty to help improve the quality of general practice for patients.

That's why NHS England is giving CCGs the opportunity to assume greater power and influence over the commissioning of primary medical care from April 2015.

Although we are confident that co-commissioning - or delegation to CCGs - is in the best interests of patients, the *offer* from NHS England is just that: it is for each and every CCG to consider carefully, and make up its own mind as to how it will respond.

We know that the imposition of a single national solution just won't work, and will fail to take into account different local contexts.

CCGs are GP-led organisations. CCGs understand primary care, and are passionate about improving its quality, across all practices in their own geographical areas.

At the same time, individual GPs will also be conflicted in specific decisions about primary care commissioning. So, in order to harness the benefits of co-commissioning, yet guard fully against the risks, we have developed robust new and transparent arrangements for managing perceived and actual conflicts of interest. NHS England is formally consulting on these before issuing as statutory guidance for the first time.

In progressing this agenda, we have sought to provide NHS England and CCG leadership that is genuinely joint and open - and which has also involved lay members and councils.

In our discussions, we have promoted vigorous debate and challenge. We intend our approach to serve as a model for wider collaboration across NHS England and CCGs, right across the breadth of our shared agenda.

Right across the country, we are confident that CCGs and NHS England regions and areas will approach co-commissioning in a spirit of openness, partnership and practical problem solving.

We are optimistic that the agreements we have reached and proposals we set out in this document pave the way for better services for patients, and better value for the taxpayer. The proof is, of course, only in the doing - and the public evaluation of the doing.

This piece of paper signals the next stage in co-commissioning. By no means is it the end of the story. We will continue to work together closely to pick up and resolve teething troubles and to assess progress.

Ian Dodge
National Director:
Commissioning Strategy,
NHS England

Dr Amanda Doyle
Chief Clinical Officer,
NHS Blackpool CCG;
Co-chair, NHS Clinical Commissioners

Contents

1 Executive summary

Next steps towards primary care co-commissioning gives clinical commissioning groups (CCGs) the opportunity to choose afresh the co-commissioning model they wish to assume. It clarifies the opportunities and parameters of each co-commissioning model and the steps towards implementing arrangements. The document has been developed by the joint CCG and NHS England Primary Care Commissioning Programme Oversight Group in partnership with NHS Clinical Commissioners.

Primary care co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. Co-commissioning is a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations. It will also drive the development of new models of care such as multispecialty community providers and primary and acute care systems.

There are three primary care co-commissioning **models** CCGs could take forward:

The **scope** of primary care co-commissioning in 2015/16 is general practice services only. For delegated arrangements this will include contractual GP performance management, budget management and complaints management. However, co-commissioning excludes all functions relating to individual GP performance management (medical performers' lists for GPs, appraisal and revalidation). Furthermore, the terms of GMS contracts and any nationally determined elements of PMS and APMS contracts will continue to be set out in the respective regulations and directions.

Under joint and delegated arrangements, CCGs will have the opportunity to design a **local incentive scheme** as an alternative to the Quality and Outcomes Framework (QOF) or Directed Enhanced Services (DES). This is without prejudice to the right of GMS practices to their entitlements, which are negotiated and set nationally. In order to ensure national consistency and delivery of the democratically-set goals for the NHS outlined in the Mandate set for us by the government, NHS England will continue to set national standing rules, to be reviewed annually. NHS England will work with CCGs to agree rules for areas such as the collection of data for national data sets, equivalent of what is collected under QOF, and IT intra-operability.

In joint and delegated arrangements, NHS England and/or CCGs may vary or renew existing **contracts for primary care provision** or award new ones, depending on local circumstances. CCGs and NHS England must comply with public procurement regulations and with statutory guidance on conflicts of interest. In delegated

arrangements, where a CCG fails to secure an adequate supply of high quality primary medical care, NHS England may direct a CCG to act.

With regards to **governance** arrangements, we have developed draft governance frameworks and terms of reference for joint and delegated arrangements on behalf of CCGs, as appended in annex D, E and F. CCGs are encouraged to utilise these resources when establishing their governance arrangements.

A significant challenge of primary care co-commissioning is finding a way to ensure that CCGs can access the necessary **resources** as they take on new responsibilities. Pragmatic and flexible local arrangements for 2015/16 will need to be agreed by CCGs and area teams.

Conflicts of interest need to be carefully managed within co-commissioning. Whilst there is already conflicts of interest guidance in place for CCGs, this will be strengthened in recognition that co-commissioning is likely to increase the range and frequency of real and perceived conflicts of interest, especially for delegated arrangements. A national framework for conflicts of interest in primary care co-commissioning will be published as statutory guidance in December 2014.

The **approvals process** for co-commissioning arrangements will be straightforward. The aim is to support as many CCGs as possible to implement co-commissioning arrangements by 1 April 2015. Unless a CCG has serious governance issues or is in a state akin to “special measures”, NHS England will support CCGs to move towards implementing co-commissioning arrangements. CCGs who wish to implement joint or delegated arrangements will be required to complete a short proforma (annex A and B) and request a constitution amendment. The approvals process will be led by regional moderation panels with the new NHS England commissioning committee providing final sign off for delegated arrangements.

We also intend to make it as simple as possible for CCGs to **change their co-commissioning model**, should they so wish. Should this need arise, CCGs should discuss their plans with the relevant area team in the first instance as part of the CCG assurance process.

On-going assurance of co-commissioning arrangements will form part of the wider CCG assurance process. NHS England intends to work with CCGs to co-develop a revised approach to the current CCG assurance framework. NHS England will also ensure it continually **evaluates** the implementation of co-commissioning arrangements to share best practice and lessons learned with CCGs and area teams.

We hope this document is useful in helping to inform CCG decision making around primary care co-commissioning models and in providing clarity on the next steps towards the implementation of new arrangements. If you require any further information, please email: england.co-commissioning@nhs.net.

2 Background and context

In May 2014, NHS England invited CCGs to come forward with expressions of interest to take on an increased role in the commissioning of primary care services. The intention was to empower and enable CCGs to improve primary care services locally for the benefit of patients and local communities. There has been a strong response from CCGs wishing to assume co-commissioning responsibilities. We want to harness this energy and address the frustrations CCGs have expressed in the current primary care commissioning arrangements, to more effectively shape high quality local services.

There are three possible models of primary care commissioning that CCGs could pursue:

The purpose of this document is to give CCGs an opportunity to choose afresh the co-commissioning model they wish to assume. It clarifies the opportunities and parameters of each model, including associated functions; governance arrangements; resources; and any potential risks, with advice on how to mitigate these. The document then sets out the steps towards implementing co-commissioning arrangements, including the timeline and approvals process.

This document is accompanied by a suite of practical resources and tools which are appended to support local implementation of co-commissioning arrangements. In addition, a national framework for the handling of conflicts of interest management for primary care co-commissioning is under development in partnership with NHS Clinical Commissioners. Whilst there is already conflicts of interest guidance in place for CCGs, we are strengthening this in recognition that co-commissioning is likely to increase the range and frequency of real and perceived conflicts of interest, especially for delegated arrangements. The conflicts of interest framework will be published as statutory guidance in December 2014.

This document has been jointly developed with CCGs and NHS England through the Primary Care Co-commissioning Programme Oversight Group. The group is co-chaired by Dr Amanda Doyle (Chief Clinical Officer, NHS Blackpool CCG and Co-chair, NHS Clinical Commissioners) and Ian Dodge (National Director: Commissioning Strategy, NHS England) with membership set out in annex G. It has also been developed in partnership with NHS Clinical Commissioners.

3 Vision and aims of co-commissioning

This section sets out the long term vision for co-commissioning and the potential benefits it could bring for local populations.

Co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. The *Forward View* emphasises the need to increase the provision of out-of-hospital care and to break down barriers in how care is delivered. Co-commissioning is a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations. It will drive the development of new integrated out-of hospital models of care, such as multispecialty community providers and primary and acute care systems.

Co-commissioning will give CCGs the option of having more control of the wider NHS budget, enabling a shift in investment from acute to primary and community services. By aligning primary and secondary care commissioning, it also offers the opportunity to develop more affordable services through efficiencies gained.

Co-commissioning could potentially lead to a range of benefits for the public and patients, including:

- Improved access to primary care and wider out-of-hospitals services, with more services available closer to home;
- High quality out-of-hospitals care;
- Improved health outcomes, equity of access, reduced inequalities; and
- A better patient experience through more joined up services.

Co-commissioning could also lead to greater consistency between outcome measures and incentives used in primary care services and wider out-of-hospital services. Furthermore, it will enable the development of a more collaborative approach to designing local solutions for workforce, premises and information management and technology challenges.

Primary care co-commissioning is the beginning of a longer journey towards place based commissioning – where different commissioners come together to jointly agree commissioning strategies and plans, using pooled funds, for services for a local population.

From 1 April 2015 we will be extending personal commissioning through The Integrated Personal Commissioning (IPC) programme. The IPC programme aims to bring health and social care together, identifying the totality of expenditure at the level of the individual, giving people more control over how this is used and enabling money to be spent in a more tailored way.

Furthermore, from 2015/16 CCGs will have the opportunity to co-commission some specialised services through a joint committee. We have also been encouraging CCGs and local authorities to strengthen their partnership approach so they can jointly and effectively work to align commissioning intentions for NHS, social care and public health services.

4 Scope of co-commissioning models

This section aims to support CCGs to make an informed decision on which co-commissioning model they would like to take forward. For each co-commissioning model, it set outs :

- the primary care commissioning functions it includes;
- governance arrangements; and
- opportunities, potential benefits and risks.

4.1 Overview of co-commissioning functions

The first step on the co-commissioning journey is for CCGs to decide which form of co-commissioning they would like to assume. There are three forms of co-commissioning CCGs could adopt:

In this section we aim to provide clarity and transparency around what each co-commissioning model would entail to support CCGs in their decision making.

4.1.1 Scope of primary care co-commissioning

Primary care commissioning covers a wide spectrum of activity. We have engaged with a large number of CCGs to agree the functions each co-commissioning model will encompass. We have agreed that in 2015/16, primary care co-commissioning arrangements will only include general practice services. CCGs have the opportunity to discuss dental, eye health and community pharmacy commissioning with their area team and local professional networks but have no formal decision making role.

However, we recognise the ambition in some CCGs to take on a greater level of responsibility in the commissioning of dental, eye health and community pharmacy services and we will be looking into this for 2016/17, with full and proper engagement of the relevant professional groups.

4.1.2 **Local flexibilities for incentive schemes and contracts**

The purpose of primary care co-commissioning is to enable clinically led, optimal local solutions in response to local Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies. This will be done by delegating functions and decision making to the local level.

Under delegated arrangements, CCGs would have the ability to offer GP practices the opportunity to participate in a locally designed contract, sensitive to the diverse needs of their particular communities, above or different from the national requirements e.g., as an alternative to QOF or directed enhanced services (DES). Similarly under joint arrangements, NHS England and CCGs could explore the option of implementing a locally designed incentive scheme. This is without prejudice to the rights of practices to their GMS entitlements which are negotiated and agreed nationally. Any migration from a national standard contract could only be affected through voluntary action.

In designing their own approach, it would be useful for CCGs that wish to design a new local incentive scheme to review the evaluation of the Somerset Practice Quality Scheme, as we learn more about this pilot initiative.

There will be no formal approvals process for a CCG which wishes to develop a local QOF scheme or DES. However, any proposed new incentive scheme should be subject to consultation with the Local Medical Committee (LMC), and be able to demonstrate improved outcomes, reduced inequalities and value for money. On-going assurance of new schemes would form part of the CCG assurance process.

With the freedoms of co-commissioning arises the need for mitigation of the potential risks of inconsistency of approach in areas where national consistency is clearly desirable. There is already an ability to set out core national requirements in GMS, PMS and APMS contracts through regulations. In line with this, NHS England reserves the right to set national standing rules, as needed, to be reviewed annually. NHS England will work with CCGs to agree rules for areas such as the collection of data for national data sets and IT intra-operability. The standing rules would become part of a binding agreement underpinning the delegation of functions and budgets from NHS England to CCGs.

4.1.3 **Commissioning and awarding contracts for primary care provision**

In joint arrangements, commissioning decisions would be taken by the CCG and NHS England area team. In delegated arrangements, CCGs would be responsible for taking these decisions.

In joint and delegated arrangements - as is the case for any services that they commission - CCGs and NHS England must comply with public procurement regulations and with statutory guidance on conflicts of interest.

In joint and delegated arrangements, NHS England and/or CCGs may vary or renew existing contracts for primary care provision or award new ones, depending on local circumstances.

In delegated arrangements, where a CCG fails to secure an adequate supply of high quality primary medical care, NHS England may direct a CCG to act. In delegated and joint arrangements, where a CCG or a CCG and NHS England are found to have breached public procurement regulations and/or statutory guidance on conflicts of interest, Monitor may direct a CCG or a CCG and NHS England to act. NHS England may, ultimately, revoke a CCG's delegation.

Consistent with the NHS Five Year Forward View and working with CCGs, NHS England reserves the right to establish new national approaches and rules on expanding primary care provision – for example to tackle health inequalities. This applies to joint and delegated arrangements.

4.1.4 **Parameters of primary care co-commissioning**

For all forms of primary care co-commissioning, there has been clear feedback from CCGs that it would not be appropriate for CCGs to take on certain specific pseudo-employer responsibilities around co-commissioning of primary medical care. We have therefore agreed that functions relating to individual GP performance management (medical performers' list for GPs, appraisal and revalidation) will be reserved to NHS England. NHS England will also be responsible for the administration of payments and list management. CCGs must assist and support NHS England in discharging its duty under section 13E of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) so far as relating to securing continuous improvement in the quality of primary medical services.

Furthermore, the terms of GMS contracts – and any nationally determined elements of PMS and APMS contracts – will continue to be set out in the respective regulations and directions and cannot be varied by CCGs or joint committees.

For the avoidance of doubt, CCGs will be required to adopt the findings of the national PMS and Minimum Practice Income Guarantee (MPIG) reviews, and any locally agreed schemes will need to reflect the changes agreed as part of the reviews.

4.1.5 Summary of co-commissioning functions

Primary care function	Greater involvement	Joint commissioning	Delegated Commissioning
General practice commissioning	Potential for involvement in discussions but no decision making role	Jointly with area teams	Yes
Pharmacy, eye health and dental commissioning	Potential for involvement in discussions but no decision making role	Potential for involvement in discussions but no decision making role	Potential for involvement in discussions but no decision making role
Design and implementation of local incentives schemes	No	Subject to joint agreement with the area team	Yes
General practice budget management	No	Jointly with area teams	Yes
Complaints management	No	Jointly with area teams	Yes
Contractual GP practice performance management	Opportunity for involvement in performance management discussions	Jointly with area teams	Yes
Medical performers' list, appraisal, revalidation	No	No	No

Further information on each co-commissioning model and the functions it encompasses is set out in section 4.2 to 4.4.

4.2 Greater involvement in primary care co-commissioning: scope and functions

Greater involvement in primary care co-commissioning is simply an invitation to CCGs to collaborate more closely with their area teams to ensure that decisions taken about healthcare services are strategically aligned across the local health economy. This form of co-commissioning will assist CCGs to fulfil their duty to improve the quality of primary medical care[1].

4.2.1 Scope of greater involvement in primary care commissioning

CCGs who wish to have greater involvement in primary care decision making could participate in discussions about all areas of primary care including primary medical care, eye health, dental and community pharmacy services, provided that NHS England retains its statutory decision-making responsibilities and there is appropriate involvement of local professional networks.

4.2.2 Governance arrangements for greater involvement in primary care decision making

No new governance arrangements would be required for a CCG to have greater involvement in the commissioning of primary care services and this involvement could be agreed between the CCG and its area team at any time. The effectiveness of these arrangements is reliant upon the development of strong local relationships and effective approaches to collaborative working. It is in the CCG and area team's own interest to also engage local authorities, local Health and Wellbeing Boards and local communities in primary care decision making.

A CCG which adopts this model of co-commissioning is unlikely to encounter an increased number of conflicts of interest, as CCGs would not have formal accountability for decision making. However, they would need to remain mindful of conflicts of interests and follow prescribed guidance as set out in section 6.

In this model, CCGs have the opportunity - already available to them - to invest in primary care services. Annex H contains a series of frequently asked questions (FAQs) on investing in primary care for CCGs and area teams. Further details on the next steps to take forward this form of co-commissioning can be found in section 7.2.

[1] Section 14S NHS Act 2006 (as amended by the Health and Social Care Act 2012).

4.3 Joint commissioning arrangements: scope and functions

A joint commissioning model enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with their area team, either through a joint committee or "committees in common". Joint commissioning arrangements give CCGs and area teams an opportunity to more effectively plan and improve the provision of out-of hospital services for the benefit of patients and local populations. Within this model CCGs also have the option to pool funding for investment in primary care services as set out in section 4.3.3.

4.3.1 Joint commissioning functions

In 2015/16, joint commissioning arrangements will be limited to general practice services. The functions joint committees could cover are:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services (LES)" and "Directed Enhanced Services (DES)");
- Design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF);
- The ability to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payments (e.g., returner/retainer schemes).

Joint commissioning arrangements will exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation). NHS

England will also be responsible for the administration of payments and list management.

CCGs have the opportunity to discuss dental, eye health and community pharmacy commissioning with their area team and local professional networks but have no decision making role.

4.3.2 Joint commissioning governance arrangements

CCGs could either form a joint committee or "committees in common" with their area team in order to jointly commission primary medical services.[2] With regards to joint committees, due to the passing of a Legislative Reform Order (LRO) by parliament, CCGs can now form a joint committee with one or more CCGs and NHS England. Further information on the LRO can be found here. NHS England's scheme of delegation is being reviewed and will be revised as appropriate to enable the formation of joint committees between NHS England and CCGs i.e., where NHS England invites one or more CCGs to form a joint committee.

A model terms of reference for joint commissioning arrangements, including scheme of delegation, are appended at annex D. This model applies to the establishment of a joint committee between the CCG (or CCGs) and NHS England. If CCGs and area teams intend to form a joint committee, they are encouraged to use this framework which could be adapted to reflect local arrangements and to ensure consistency with the CCGs' particular governance structures. The joint committee structure allows a more efficient and effective way of working together than a committees-in-common approach and so this is the recommended governance structure for joint commissioning arrangements.

In joint commissioning arrangements, individual CCGs and NHS England always remain accountable for meeting their own statutory duties, for instance in relation to quality, financial resources, equality, health inequalities and public participation[3]. This means that in this arrangement, NHS England retains accountability for the discharge of its statutory duties in relation to primary care commissioning. CCGs and NHS England must ensure that any governance arrangement they put in place does not compromise their respective ability to fulfil their duties, and ensures they are able to meaningfully engage patients and the public in decision making. Arrangements should also comply with the conflicts of interest guidance – please refer to section 6 for further information.

The effectiveness of joint arrangements is reliant upon the development of strong local relationships and effective approaches to collaborative working. NHS England and CCGs need to ensure that any governance arrangements put in place enable them to collaborate effectively.

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[2] A joint committee is a single committee to which multiple bodies (e.g. NHS England and one or more CCGs) delegate decision-making on particular matters. The joint committee then considers the issues in question and makes a single decision. In contrast, under a committees-in-common approach, each committee must still make its own decision on the issues in question.

[3] In the CCG's case these duties are set out in sections 14R, 14R, 14Z1, 14Z11, 14Z15, 223H, 223I, 223J and 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012; the Equality Act 2010.

Membership of joint committees

It is for area teams and CCGs to agree the full membership of their joint committees. In the interests of transparency and the mitigation of conflicts of interest, a local HealthWatch representative and a local authority representative from the local Health and Wellbeing Board will have the right to join the joint committee as non-voting attendees. HealthWatch and Health and Wellbeing Boards are under no obligation to nominate a representative, but there would be significant mutual benefits from their involvement. For example, it would support alignment in decision making across the local health and social care system.

CCGs will want to ensure that membership (including any non-voting attendees) enables appropriate contribution from the range of stakeholders with whom they are required to work. CCGs and area teams are encouraged to consult the Transforming Participation in Health and Care guidance when considering the membership of their committees. It will be important to retain clinical leadership of commissioning in a joint committee arrangement to ensure the unique benefits of clinical commissioning are retained.

4.3.3 Pooled funds for joint commissioning

CCGs and area teams may wish to consider implementing a pooled fund arrangement under joint commissioning arrangements as per section 13V of Chapter A1 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012). Establishing a pooled fund will require close working between CCG and area team finance colleagues to ensure that the arrangement establishes clear financial controls and risk management systems and has clear accountability arrangements in place.

The funding of core primary medical services is an NHS England statutory function. Although NHS England can create a pooled fund which a CCG can contribute to, the CCG's contribution must relate to its own functions and so could not relate to core primary medical services. However, CCGs are able to invest in a way that is calculated to facilitate or is conducive or incidental to the provision of primary medical care and provided that no other body has a statutory duty to provide that funding. For example,

Where an area team currently commissions services using an APMS contract they could consider pooling funds with a CCG to secure a wider range of services, for example, enhanced care for vulnerable older people.

Further details on the next steps to take forward joint commissioning can be found in section 7.3.

4.4 Delegated commissioning arrangements: scope and functions

Delegated commissioning offers an opportunity for CCGs to assume full responsibility for commissioning general practice services. Legally, NHS England retains the residual liability for the performance of primary medical care commissioning. Therefore, NHS England will require robust assurance that its statutory functions are being discharged effectively. Naturally, CCGs continue to remain responsible for discharging their own statutory duties, for instance, in relation to quality, financial resources and public participation[4].

4.4.1 Delegated commissioning functions

There was considerable variation in the range of primary care commissioning functions that CCGs proposed to assume in their initial expressions of interest. Following discussions with CCGs, we have agreed that a standardised model of delegation would make most sense for practical reasons. CCGs have expressed a strong interest in assuming the following primary care functions which will be included in delegated arrangements:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action, such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services (LES)" and "Directed Enhanced Services (DES)");
- Design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF);
- The ability to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payments (e.g., returner/retainer schemes).

[4] Section 14Z2 of the NHS Act (2006), as amended by the Health and Social Care Act (2012).

Delegated commissioning arrangements will exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation). NHS England will also be responsible for the administration of payments and list management.

CCGs have the opportunity to discuss dental, eye health and community pharmacy commissioning with their area team and local professional networks but have no decision making role.

4.4.2 **Delegated commissioning governance arrangements**

NHS England has developed a model governance framework for delegated commissioning arrangements in order to avoid the need for CCGs to develop their own model. The recommendation is that CCGs establish a primary care commissioning committee to oversee the exercise of the delegated functions. A model terms of reference for delegated commissioning arrangements including scheme of delegation are appended at annex F. If CCGs intend to assume delegated responsibilities, they are encouraged to use this framework which could be adapted to reflect local arrangements and to ensure consistency with the CCGs' particular governance structures.

A draft delegation is also appended at annex E. This is the formal document which records the delegation of authority by NHS England to CCGs. NHS England will issue a formal delegation agreement once the approvals process is completed.

In delegated commissioning arrangements, CCGs will remain accountable for meeting their own pre-existing statutory functions, for instance in relation to quality, financial resources and public participation[5]. CCGs must ensure that any governance arrangement they put in place does not compromise their ability to fulfil their duties, and ensures they are able to meaningfully engage patients and the public in decision making.

Membership of CCG primary care commissioning committees

It is for CCGs to agree the full membership of their primary care commissioning committee. CCGs will be required to ensure that it is chaired by a lay member and have a lay and executive majority. Furthermore, in the interest of transparency and the mitigation of conflicts of interest, a local HealthWatch representative and a local authority representative from the local Health and Wellbeing Board will have the right to join the delegated committee as non-voting attendees. HealthWatch and Health and Wellbeing Boards are under no obligation to nominate a representative, but there would be significant mutual benefits from their involvement. For example, it would support alignment in decision making across the local health and social care system.

[5] Sections 14R, 223H, 223I, 223J and 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012.

CCGs will want to ensure that membership (including any non-voting attendees) enables appropriate contribution from the range of stakeholders with whom they are required to work. CCGs and area teams are encouraged to consult the Transforming Participation in Health and Care guidance when considering the membership of their committees. Furthermore, it will be important to retain clinical involvement in a delegated committee arrangement to ensure the unique benefits of clinical commissioning are retained.

In this model new steps will be needed to manage potential conflicts of interest and these are set out in section 6.

Further details on the next steps to take forward delegated commissioning can be found in section 7.4.

5 Support and resources for co-commissioning

This section sets out how CCGs can access support and resources to deliver primary care co-commissioning.

A significant challenge involved in implementing primary care co-commissioning is finding a way to ensure that all CCGs can access the necessary resources as they take on new co-commissioning responsibilities. Both CCGs and NHS England recognise the difficulties of managing this fairly and in a way that both supports those CCGs which want to take on co-commissioning responsibilities and allows area teams to continue to safely and effectively deliver their remaining responsibilities.

Primary care commissioning is currently delivered by teams covering a large geography normally spanning several CCGs, and also covering all parts of primary care not just limited to general practice. There is no possibility of additional administrative resources being deployed on these services at this time due to running cost constraints.

Pragmatic and flexible local solutions will need to be agreed by CCGs and area teams to put in place arrangements that will work locally for 2015/16. These local agreements will need to ensure that:

- CCGs that take on delegated commissioning responsibilities have access to a fair share of the area team's primary care commissioning staff resources to deliver their responsibilities; and
- Area teams retain a fair share of existing resources to deliver all their ongoing primary care commissioning responsibilities.

There will be no nationally prescribed model: this will be a matter for local dialogue and determination. However, NHS England is committed to supporting local discussions in any way deemed helpful, and the current Primary Care Co-Commissioning Programme Oversight Group will continue to operate during the implementation period to help address practical issues.

5.1 Potential approaches for staffing

Where CCGs intend to take on joint or delegated responsibility for primary care commissioning, they should have a conversation with the area team regarding accessing support through the existing primary care team.

Given the limited size of existing primary care teams, potentially only part-time capacity would be available for individual CCGs taking on delegated commissioning responsibility, so it may be that collaborative arrangements between CCGs would be desirable to achieve greater critical mass. Staffing models for these arrangements will vary across the country and will require careful discussion to ensure that the practical, legal and staff engagement issues are clearly understood.

However, it is for CCGs to agree whether and how they would wish to work together. Where like-minded CCGs in an area team patch wish to collaborate, they need not necessarily be contiguous. In instances where they are not contiguous, the area team and CCGs would need to consider geographical practicalities for the staff concerned. These arrangements will need to take into account the size of the CCG, the number of primary care contracts held and the need for the area team to continue to deliver primary care commissioning functions not being delegated to CCGs and for areas where CCGs do not opt to take on delegated responsibilities.

Alternatively, some CCGs may wish to integrate primary care commissioning support with wider commissioning support from their Commissioning Support Unit (CSU). Again, in this scenario, arrangements should be agreed and implemented locally with particular attention to the practicalities.

It will be critical that local conversations are handled with maturity and due regard for members of staff involved to ensure transparent and mutually workable solutions.

5.2 Financial arrangements for co-commissioning

5.2.1 Financial information sharing

NHS England will ensure transparency in sharing financial information on primary care with CCGs. All CCGs will have the opportunity to discuss the current financial position for all local primary care services with their area team. CCGs will be provided with an analysis of their baseline expenditure for 2014/15 broken down between GP services and other primary care services by the end of November 2014. Final decisions regarding allocations for 2015/16 will be made by the NHS England Board in December 2014. An example of the level of detail area teams will be able to share can be found in the financial plan template – direct commissioning section of the NHS England website.

5.2.2 Financial allocations and running costs

We recognise that it will be challenging for some CCGs to implement co-commissioning arrangements, especially delegated arrangements, without an increase in running costs. Whilst it is not within our gift to increase running costs in 2015/16, NHS England will keep this situation under review. CCGs should discuss

with area teams options for sharing administrative resource to support the commissioning of primary care services.

In delegated arrangements, CCGs will receive funding for known future cost pressures within current allocations e.g. net growth in list sizes. In such circumstances, there may be a linked efficiency requirement which will need to be delivered in order for budgets to balance. Furthermore, if supported by clear strategies, CCGs would also have greater flexibility to "top up" their primary care allocation with funds from their main CCG allocation. For example:

A CCG currently commissions district nursing services from its community provider. The CCG could consider pooling the funding for this service with its primary care funding and arrange for district nursing services to be commissioned as part of primary care linked to GP practice nursing.

Full details on how area team allocations for primary care for 2014/15 and 2015/16 were calculated are published in the Technical Guide to the formulae for 2014-15 and 2015-16 revenue allocations to Clinical Commissioning Groups and Area Teams. Annex F of this technical guide also sets out the detailed pace of change for each area team primary care allocation for 2014/15 and 2015/16.

Work is also currently underway to develop a target formula and place based allocations. Further information on the target formula will be available in early 2015 and the 'place-based' target in late 2015. It is anticipated that in 2015/16 the actual allocations for primary care will be made at CCG level rather than area team level.

5.2.3 **Variations in primary care funding**

It is recognised that there are historic variations in primary care funding across England and localities and we are taking steps to move towards a fair distribution of resources for primary care, based on the needs of diverse populations. The GMS Minimum Practice Income Guarantee (MPIG) will be phased out by April 2020, and a review of local PMS agreements is underway as set out in the Framework for Personal Medical Services (PMS) Contracts Review. Area teams should ensure that any decisions relating to future use of PMS funding are agreed with CCGs.

We envisage that CCG and primary care allocations will continue to move towards a fair distribution of resources and reflect inequalities, as in the current CCG formula. As part of any delegation of primary care commissioning responsibilities, area teams will provide details of any differential funding levels across localities.

6 Conflicts of interest

This section provides advice on conflicts of interest management for CCGs that implement co-commissioning arrangements.

Conflicts of interest, actual and perceived, need to be carefully managed within co-commissioning. Conflicts of interest are a matter of public interest, and it is also in the interest of the profession that this issue is robustly and transparently handled. CCGs are already managing conflicts of interests as part of their day-to-day work and there is formal guidance on Managing conflicts of interests and a Code of conduct in place for CCGs and General Practitioners in commissioning roles.

However, without a strengthened approach, co-commissioning could significantly increase the frequency and range of potential conflicts of interest, especially for delegated arrangements. Therefore, NHS England, in partnership with NHS Clinical Commissioners, has developed a significantly enhanced framework for conflicts of interest management with clear minimum expectations for CCGs which assume co-commissioning responsibilities.

6.1 Current conflicts of interest guidance

There is a legal requirement for CCGs to have arrangements in place for managing conflicts of interest. Section 14O of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) sets out minimum requirements including:

NHS England must:

- Publish guidance to CCGs on the discharge of their duties.

CCGs must:

- Maintain appropriate registers of interests;
- Publish or make arrangements for the public to access those registers;
- Make arrangements requiring the prompt declaration of interests by the persons specified (members and employees) and ensure that these interests are entered into the relevant register;
- Make arrangements for managing conflicts of interest and potential conflicts of interest (e.g. developing appropriate policies and procedures); and

- Have regard to guidance published by NHS England in relation to conflicts of interest.

NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013

- A relevant body (including a CCG) must not award a contract for NHS health care services where conflicts, or potential conflicts of interest affect, or appear to affect, the integrity of the award.

6.2 Forthcoming guidance on managing conflicts of interest in primary care co-commissioning arrangements

A national framework for conflicts of interest management in primary care co-commissioning is being developed in partnership with NHS Clinical Commissioners and with formal engagement of Monitor and HealthWatch England. The guidance will:

- build on existing guidance;
- have regard to any statutory guidance issued by Monitor; and
- continue to facilitate clinically-led decision-making as far as possible within the important constraint of the effective management of conflicts of interests.

The guidance will include a strengthened approach to:

- **the make-up of the decision-making committee**: the committee must have a lay and executive majority and have a lay chair;
- **national training for CCG lay members** to support and strengthen their role;
- **external involvement of local stakeholders**: the local HealthWatch and a local authority member of the local Health and Wellbeing Board will have the right to serve as observers on the decision-making committee;

- **register of interest**: the public register of conflicts of interest will include information on the nature of the conflict and details of the conflicted parties. The register would form an obligatory part of the annual accounts and be signed off by external auditors; and

- **register of decisions**: CCGs will be required to maintain and publish, on a regular basis, a register of procurement decisions.

The guidance will be published in December 2014 as statutory guidance in accordance with section 14Z8 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012). The guidance will be specifically aimed at CCGs exercising delegated authority but all CCGs will be required to have regard to the principles set out in the guidance.

The CCG's audit committee chair and CCG Accountable Officer will be required to provide direct formal attestation that the CCG has complied with conflict of interest guidance.

7 Approvals and implementation process 2014/15

This section sets out the approvals and implementation process for co-commissioning arrangements including the:

- process for reviewing your preferred co-commissioning approach;
- approvals process for co-commissioning arrangements; and
- implementation timeline for 2014/15.

7.1.1 Principles of the approvals process

Based on feedback from CCGs and area teams, and in recognition that CCGs undertook a robust authorisation process in their establishment as statutory bodies, the approvals process for co-commissioning arrangements will be as straightforward as possible. The process will be governed by the following principles:

- It will be conducted openly and transparently and contain no surprises;
- It will minimise the administrative demands placed on CCGs and area teams; and
- On-going assurance of co-commissioning arrangements will form part of the CCG assurance process.

Unless a CCG has serious governance issues or is in a state akin to "special measures," NHS England will support CCGs to move towards implementing co-commissioning arrangements. CCGs must also be able to demonstrate appropriate levels of sound financial control and meet all statutory and business planning requirements to progress delegated arrangements.

7.1.2 Opportunity to review your preferred co-commissioning arrangement

CCGs have requested a fresh opportunity to decide upon their preferred approach to primary care commissioning. We are therefore inviting CCGs to review their intentions and indicate their preferred co-commissioning arrangement in **January 2015**. As membership organisations, CCGs should fully engage with their members when considering co-commissioning options. It would also benefit CCGs and local stakeholders such as patients, local authorities, Health and Wellbeing Boards and HealthWatch to have an open and inclusive conversation about options and possible arrangements.

CCGs and area teams are asked to complete a short proforma should they wish to assume joint or delegated arrangements, as set out in the table below.

Co-commissioning model	Proforma	Submission date
Greater involvement in primary care commissioning decision making	There is no proforma to complete. Please liaise with your area team to take forward these arrangements, as set out in section 7.2.	Not applicable.
Joint commissioning	CCGs and area teams are asked to complete a proforma for joint arrangements (annex A). This proforma focuses upon the proposed governance arrangements for joint committees.	**30 January 2015**
Delegated commissioning	CCGs and area teams are asked to complete a proforma for delegated arrangements (annex B). This proforma focuses upon the CCG's approach to conflicts of interest management.	**12 noon on 9 January 2015**

Proformas for joint and delegated arrangements should be emailed to england.co-commissioning@nhs.net along with the requested supporting documentation which includes constitution amendment requests.

All delegated proformas must be submitted by **12 noon** on **9 January 2015** for arrangements to be implemented on **1 April 2015**. This is to allow sufficient time for financial transfers to be made. It would be preferential if arrangements were put in place on 1 April 2015 in the interests of agreeing staffing arrangements with area teams, although it may be possible to enable CCGs to implement delegated arrangements in-year in 2015/16.

Whilst these are formal deadlines, we know that in many areas CCGs and area teams are already engaging about co-commissioning, including financial arrangements and resources. We consider this to be good practice and would encourage all CCGs and area teams to adopt this approach.

7.1.3 **Procedure to agree a change to a CCG constitution**

Proposals for joint and delegated commissioning arrangements will require an amendment to a CCG's constitution. A suggested form of words for joint commissioning constitutional amendments, which can be tailored to individual circumstances, is included in annex C. Other minor amendments may also be

required in relation to delegated commissioning arrangements and these will be considered on an individual CCG basis.

The procedure for making an amendment is set out in the following guidance: Procedures for clinical commissioning group constitution change, merger and dissolution. As membership organisations, CCGs should consult with their members on any constitutional changes. CCGs also have a duty to consult with relevant stakeholders, such as local authorities, on constitutional changes.

The deadline for constitution amendment requests has been extended from 1 November 2014 to **12 noon** on **9 January 2015**. There is a further extension till 30 January 2015 for constitution amendments that relate solely to joint commissioning arrangements.

Co-commissioning form	Submission date for CCG constitutional changes
Joint commissioning	30 January 2015
Delegated commissioning	9 January 2015
All other constitution amendment requests	9 January 2015

All requests for constitution amendments should be emailed to england.co-commissioning@nhs.net **and the relevant regional team**. NHS England will acknowledge all applications for constitutional variations within two weeks of receipt and will notify the CCG in writing of the outcome of its decision within 8 weeks.

7.1.4 Governance arrangements for joint and delegated commissioning models

This document is accompanied by a suite of practical tools to support CCGs to implement co-commissioning arrangements locally including:

- Joint commissioning model governance structure, including model terms of reference for joint commissioning arrangements and scheme of delegation (Annex D)
- Draft delegation by NHS England (Annex E)
- Delegated commissioning model-draft terms of reference (Annex F)

NHS England has developed the governance frameworks on behalf of CCGs. CCGs are encouraged to use the template documents when developing co-commissioning arrangements. They can be amended to reflect local arrangements and to ensure consistency with the CCG's particular governance structure. They contain a number of points where the detail will need to be discussed and agreed as co-commissioning proposals are developed.

7.1.5 **Overview of the approvals process**

The approvals process for primary care co-commissioning is intended to be straightforward:

Co-commissioning model	Approvals process
Greater involvement in primary care commissioning decision making	No formal approvals process. Arrangements should be taken forward locally.
Joint commissioning	Proposals should be submitted to england.co-commissioning@nhs.net by 30 January 2015. Proposals will be agreed by regional teams, if they are assured that arrangements comply with the governance framework, for instance through the creation of a joint committee or "committee in common".
Delegated commissioning	Proposals should be submitted to england.co-commissioning@nhs.net by **12 noon** on **9 January 2015** for initial review by regional moderation panels. Final sign off will be undertaken by the proposed new Commissioning Committee of NHS England's Board.

Further information on the approvals process is set out in sections 7.2 to 7.4. On-going assurance of arrangements will form part of the CCG assurance process.

7.2 Greater involvement in primary care co-commissioning: approvals process and timeline

There is no formal approvals process for any CCG which wishes to have greater involvement in primary care decision making. Many CCGs are already working closely with their area teams to influence and shape primary care decision making and NHS England will continue to work with CCGs to establish effective arrangements. Periodic surveys will be conducted to provide an opportunity for CCGs and area teams to feedback on local arrangements. More information on the surveys will be provided in due course.

7.2.1 Summary of the approvals process and timeline

From now onwards	Arrangements to be implemented locally
2015/16	Periodic surveys to review arrangements

7.3 Joint commissioning proposals: approvals process and timeline

7.3.1 Joint commissioning proforma

CCGs that wish to assume joint commissioning responsibilities should work with their area teams to complete a short proforma (annex A) to confirm the agreed governance arrangements. Proformas should be submitted to england.co-commissioning@nhs.net by **30 January 2015** along with requested supporting information, including the proposed governance structure and constitution amendment request. A draft governance structure for joint commissioning arrangements is appended at annex D and can be amended to reflect local arrangements.

7.3.2 Approvals process

Regional moderation panels will convene in early February 2015 to review all submitted proposals, focusing upon the proposed governance arrangements and ensuring consistency of area team approach. Where a joint commissioning arrangement involves a pooled fund, the arrangement would need to comply with financial instructions (please refer to section 4.3.3). This is also an opportunity to take stock of the practical arrangements put in place locally by CCGs and area teams and to highlight and share best practice in this area.

Once regional teams are satisfied that the proposed arrangements comply with the legal framework and constitution amendments have been approved, arrangements can be implemented by **1 April 2015**. Area teams will inform CCGs once proposals have been approved and CCGs and NHS England will be required to sign a legally binding agreement to confirm how NHS England and CCGs will operate under the joint arrangement. Where proposals are not recommended for approval, regional teams will work with CCGs and area teams to support the development of joint arrangements.

All new arrangements for information handling as a result of joint commissioning arrangements must meet relevant information governance standards. CCGs are encouraged to review their Information Governance Toolkit assessment to ensure compliance with Department of Health Information Governance policies and standards.

7.3.3 **Summary of the approvals process and timeline**

November 2014 to January 2015	• CCGs and area teams should work together to further develop joint commissioning proposals.
30 January 2015	• Submission of proposal for joint arrangements (annex A). • Submission of constitutional amendment (annex C).
February to March 2015	• Regional moderation panel reviews proposals and makes recommendations for approval. • CCGs informed of the outcome of their constiutional amendment request. • If required, regional teams support the further development of proposals.
From 1 April 2015 onwards	• Arrangements implemented in full locally.

7.4 Delegated commissioning arrangements: approvals process and timeline

7.4.1 Delegated commissioning proforma

CCGs that wish to assume delegated commissioning responsibilities are asked to submit a short proforma (annex B) which focuses on the CCGs approach to conflicts of interest management. Proformas should be submitted to the national support centre team (england.co-commissioning@nhs.net) by **12 noon** on **9 January 2015** along with the requested supporting information, including the proposed delegated governance structure and constitution amendment request.

7.4.2 Approvals process

Regional moderation panels will convene in **mid-January 2015** to review all delegated proposals, specifically the CCG's proposed approach to conflicts of interest management. This is also an opportunity to take stock of the practical arrangements put in place locally by CCGs and area teams and to highlight and share best practice in this area.

A national moderation panel, in place to ensure consistency of approach across the country, will make final recommendations to the relevant new NHS England committee (likely to be the proposed new Commissioning Committee) on which proposals are ready to be taken forward from 1 April 2015. The committee will provide final sign off for delegated proposals in **February 2015**. Once proposals are approved, CCGs will need to set out their plans as per the 2015/16 NHS planning guidance which will be published in December 2014. Proposals will then be implemented on **1 April 2015**.

Where proposals are not recommended for approval, an appropriate plan will be developed between the CCG and area team, supported by regional teams, to either further develop proposals or to establish joint arrangements for 2015/16, if this is agreed to be the preferred approach. It would be preferential if arrangements were put in place on 1 April 2015 in the interests of agreeing staffing arrangements with area teams. However, there may be some flexibility to enable CCGs, who submit delegated arrangement proposals for 2016/17 to implement delegated arrangements in year in 2015/16.

Once delegated arrangements have been established, their effectiveness will be monitored as part of the CCG assurance process.

7.4.3 **Implementation arrangements**

Once delegated commissioning proposals have been signed off by the proposed new Commissioning Committee, CCGs will be required to sign a legally binding agreement to confirm the detail of how NHS England will delegate its general practice functions to CCGs.

NHS England's finance directorate will arrange for funds to be transferred on **1 April 2015** to enable CCGs to take forward arrangements thereafter**.** Funds will be transferred via an inter authority transfer in 2015/16. When discharging their duties, CCGs must comply with the Statement of Financial Entitlement (SFE) directions which set out the payments to be made under general medical services contracts. Business rules, which CCGs currently adhere to, will also apply to primary care commissioning. The 2014/15 business rules can be found in annex B of the financial plan template – direct commissioning section of the NHS England website.

All new arrangements for information handling as a result of delegated commissioning arrangements must meet relevant information governance standards. CCGs are encouraged to review their Information Governance Toolkit assessment in compliance with Department of Health Information Governance policies and standards. Information sharing will form part of the formal delegation agreement once arrangements have been approved.

7.4.4 **Summary of the approvals process and timeline**

November 2014 to January 2015	• CCGs and NHS England work together to further develop delegated commissioning proposals.
9 January 2015 (12 noon)	• Submission of proposal for delegated arrangements (annex B). • Submission of constitutional amendment (annex C).
February 2015	• Regional moderation panel review proposals and make recommendations for approval. • NHS England Commissioning Committee approves proposals
March 2015	• Subject to approval, NHS England's finance directorate arrange the transfer of delegated budgets. • CCGs informed of the outcome of their consitutional amendment request.
From 1 April 2015 onwards	• Arrangements implemented in full locally.

8 Changing a co-commissioning arrangement from 2015/16 onwards

This section sets out the process for changing a co-commissioning arrangement from 2015/16. This includes the approvals process and timeline.

CCGs are at different stages of their developmental journey and are facing a variety of local challenges. Therefore it is likely that the appetite to take on further responsibilities for primary care co-commissioning will vary across the country. We want CCGs to be able to move at their own pace, whilst also indicating that we see co-commissioning as a needful development towards mitigating current health inequalities and securing better integrated, more easily accessed, high quality care for patients. We expect that many CCGs may wish to enter into joint commissioning arrangements for 2015/16 to see how the agenda develops, before deciding to take on delegated responsibilities for 2016/17.

We intend to make it as straightforward as possible for CCGs to assume greater commissioning responsibilities from 2015/16 onwards, should they wish to. For example:

- CCGs which have no co-commissioning arrangements in place or opted for greater involvement, could apply for joint or delegated arrangements; or
- CCGs in joint arrangements could apply for delegated arrangements.

CCGs should discuss any plans to change their co-commissioning model with their area team in the first instance and new proposals should be discussed and planned as part of the CCG assurance process.

Future co-commissioning model	Approvals process *from 1 April 2015/16 onwards* to assume a new co-commissioning arrangement
Joint commissioning	CCGs should discuss their proposals with their area team and regional team. Any requests should be reviewed and agreed within the quarterly CCG assurance review meetings. The approvals process will follow the process set out in section 7.3 and the timeline will be confirmed by the area team.
Delegated commissioning	CCGs should discuss their proposals with their area team and regional team. NHS England and NHS Clinical Commissioners will in due course be developing the timetable for applications for 2016/17.

In the circumstance that a CCG wishes to terminate their co-commissioning arrangement, this would need to be by mutual agreement with NHS England. In these circumstances, it is expected that the CCG would move either from delegated arrangements to joint arrangements or joint arrangements to greater involvement.

9 Ongoing assurance

This section sets out on-going assurance arrangements for co-commissioning.

9.1 Overarching approach

NHS England is committed to working with CCGs to co-develop a revised approach to the current CCG assurance framework for 2015/16. The new assurance framework will be published in 2015. The on-going assurance of primary care co-commissioning arrangements will be managed as part of this wider CCG assurance process.

9.2 Principles

NHS England requires on-going assurance that its duties are being discharged effectively. The assurance process will be adapted according to the commissioning function that the CCG is undertaking. NHS England will look at ways of reducing the burden of assurance on the service whilst implementing a robust process that is mindful of the legislative framework.

There are three key principles governing the assurance process:

- It will be simplified to reduce unnecessary bureaucratic processes for both CCGs and NHS England;
- It will be based on a supportive conversation and the process will reflect the flexibility of NHS England to intervene differently in different circumstances; and
- There will be clear interventions for failing CCGs.

In particular, for co-commissioning the new assurance process will:

- test that core governance arrangements are working successfully, with specific attention to the effective local management of conflicts of interest;
- be specific about the achievement of local outcomes, with a particular focus on service delivery across the local health economy; and it will
- be co-designed and developed in strong partnership with CCGs and other key stakeholders prior to publication.

10 Development support and evaluation

This section sets out the support available to CCGs to implement co-commissioning and the on-going evaluation of co-commissioning arrangements.

10.1 Implementation roadshows and legal support

A series of roadshows will take place across the country to support CCGs and area teams to move towards implementing primary care co-commissioning arrangements. The purpose of these events is to:

- Set out the vision for the future as we move towards place-based commissioning, taking into account the vision described in the Five Year Forward View;
- Provide an opportunity for CCGs and area teams to raise any questions they may have about primary care co-commissioning and the impact of the changes;
- Provide technical advice to support the implementation of co-commissioning, specifically on the timeline and approvals process, the legalities of joint and delegated arrangements and conflicts of interest management; financial arrangements and HR and resources, and
- Offer a further opportunity for area teams and CCGs to work together on their joint proposals if they so wish.

The workshops will take place between 19 November and 2 December 2014. Further information and registration details can be found here. Due to high demand, CCGs are asked to only send one representative to the events. The events are not open to private businesses.

Further legal advice will also be available for CCGs that intend to implement joint and delegated arrangements. Your regional team will provide further information on how this can be accessed.

10.2 Learning and continuous development

It will be important that we review and share learning from the implementation of co-commissioning arrangements in real time in order to support CCGs' continuous development and improvement. We will evaluate the following:

- what is and is not working;
- any unforeseen perverse incentives and system blockages; and
- examples of good practice.

This will help us to improve the policy for future years. In addition, we are exploring options on how best to do the following:

- provide technical support where required;
- enable the dissemination of 'lessons learned' and supporting a network of practitioners to problem solve and share learning and experiences; and
- provide a web-based interactive platform for exchange and ideas.

Further information will be shared in due course.

11 Next steps

We hope this document is useful in helping to inform CCG decision making around primary care co-commissioning models and in providing clarity on the next steps towards the implementation of co-commissioning arrangements. If you require any further information, please email: england.co-commissioning@nhs.net.

We will be keeping the arrangements set out in this document under review in the light of the experience of their operation during 2015/16.

Furthermore, as primary care co-commissioning is the start of a longer journey towards place based commissioning, we recognise there is much work to be done to achieve this goal. NHS England is therefore committing to the following in 2015/16:

- We will look at options for the co-commissioning of dental, eye health, community pharmacy and public health services (such as immunisation and vaccinations), as we know some CCGs are keen to assume commissioning responsibilities in these areas. This will be done with full and proper engagement of the relevant professional groups.
- We will continue to work on arrangements for involving CCGs in the commissioning of specialised services.
- We will continue to monitor running cost allowances and resources to ensure that co-commissioning arrangements are sustainable.
- We will look into GP premises development, as part of the implementation of the NHS Five Year Forward View.

12 Glossary

APMS	Alternative Provider Medical Services
CCGs	Clinical Commissioning Groups
CSU	Commissioning Support Unit
DES	Directed Enhanced Services
FAQs	Frequently Asked Questions
GMS	General Medical Services
GPs	General Practitioners
IPC	Integrated Personal Commissioning Programme
JSNAs	Joint Strategic Needs Assessments
LES	Local Enhanced Services
LMC	Local Medical Committee
LRO	Legislative Reform Order
MPIG	Minimum Practice Income Guarantee
PMS	Personal Medical Services
QIPP	Quality Innovation Productivity and Prevention
QOF	Quality Outcomes Framework
SFE	Statement of Financial Entitlement

13 References

Department of Health, Information Governance Toolkit

Department of Health, 16 July 2008, End of Life Care Strategy

Department of Health, 29 September 2014, Statement of Financial Entitlement

HM Government, 2012, Health and Social Care Act 2012

NHS, 23 October 2014, NHS Five Year Forward View

NHS England, October 2012, Managing conflicts of interest where GP practices are potential providers of CCG-commissioned services

NHS England, 28 March 2013, Managing conflicts of interests: Guidance for clinical commissioning groups

NHS England, 7 May 2013, CCG Assurance Framework 2013/14

NHS England, 24 May 2013, Procedures for clinical commissioning group constitution change, merger and dissolution

NHS England, September 2013, Transforming Participation in Health and Care guidance

NHS England, 25 March 2014, Technical Guide to the formulae for 2014-15 and 2015-16 revenue allocations to Clinical Commissioning Groups and Area Teams

NHS England, September 2014, Framework for Personal Medical Services (PMS) Contracts Review

NHS England, 4 September 2014, Integrated Personal Commissioning (IPC) programme

NHS England, 29 September 2014, Update on the Legislative Reform Order (letter)

NHS England, Financial plan template – direct commissioning 2014/15 to 2018/19

14 Annexes

This document is accompanied by a suite of practical tools to support CCGs to implement co-commissioning arrangements locally including:

Annex A: Submission proforma for joint commissioning arrangements

Annex B: Submission proforma for delegated commissioning arrangements

Annex C: Model wording for amendments to CCGs' constitutions

Annex D: Model terms of reference for joint commissioning arrangements, including scheme of delegation

Annex E: Draft delegation by NHS England

Annex F: Delegated commissioning model - draft terms of reference

Annex G: Members of the Primary Care Co-commissioning Programme Oversight Group

Annex H: CCG investment in primary care frequently asked questions (FAQs)