Public Document Pack

Shropshire Council

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

Date: Friday, 21 March 2014
My Ref:
Your Ref:

Committee:
Health and Wellbeing Board

Date: **Friday, 28 March 2014**
Time: **10.30 am**
Venue: **Oswestry 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 and Substitutes

To receive apologies for absence and any substitutions that may be notified.

2 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.

3 Better Care Fund: Governance Structure (Pages 1 - 4)

To receive a report

Contact: Dr Julie Davies (01743) 252295, Stephen Chandler (01743) 253704

4 Better Care Fund: Terms of Reference for 3 Sub Groups (Pages 5 - 12)

To receive a report

Contact: Dr Julie Davies (01743) 252295, Stephen Chandler (01743) 253704

5 Better Care Fund Co-ordinator (Pages 13 - 20)

To receive a report

Contact: Dr Julie Davies (01743) 252295, Stephen Chandler (01743) 253704

6 Better Care Fund Plan (Pages 21 - 66)

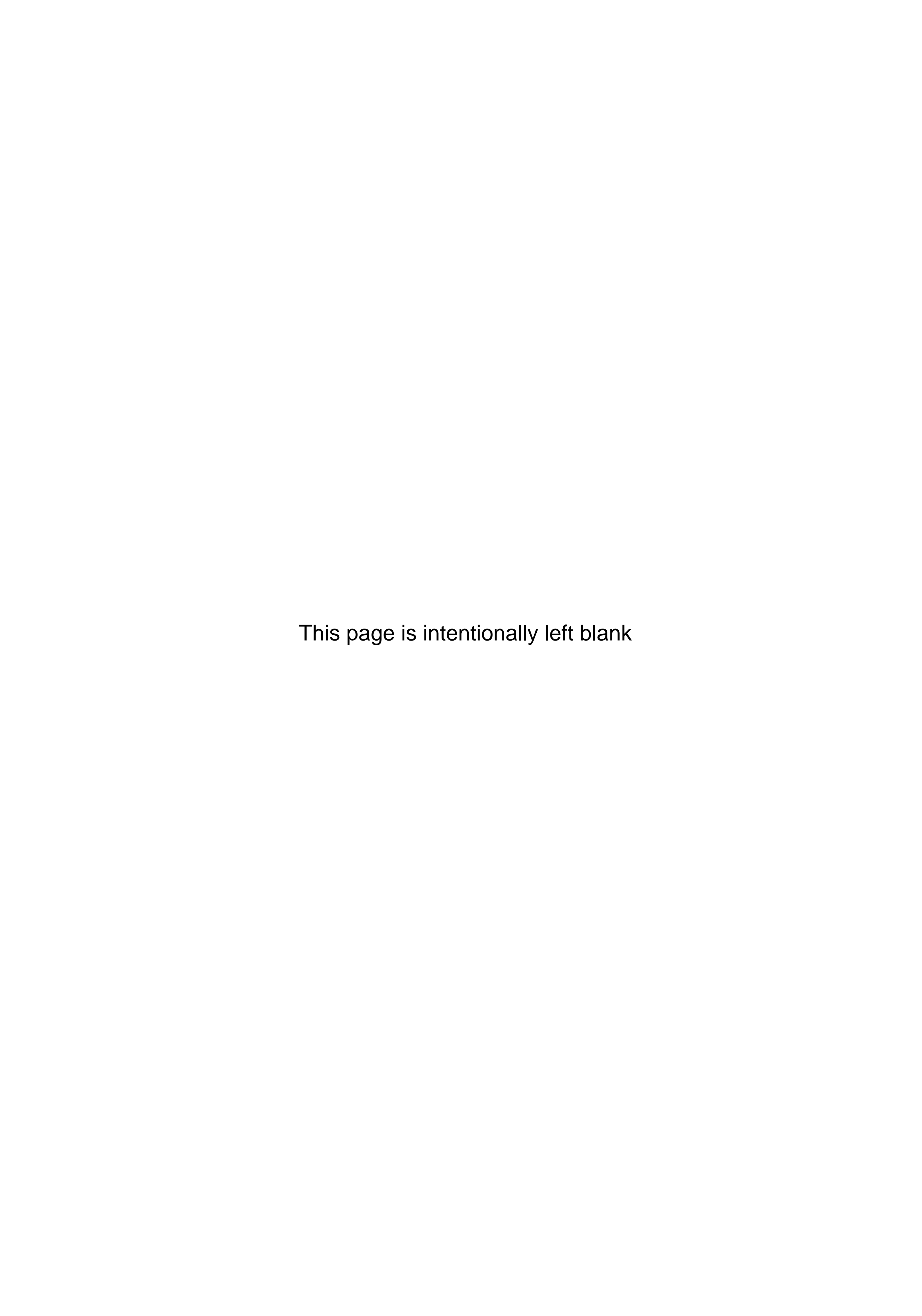
To receive a report

Contact: Dr Julie Davies (01743) 252295, Stephen Chandler (01743) 253704

7 CCG 5 Year Plan (Pages 67 - 140)

To receive a report

Contact: Paul Tulley (01743) 277580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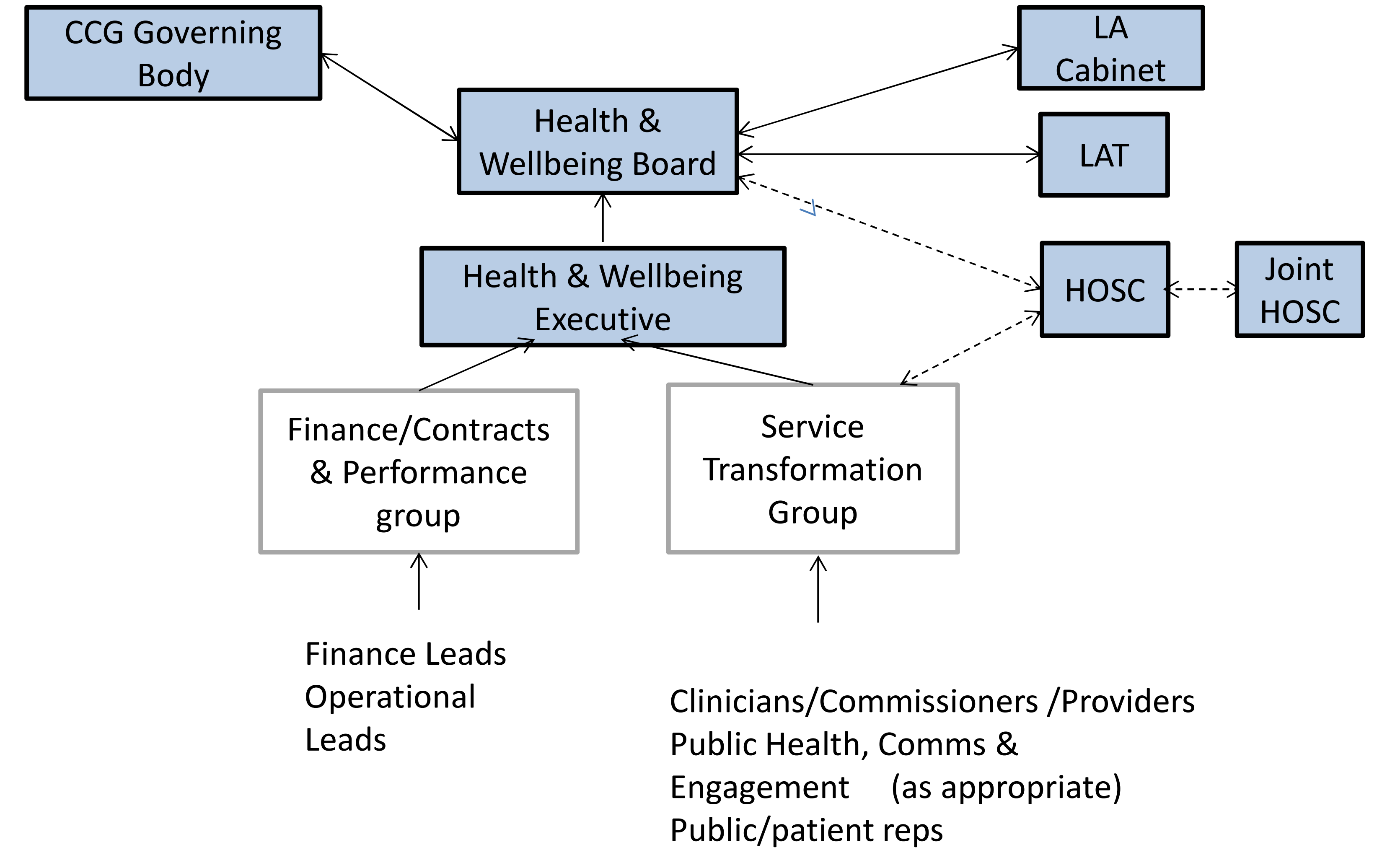
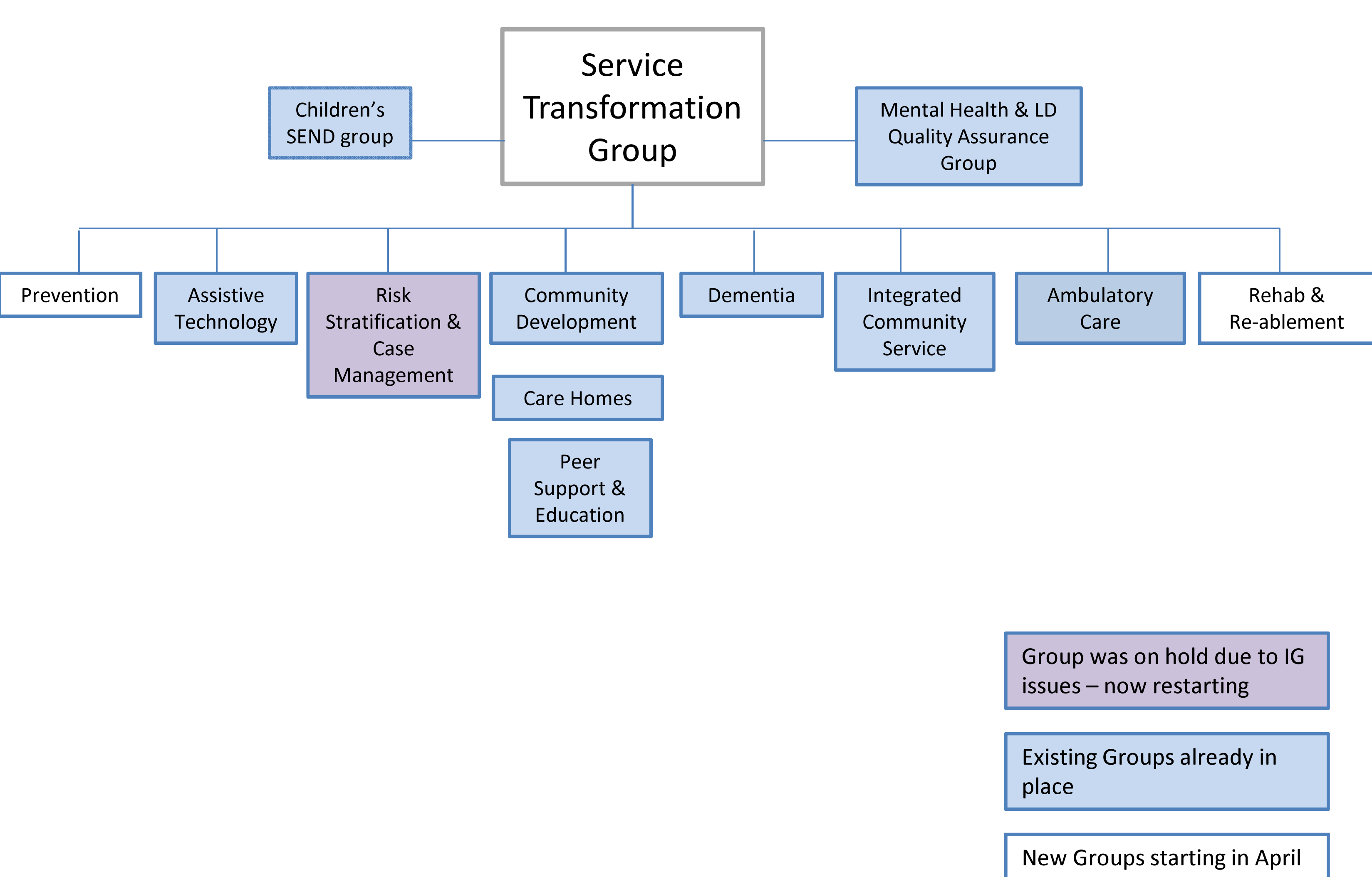
Better Care Fund Proposed Governance



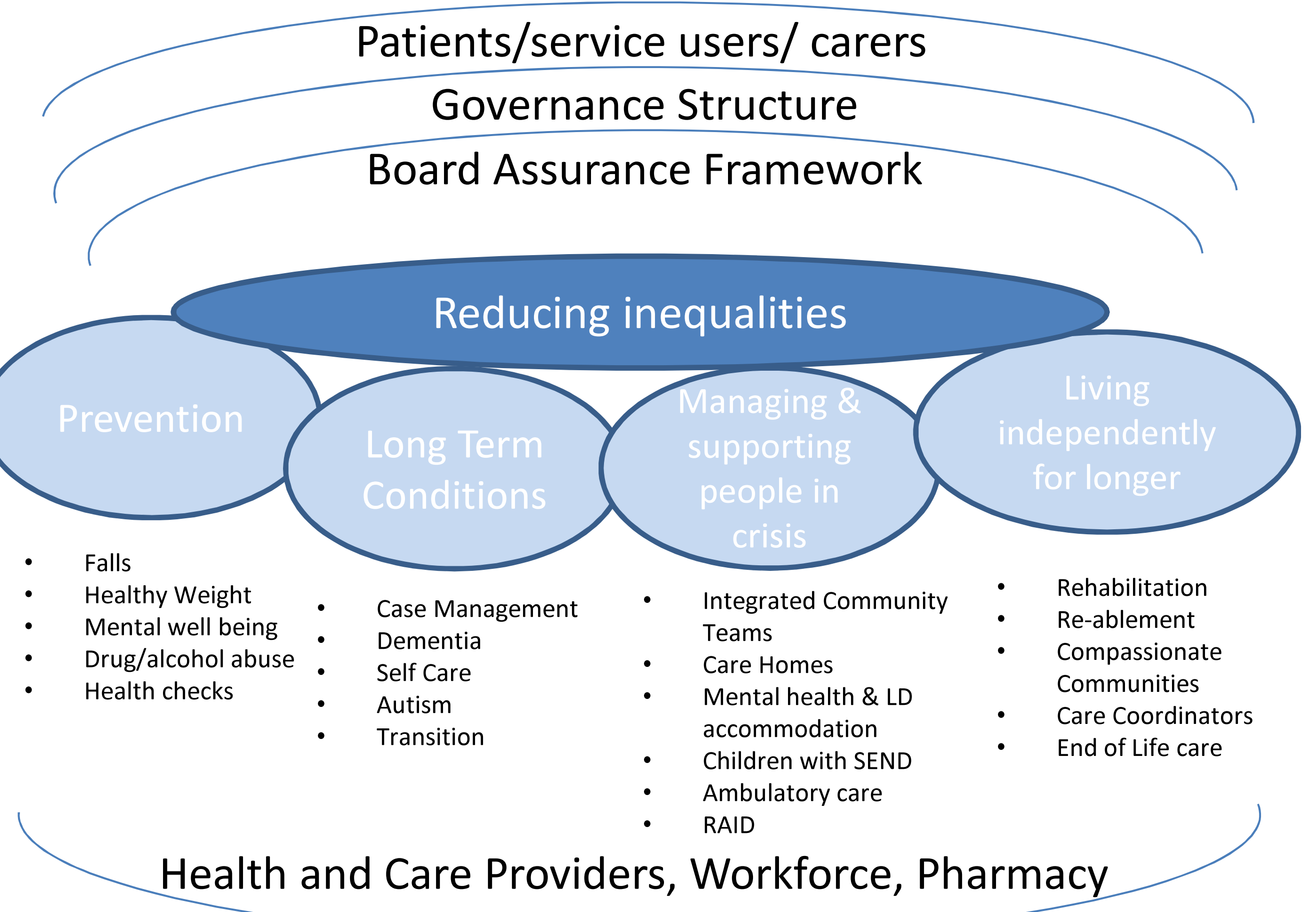
Service Transformation Group + Task & Finish Groups



Better Care Fund

Plan on a page!

The Challenge :- To improve services and outcomes for the people of Shropshire and make the local health and social care system financially sustainable into the future.



Assistive Technology , Community Capacity /Peer support, Support for Carers
Integrated Health & Social Care Data

Measures of Success

Terms of Reference for the Better Care Fund Service Transformation Group	
Purpose	The purpose of the Service Transformation group is to coordinate the redesign of health and social care services within the scope of the Better Care Fund and implement any resulting re-commissioning and/or de commissioning as required.
Vision	To improve services and outcomes for the people of Shropshire and make the local health and social care system financially & clinically sustainable into the future.
Objectives	The Service Transformation Group will implement a joint approach to the commissioning, decommissioning and redesign of services within the scope of the Better Care Fund which will improve the health and wellbeing of local people. It will:- o develop services to meet the needs the health and social care needs of the local community as identified in the Joint Strategic Needs Assessment. o ensure that that the appropriate engagement and involvement of patient and service users takes place at all stages of service redesign. o ensure that that the appropriate engagement and involvement of providers including the voluntary sector takes place at all stages of service redesign. o use the Better Care Fund as a vehicle for the integration of health services and social care services in provision and procurement. o coordinate the service transformation necessary in each of the four priorities areas:- Prevention Long Term Conditions Managing & supporting people in crisis Living independently for longer o receive exception reports on the progress against the projects/areas of work and achievement of associated timescales. o take the outcomes of service redesign to CCG Clinical Assurance Panel and the local authority senior management team where appropriate prior to commencing any formal re-commissioning o make recommendations on service specifications and procurement decisions to the Health & Well Being Executive.

	o ensure appropriate reviews are carried out of any service changes to monitor effectiveness and value for money. o Ensure that the Better Care Fund objectives are designed into any service redesign undertaken o link with chair of HOSC regarding any specific changes that require formal overview and scrutiny and ensure that appropriate changes are taken to HOSC for approval.
Membership	Chair: TBA Group Membership: § CCG Director of Strategy & Service Redesign § CCG Head of Programmes & Redesign § CCG Clinical Director of Delivery, and Clinical Director for LTCs § Better Care Fund Manager § Patient/public representative § Head of Service: Improvement and Efficiency – Adult Services § Director of Preventative Health Programmes § Head of Children's Social Care & Safeguarding § Commissioning Manager - People Lead managers, service leads and clinicians from CCG/local authority to attend for appropriate Task & Finish areas of work, as required. Additional patient and individual provider representation will be an intrinsic part of the individual task and finish group
Reports to	Health & Wellbeing Executive with individual reports to the HOSC as requested.
Links to	Clinical Assurance Panel and Service Review & Procurement Group at the CCG Senior management team at the council
Frequency of Meetings	**Monthly from April 2014.**
Administration	Personal Administrator for the Chair
Review Record	**The chair will sign off the previous month's action notes and these shall form the written review record.**
Quorum	Minimum of 2 senior management representatives and 1 senior clinician from both the CCG and the local authority

Date drafted for initial review by group: March 2014
Date revised following comment: May 2014
Date for future review: October 2014

Terms of Reference Better Care Fund Finance, Contracts and Performance Sub-Group	
Purpose	1. Detailed Budget for the year 2. Monthly performance monitoring of Finance, contracts and Performance.
Vision	To improve services and outcomes for the people of Shropshire and make the local health and care system financially and clinically sustainable into the future
Objectives	• To prepare the annual budget for the BCF and make recommendations on the same • To review and ensure adherence to procurement processes as applicable against BCF approved budgets • To ensure contracts are in place for approved budgets as appropriate • To put performance monitoring processes in place • To receive, review and report on Financial Performance of BCF, analysing risks and putting mitigations in place as appropriate • To receive, review and report on Outcomes Performance of BCF, analysing risks and putting mitigations in place as appropriate • To provide financial, contracting and performance advice to the Health and Wellbeing Executive on all matters in relation to the fund • Co-ordinate the service transformation necessary in each of the four priority areas: Prevention Long term Conditions Managing and supporting people in crisis Living Independently for longer
Membership	Chair: TBC Members: Deputy Director of Finance, CCG Finance Lead LA Contracts Lead CSU/LA Performance Lead CSU/LA Patient/Public Representative Director of Adult Service – Shropshire Council Better Care Fund Manager Other Attendees as required: Programme Leads, Clinical Leads, Provider representatives, Planning and Partnerships Leads
Reports to	Health and Wellbeing Executive
Links to	Service Development Sub-Group CCG Quality Performance and Resource Committee CCG Supporting Delivery (QPR) Sub-group
Frequency of Meetings	Monthly

Administration	Personal Administration for the Chair (on a rotational basis)
Review Record	**The chair will sign off the previous month’s action notes and these shall form the written review record.**
Quorum	Minimum of 2 senior management representatives from both the CCG and Local Authority

Date drafted for initial review by group: March 2014
Date revised following comment: May 2014
Date for future review: October 2014

Terms of Reference Health and Wellbeing Delivery Group	
Purpose	The purpose of the Shropshire Health & Wellbeing Delivery Group (as a sub-group of the Health and Wellbeing Board), is to drive the development and delivery of the Health and Wellbeing work/ action plans by leading on integrated working, and performance monitoring. In particular, to take responsibility for the day to day management of the Better Care Fund including financial and performance monitoring.
Vision	**Everyone living in Shropshire is able to flourish by leading healthy lives, reaching their full potential and making a positive contribution to their communities**
Objectives	The Health and Wellbeing Delivery Group will: o Lead on Outcome 5 of the Health and Wellbeing Strategy – Health, social care and wellbeing service are accessible, good quality and seamless. The two priorities are; (i) developing collaborative commissioning between the local authority and the CCG (ii) making it easier for the public and professionals to access information, advice and support. o Lead on the implementation and delivery of the Better Care Fund Plan, ensuring quarterly financial and performance reporting to the Health and Wellbeing Board o To Manage the Better Care Fund Assurance Framework, ensuring that any areas of concern are reported to the Health and Wellbeing Board and mitigating actions are agreed and implemented. o To receive regular reports from the Finance/ Contracts and Performance Group and the Service Transformation Group o Develop a genuinely collaborative approach to commissioning of improved health and care services which improve the health and wellbeing of local people. o Monitor the work plans (actions plans) and performance of all Health and Wellbeing Strategy outcomes and priorities, including HWB Board subgroups to ensure work is moving forward.

	- Ensure that appropriate stakeholders, including commissioners, provider organisations, patient and participation groups, and the VCSA, are involved with the development and delivery of Health and Wellbeing work/action plans. - Ensure that stakeholders have appropriate methods for engagement including providing ideas, concerns, and feedback on action plans, the Better Care Fund Plan and Health and Wellbeing developments. - To discuss Health and Social Care issues affecting service delivery in Shropshire items and their relevance to the Health and Wellbeing Board. - The Health and Wellbeing Delivery group will follow the Health and Wellbeing Board Principles: • The Health & Wellbeing Board will work primarily to improve the health and wellbeing of the citizens of Shropshire. • The Health & Wellbeing Board will work collaboratively and consensually. • The Health & Wellbeing Board will add value over and above our current arrangements to really tackle key priorities and delivery outcomes for our communities. • Members of the Health & Wellbeing Board will have genuine levels of trust and an open and honest willingness to work collaboratively. • The Health & Wellbeing Board will communicate, listen and engage with the communities they serve, actively seeking ways to enable stakeholders to influence the work of the Health & Wellbeing Board. • Decisions will be based on evidence (both qualitative and quantitative) and data sharing will be the norm. • Will develop creative and constructive challenge to ensure that the Board is always working to maximise its potential as partners • Will be pro-active by developing collaborative working to deliver the HWB strategy, and the Better Care Fund Plan whilst maintaining appropriate flexibility to respond to issues as they arise.

	• Responsibility and accountability - to our members, our staff and our public. • The role and functioning of the Health & Wellbeing Board is evolving and will be subject to regular review.
Membership	Chair: TBA Minutes: PA of Chair Group Membership: • Director of Public Health (Chair) • Director of Children's Services • Director of Adult Services • Clinical Commissioning Group – Clinical Director- Better Care Fund & Special Projects • Clinical Commissioning Group – Director of Strategy and Service Design • Clinical Commissioning Group – Chief Operating Officer (Vice Chair) • Clinical Commissioning Group – Head of Partnership and Planning • Representative from Housing • Shropshire Commander, West Mercia Police • Director of Commissioning, Shropshire Council • Head of Service: Improvement and Efficiency • Better Care Fund Manager Membership to send deputies when not available
Reports to	Health & Wellbeing Executive Board with individual reports to the HOSC as requested.
Links to	Clinical Assurance Panel and Service Review & Procurement Group at the CCG Senior management team at the council
Frequency of Meetings	**Monthly from April 2014.**
Administration	Personal Administrator to the Chair
Review Record	**The chair will sign off the previous month's action notes and these shall form the written review record.**
Quorum	Minimum of 2 senior management representatives and 1 senior clinician from both the CCG and the local authority

Date drafted for initial review by group: March 2014

Date revised following comment: May 2014

Date for future review: October 2014

Better Care Fund Manager

Job Title: Better Care Fund Manager

Band: Band 8a or equivalent Council grade

Responsible to: TBC

Accountable to: Both the CCG and Council equally. Health and Wellbeing Board Chair
Host employer will be agreed with the successful candidate

Responsible for: Responsible for day to day management of the Better Care Fund work stream, its associated budget and performance management requirements.

Location: The post holder may be required to work at any of the Clinical Commissioning Group or Local Authority establishments at any time throughout the duration of their contract. Main base will be confirmed on appointment but would either be at a Council or CCG premises in Shrewsbury

1. Job Summary

- To manage a complex programme of work to deliver the requirements of the Better Care Fund.
- To link with other programmes associated with other national developments (e.g. The Care Bill).
- To provide regular reporting and assurance on the delivery of the work associated with the Better Care Fund to the Health & Wellbeing Board.
- To ensure the delivery of the Better Care Fund meets the National Conditions and Metrics as set out by the Government
- The job description and person specification may be reviewed on an ongoing basis in accordance with the changing needs of the Department and the Organisation.

2. Key Working Relationships

- Operate effectively in a flexible and demanding environment and proactively engage with NHS and Local Authority, staff service providers and a range of other stakeholders working on a variety of topics.
- Provide and receive highly complex, sensitive and contentious information, presenting information, to a wide range of stakeholders in a formal setting.
- Engage with the Health and Wellbeing Board and its sub groups associated with the delivery of the Better Care Fund
- Committed to working and engaging constructively with internal and external stakeholders on a range of business sensitive issues

- Nurtures key relationships and maintains networks internally and externally, including national networks

- Close liaison with the Communications team on public relations and marketing activities

- Link with managers and members of other functions, to address inter-dependencies and ensure alignment

- Apply a structured change management approach and methodology for the impact of any change

- Deputise for the Head of Department as required, expanding on knowledge, skills and experience within personal professional development.

3. Functional Responsibilities

3.1 Operational

- § To support the delivery of day to day activities associated with delivery of the Better Care Fund
- § To operate in a highly political and sensitive environment
- § To manage reputational issues for both the CCG and LA associated with the Better Care Fund
- § To ensure the Health & Wellbeing Delivery group is advised of any new developments or directives in relation to the Better Care Fund
- § To maintain knowledge of guidance, best practice and developments in other areas that can inform the approach locally

3.2 Project Management

- To be accountable for the co-ordination and delivery of the programme, made up of a range of projects/ work streams across the local Health and Social Care landscape, as necessary to implement the requirement of the Better Care Fund.

- To lead on the implementation of selected projects/ workstreams and participate in those which may be led by other project managers within the LA or CCG

- To monitor and co-ordinate progress on each aspect of programme delivery liaising as appropriate with lead officers across all projects/ workstreams aligned to the key outcomes of the Better Care Fund and ensuring appropriate links with other projects and strategies

- Ensure appropriate records are maintained in a timely fashion

- To report progress to the Health & Wellbeing Board and Health and Wellbeing Delivery Group in accordance with the agreed schedule

- To carry out impact assessment of aspects of the work programme and advise the Health & Wellbeing Delivery Group accordingly

- To identify any risks to implementation within agreed timescales and report through agreed lines.

- Lead the delivery of project plans, allocating tasks as appropriate, identifying risks, issues and dependencies, considering best practice and current options and ultimately making decisions in the best interest of the delivery of the Better Care Fund.

- Develop a comprehensive and cohesive implementation plan which meets the strategic direction of the Better Care Fund Plan approved by the Health & Wellbeing Board and minimises unnecessary disruption to stakeholders involved in the process and is operationally sound.

- Pro-actively manage stakeholders, respond to and resolve conflict between different stakeholders when this arises through facilitation or other appropriate mechanisms.

- Be responsible for a high standard of work supporting the delivery of projects on time, to quality standards and in a cost effective manner. Maintain the project initiation document and associated plans with regular team meetings to monitor progress and resources.

- Ensure the flexibility of the project if required to meet conflicting/changing requirements.

- Responsible for the planning and organisation of numerous events/meetings. Ensuring communication tools are used to their maximum value for circulating the minutes, agenda and presentations in a timely manner.

- Maintain a comprehensive risk register associated with the delivery of the Better Care Fund and ensure the Health and Wellbeing Delivery group is kept up to date regarding risk and their mitigations.

3.3 Financial and Physical Resources

- Act in a way that is compliant with Standing Orders and Standing Financial Instructions of the budget hosting agency in the discharge of budget management responsibilities.

- Responsible for ensuring adherence to the budget, ongoing monitoring of expenditure against budget and ensuring the appropriate documentation is available for scrutiny.

- Identify products, equipment, services and facilities for assigned activities, achieving stakeholder buy-in as required. Placing orders and signing invoices, keeping mindful of budget limitations.

- Responsible for making recommendations, providing advice and able to prepare strategic reports/briefings for the Head of Department, Steering/Reference Groups and others as required.

3.4 Information Management

- Drafting reports summarising status on issues, appraising outcomes, and providing progress reports for the Head of Department.

- Collate as required, qualitative and quantitative information and lead appropriate analysis to develop robust business cases and contribute to project ‘products’.

- Analyse, interpret and present data to highlight issues, risks and support decision making.

- To arrange, lead or participate in information sharing and consultations with a range of groups, including people who use services, families, carers and the general public.

- Present information to a range of groups in a range of appropriate formats. This will include preparing reports for the Health & Wellbeing Board and its Delivery Group and other bodies as required to inform the Council’s and CCG’s decision making

3.5 <u>Policy and Service Development</u>

- Responsible for proposing and drafting changes, implementation and interpretation to policies, guidelines and service level agreements (SLA’s) which may impact service.

- The post holder will need to maintain a good knowledge of emerging policies from government departments for example pensions, change management, constitution.

3.5 <u>Research and Development</u>

- Plan, develop and evaluate methods and processes for gathering, analysing, interpreting and presenting data and information

- Deliver projects to comply with key performance indicators.

- Co-ordinating Research & Development initiatives, delegating as appropriate.

3.6 <u>Planning and Organisation</u>

- Contribute to the strategic planning of Team projects, identifying interdependencies across projects/functions, potential impacts on wider organisation, resource requirements and building in contingency and adjustments as necessary.

- Contribute to the development of performance and governance strategies and the development and implementation of improvement programmes.

- Contribute to short, medium and long term business plans, achieving quality outcomes.

Person Specification

Supporting Evidence

In the supporting evidence of your application form, you must demonstrate your experiences by giving specific examples for the criteria within the person specification.

Factors	Description	Essential	Desirable	Assessment
Knowledge, Training and Experience	Educated to masters level or equivalent level of experience of working at a senior level in specialist area.	√		A/C
	Extensive knowledge of specialist areas, acquired through post graduate diploma or equivalent experience or training plus further specialist knowledge or experience to master's level equivalent	√		A/I
	Evidence of post qualifying and continuing professional development	√		A/I
	Must have an understanding of the background to and aims of current health and social care policy and appreciate the implications of this on engagement	√		A/I
	Should have an appreciation of the relationship between Health and Social Care and individual provider and commissioning organisations	√		A/I
	Understanding of and commitment to the principles underlying the Better Care Fund and the ability to ensure that the implications are reflected in all developments	√		A/I
Communication Skills	Must be able to provide and receive highly complex, sensitive or contentious information, negotiate with senior stakeholders on difficult and controversial issues, and present complex and sensitive information to large and influential groups	√		A/I
	Negotiate on difficult and controversial issues including performance and change.	√		A/I

Analytical	Problem solving skills and ability to respond to sudden unexpected demands	√		A/I
	Ability to analyse complex facts and situations and develop a range of options	√		A/I
	Takes decisions on difficult and contentious issues where there may be a number of courses of action.	√		A/I
	Strategic thinking – ability to anticipate and resolve problems before they arise	√		A/I
Planning Skills	Demonstrated capability to plan over short, medium and long-term timeframes and adjust plans and resource requirements accordingly	√		A/I
	Comprehensive experience of project principles techniques and tools such as Prince 2 and Managing Successful Projects		√	A/I
	Ability to work as part of a multi agency team as well as undertaking complex work on own initiative			
Management Skills	Must be able to prioritise own work effectively and be able to direct activities of others. Experience of managing and motivating a team and reviewing performance of the individuals.	√		A/I
	Experience of managing complex projects			
Autonomy **Freedom to Act**	Must be able to use initiative to decide relevant actions and make recommendations to Sponsor/ Manager, with the aim of improving deliverables and compliance to policies.	√		A/I
	Ability to make decisions autonomously, when required, on difficult issues, working to tight and often changing timescales	√		A/I
	Experience of identifying and interpreting National policy. Experience of researching best practice (globally, private and public sector), interpreting its relevance and processes/ practices which could be implemented successfully to achieve system reform (advising on policy implementation)	√		A/I

Physical Skills	Working knowledge of Microsoft Office with intermediate keyboard skills.	√		A/I
Equality and Diversity	Needs to have a thorough understanding of and commitment to equality of opportunity and good working relationships	√		A/I
Financial and Physical Resources	Previously responsible for a budget, involved in budget setting and working knowledge of financial processes	√		A/I
Other	Used to working in a busy environment	√		A/I
	Adaptability, flexibility and ability to cope with uncertainty and change	√		A/I
	Willing to engage with and learn from peers, other professionals and colleagues in the desire to provide or support the most appropriate interventions	√		A/I
	Professional calm and efficient manner	√		A/I
	Effective organizer, influencer and networker	√		A/I
	Demonstrates a strong desire to improve performance and make a difference by focusing on goals.	√		A/I
	Completer/Finisher	√		A/I
	Ability to travel around the county as required			
	Some evenings			

***Assessment will take place with reference to the following information**

A=Application form **I=Interview** **T=Test** **C=Certificate**

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Agenda item 6

Health and Wellbeing Board
28 March 2014

BETTER CARE FUND PLAN AND ASSOCIATED DOCUMENTATION

Responsible Officers Dr Julie Davies and Stephen Chandler

1. Introduction

Part One: Better Care Fund

1.1 In February the Health and Wellbeing Board signed off the first draft submission to NHS England of the Better Care Fund Plan. Following receipt of feedback from our NHS Local Area Team and the continued work of the Better Care Fund Task and Finish Group a final draft of the Better Care Fund Plan (attached) has been prepared for final submission to NHS England on 4 April.

2. Recommendations

2.1 The Board is asked to agree the following recommendations:

a) To note and agree the final Better Care Fund Plan for submission to NHS England on 4 April 2014. In particular to agree that the section relating to 7 day services can be finalised once the Service Delivery and Improvement Plans have been received from provider organisations following the Extraordinary Health & Wellbeing Board meeting but prior to 4 April submission date.

b) To note and agree the Better Care Fund Outcomes and Finance spreadsheet. In particular to note and agree the proposed local outcome measure

c) To note and agree:
   i. Better Care Fund Governance Structure
   ii. Terms of Reference – Health and Wellbeing Delivery Group. In particular to agree the recently ratified Terms of Reference for the Health & Wellbeing Board to be updated to reflect the role of the Delivery Group
   iii. Terms of Reference – Service Transformation Group
   iv. Terms of Reference – Contracts and Performance Sub Group
   v. Better Care Fund Manager Job Description

vi. Better Care Fund Plan on a Page
vii. Better Care Fund Assurance Framework

d) To agree that quarterly performance reporting be presented to the Health & Wellbeing Board with updates on progress of the Better Care Fund being a regular agenda item

R E P O R T

3. Purpose of Report

3.1 Final plans for the use of the Better Care Fund must be submitted to NHS England on 4 April 2014. The Health and Wellbeing Board is responsible for signing off this submission. Attached is a copy of the final Better Care Fund Plan and its associated Finance and Outcomes template as well as a range of supporting documentation for consideration by the Health and Wellbeing Board.

3.2 Section e) of the Better Care Fund Template sets out a range of additional documentation to
be submitted to support the Better Care Fund Plan for Shropshire. A number of these documents were included in the first draft submission in February. However, further to the continued work undertaken by the Better Care Fund Task and Finish Group to develop the plan and taking into consideration the feedback given by our NHS Local Area Team, a range of additional documentation has been developed to demonstrate the structures and processes that will support the delivery of the plan. These are:

- A Better Care Fund Governance Structure which where possible builds on existing structures and working groups in existence
- Terms of reference to support the delivery of the necessary work to meet the Better Care Fund outcomes and objectives and to ensure appropriate communication and governance is maintained
- A Better Care Fund Job Description. This post will bring valuable capacity to what is a significant agenda and co-ordinate the day to day management of the programme of work on behalf of the Health & Wellbeing Board
- A Better Care Fund Plan on a Page. This has been developed as an oversight tool to demonstrate, at a glance, the elements of work which will feed into the Better Care Fund and how they link together
- A joint Assurance Framework. This has been developed across the Council and CCG to ensure that the risks associated with such a complex piece of work are identified and mitigating actions taken to reduce or eliminate their impact as far as possible. This will be a live document which is regularly updated and presented to the Health & Wellbeing Board as part of the periodic performance reporting.

3.3 In light of the performance monitored element of the Fund and the associated financial implications of this it is proposed that quarterly monitoring be presented to the Health and Wellbeing Board with a regular update on progress as a standard agenda item

4. Background

4.1 The Better Care Fund (formerly the Integrated Transformation Fund) was announced in the spending review in June 2013. The Fund was described as an opportunity to create a shared plan for the totality of health and social care activity and expenditure that would have benefits beyond the mandated pooled fund (section 256 agreement) and would encourage Health and Wellbeing Boards to extend the scope and plans for these budgets. The Fund does not constitute new funding but brings together NHS and Local Government resources already committed to existing core activity requiring Councils and CCG's to redirect funds into shared activities and programmes that will deliver better outcomes for individuals.

4.2 The Better Care Fund will commence with a transitional year in 2014/15 with full implementation in 2015/16. There is a required minimum financial allocation which in 2014/15 is £6,151,000 rising to £21,451,000 in 2015/16. However due to a number of existing joint schemes across the Council and CCG within 2014/15 the amount to be allocated into the Fund will be £9,358,613 in anticipation of the following years minimum requirement and the Better Care Fund Plan supported this two phase approach to allow time for proper development of service redesign and transformation.

5. Engagement

5.1 The attached report sets out plans for consultation and engagement

6. Risk Assessment and Opportunities Appraisal (including Equalities, Finance, Rural Issues)

6.1 The supporting documentation includes the current Assurance Framework for consideration by the Health & Wellbeing Board

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Version	Principle Risk 'What could prevent this objective being achieved and where was it identified'	Initial Assessment L= Likelihood I = Impact		
		L	I	Rating
Key Principle 1 **Deliver a continually improving Healthcare and Patient Experience** **Key Principle 2** **Develop a 'true membership' organisation (active engagement and clinically led organisation)** **Key Principle 3** **Achieve Financial sustainability for future investment** **Key Principle 4** **Visible leadership of the local health economy through behaviour and action** **Key Principle 5** **Grow the leaders for tomorrow (Business Continuity)**				
C.McI /JD	Vacancy for Mental health & LD Programme lead	5	3	15
C.McI /JD	Resignation of Women & Childrens Commissioner	5	3	15
C.McI /JD	Vacancy for Planned care post	5	3	15
C.McI /JD	Older People's commissioner vacant due to secondment	5	3	15
C.Mc/JD/DMcG	Access to PID, potential to restrict/limit redesign e.g. frequent users of ambulance servcies, frequent emergency admissions	5	4	20

C.Mc/JD/DMcG	Community PAM - lack of clarity regarding the costs of individual services make redesigning community servcies very difficult and can be a barrier to change	4	4	16
C.Mc/JD/DMcG	Community Trust performance data is not comprehensive so there is a risk of hidden performance issues	5	4	20
CMc/JD	Community Trust - waiting list concerns across a number of services, both 18wks and other e.g. CAMHS, paediatric psychiatry, paediatric therapies, APCS services etc	5	4	20
CSU/DMcG	Lack of contract monitoring = QIPP monitoring, risk on delivery of QIPP , when no view on Month 1 at mid July point	5	4	20
CMc/EP	DTOC - high level of in patient delays - adversely affecting A&E performance in SaTH	5	4	20
CMc/JD	Paed admissions increase	5	4	20
CMc/BG	Paediatric reconfiguration - short term x4 bed closure	5	2	10
CMc/DW	Cancer - risk associated with inconsistent achievementsof targets and future capacity/pathway issues	3	3	9

CMc/PC/JP	CAMHS- lack of MH commissioner has delayed progress on CAMHS redesign, linked to risk on BAF	4	3	12
CMc/JD	Changes in commissioning responsibilties e.g LAT, Public Health, Specialised Commissioning - impacting on patient pathway decisions and taking up a huge amount of commissioners time working through individual issues to gain clarification of responsibilities.	5	3	15
CMc/PC	GP counselling risks identified upon sudden death of counsellor :- Record keeping Patient confidentiality Hidden waiting lists	4	4	16
CMc/PC	LD self assessment framework - national self assessment will be launched in the next few weeks, will require signifcant resource from CCG alongside the Local Authority -risk is due to lack of LD commissioning post.	4	3	12
C Mc/SR/JD	Dementia - loss of older peoples commissioner has affected progress on dementia strategy and support for Dr Sal Riding as CD	5	3	15
CMc/EP/JD	Lack of winter monies - if no winter monies made available this year there is a significnat risk of poor performance during the Winter if additional contingencies cannot be put in place due to lack of money.	3	4	12
CMc/EP/PCl/BG	Frail & Complex risks:- Lack of workforce to implement model of care Not one of the ATOS priority projects QIPP was based on this project being rolled out	4	4	16
PH/WS	Ophthalmology risks:- Loss of clinical engagement as a result of encouraging new providers onto the patch New providers don't have sufficent short term capacity to match demand Affordability of initial activity required to eliminate backlog and implement NICE tags	3	4	12
NW/IN/JD	Rheumatology - risk of SaTH being unable to provide the service due to the deanery removing a clinical post.	5	4	20

CMc/JD	Lack of development monies for redesign - risk is that only redesign projects that can deliver in year savings will now progress. Transformational change is unlikely to be achieved in this way	5	4	20
CMc	Dermatology - risk associated with introduction of Teledermatology and ability of existing local services to manage short term rise in demand as a result.	4	3	12
WS/SR/JP	Cardiology - issues with current demand exceeding clinical capacity at SaTH despite pathway redesign including Advice & Guidance and straight to test.	4	3	12
CMc	Temporary consolidation of Stroke Services at PRH for July/August - risk is potential deterioration in hyper acute stroke services due to temporary reduction in consultant capacity.	4	4	16

CMc- Carol McInnes		No change in ris
JD – Julie Davies		
BG- Bill Gowans		
JP –Julian Povey		Risk Level reduc
SR- Sal Riding		
DMcG- Donna McGrath		
DW- David Whiting		
WS- Wendy Southall		Risk level increa
EP- Emma Pyrah		
PC- Paul Cooper		
PCl- Peter Clowes		
PH -Paul Haycox		
IN-Ilse Newsome		

Assessment of risk level - Low / Medium / High / Extreme Risk	Risk Appetite Level of exposure to the risk the CCG is willing to accept	Key Controls 'What controls / systems are in place to manage the risk'
Extreme	4	CSU community and mental heath contract lead providing support for MH and Head of planning & partnership has led on LD in the interim
Extreme	4	TBD - being agreed by 19th July
Extreme	4	Some areas being managed by LTC and Urgent Care commissioners. Cover for pain, Rheumatology and T&O still being provided by N.White.
Extreme	4	Some areas being managed by LTC, Urgent Care and Cancer commissioners. Head of Planning & Partnerships covering voluntray sector related work
Extreme	6	Pseudonimisation process being developed by the CSU

Extreme	4	Agreement with the CT that this will be agreed in year
Extreme	4	Data Quality improvement plan is included in the contract
Extreme	4	As above
Extreme	4	None
Extreme	2	Daily monitoring of delays in place
Extreme	4	Monthly contract monitoring Monthly project board in place to review and develop:- Pathways Systems & processes Agree commissioning arrangements (coding & counting)
High	4	Daily monitoring of paediatric bed base / capapcity in place
High	4	Regular monthly monitoring of targets and monthly Cancer board to be implemented to track delivery of action plan and manage future risks

High	4	Temporary resource drafted in alongside local authority (Jo Robbins) Regular performance meetings
Extreme	2	None
Extreme	1	Short term control- practice obtained patient records, ensured confidentiality and security, confirmed patient details and status of referral and waiting time.
High	2	LD commissioner will be in post on 22nd July and will lead this piece of work on behalf of the CCG
Extreme	2	No capacity within the current resource to control this risk
High	9	Three scenarios being planned for , same money as 2013, 50% and none.
Extreme	4	Mapped original QIPP against new ATOS streams and ongoingwork programmes for urgent care and LTCs -
High	4	Regular project board with local Optoms, Consutlants and the new providers Can't control capacity of new providers Raised risk of affordability with CFO
Extreme	1	Developed plan with RJAH for them to take over the service , but still delivered at RSH. Temporary additional consultant cover provided by RJAH paid for by CCG during transition.

Extreme	4	Any developments are intially being considered by Supporting Delivery Group and on to QPR if the return on investment can be demonstrated.
High	4	Delay implementation of Teledermatology until assurance can be given regarding the current providers ability to flex capacity in the short term to meet the expected temporary rise in demand
High	6	SaTH continuing to do waiting list initiatives and brought in temporary additional consultant capacity to reduce passed max wait list
Extreme	4	Consolidation has minimised risk by putting limited consultant resource onto 1 site

sk level since previous report

ced since last report

sed since last report

e Risk Assurance Framework
edesign

Source of Assurance Where can we gain evidence (internal or external) that our controls / systems on which we are placing our reliance are effective?	**Current Assessment L= Likelihood I = Impact**			**Assessment of risk level - Low / Medium / High / Extreme Risk**
	L	I	Rating	
Track provider performance and key performance measures for MH and LD	4	3	12	High
Track provider performance and key performance measures for Women & Childrens services	4	3	12	High
Track provider performance for 18wks RTT, passed max waits etc.	4	3	12	High
Head of Programmes & Redesign maintaining overview of projects and need	4	3	12	High
New process used to allow individual case studies to be included in redesign work	4	3	12	High

CCG requests internal costs of service from provider when embarking on a service re-design, however yet to be received	4	3	12	High
Monthly contract performance meetings	5	3	15	Extreme
As above	5	2	10	High
No controls = no source of assurance	5	4	20	Extreme
Daily report for 16/7/13 showed level of 8	2	1	2	Low
No current assurance due to no YTD contract monitoring	4	3	12	High
Regular conference calls to assess current position	4	2	8	High
Monthly performance has improved in May and June compared to April	3	2	6	Moderate

Limited until PC in post, weekly operational calls in place to manage any short term issues	3	3	9	High
No assurance	5	3	15	Extreme
CCG taken responbility for securing alternative provision and esnuring patients seen as soon as possible.	3	3	9	High
Regular update on progress of self assessment will be reported to Senior Managers Meetings	3	2	6	Moderate
Head of Programmes & Redesign maintaining overview of projects, need and meeting regularly with SR	4	3	12	High
Without any funding no assurance can be provided	3	4	12	High
Current re-mapping matches QIPP commitments. EP is project manager for F&C and it is being progressed via Transformation part of the Urgent Care Network Board	3	3	9	High
Good attendance at project board from clinicians, local Optom advisor supportive of the work, draft joint capacity plans from SaTH and Viewpoint will confirm level of capacity	3	3	9	High
Eliminated 18wk backlog and ensure patients seen within 18wks and passed max wait backlog eliminated.	2	2	4	Moderate

Limited as future delivery is at risk without transformational change	4	4	16	Extreme
Confirmation that additional capacity can match expected temporary rise in demad	3	2	6	Moderate
Assurance is passed max wait is coming down but not sustainable.	3	3	9	High
CCG has requested for QIAs for the change, copies of new pathways, monthly contract performance review agenda has been amended to include this as a stand alone item	3	3	9	High

Action / Lead Name / Timescale 'Action to be taken'	Residual Target Risk Score (after actions completed)			Assessment of risk level - Low / Medium / High / Extreme Risk
	L	I	Rating	
Paul Cooper starts in post 22nd July 2013	2	2	4	Low
Interviews conducted on 15th July, post offered awaiting acceptance.	2	2	4	Low
Interviews scheduled for the 15th August.	2	2	4	Low
Going out to advert for fixed term post to provide cover for the duration of the secondment	2	2	4	Low
Output from CSU workshop shared with programme leads, and working with CSU when process available	2	2	4	Low

Awaiting costs from CT , risk will reduce to score of 9 when this is received.	4	1	4	Moderate
Information for highlighted services has been requested. Received for CAMHS only to date. CSU have been asked to consolidate specification waiting time requirements to monitor against. Risk score will be reviewed when data matched against specification - end of August.	4	1	4	Moderate
See above	4	1	4	Moderate
Cause is national issue, CFO escalating to CSU and Area Team	2	2	4	Moderate
Ongoing management via Urgent Care Lead	2	1	2	Low
First project board meeting held 16/7/13, priority pathways agreed, and outline project plan for implementation agreed. Service review of community paediatric services has also been completed to identify gaps in provision.	2	2	4	Moderate
Pathway work above will reduce risk in time for Winter 2013/14	3	2	6	Moderate
Action plan has been agreed with SaTH and monthly Cancer Board being set up.	2	2	4	Moderate

Head of Programmes & Redesign managing current short term risks directly with CT until PC starts 22nd July 2013	2	2	4	Moderate
Raising with Area Team as an issue which is having a serious impact on the day to day workload of the commissioning team.	2	2	4	Moderate
Secured alternative provision for CBT services, confirmed accuracy of records, writing out to patients wiating offering alternative provider. Review of GP counselling will be undertaken by the new MH commissioner and recommendations made as to future	1	1	1	Low
Paul Cooper starts in post 22nd July 2013. Once work on assessment begins, regular updates/issues will be brought to Senior Managers as required	1	2	2	Low
Going out to advert for fixed term post to provide cover for the duration of the secondment	2	1	2	Low
Confirming committed spend against Frail & complex monies to identify any that could be re-directed to minimise impact for Winter. Ensuring this is kept on the agenda for Area Team meetings.	3	3	9	High
Matching of QIPP to be reviewed at Supporting Delivery Group F&C revised implementation plan going to the next UCN Transformation board	2	2	4	Moderate
Paul Haycox chairing project board with support of Optom advisor and Wendy Southall. In addition SaTH have provided some project management support to the Viewpoint work and are now leading on that element. CCG to retain lead of medium-longer term solution with " The Practice".	2	2	4	Moderate
Finalised formal transfer date with RJAH and complete formal contrcat variation to transfer from SaTH contract to RJAH	1	1	1	Low

Team focusing on delivery of projects critical to this year and planning for projects that require investment for 2014/15.	4	3	12	High
Currently working with two local providers to determine additional capacity that could be available and map to projections of impact of teledermatology.	2	2	4	Moderate
Cardiology pathway group to look at this issue as well as LTC implications.	2	3	6	Moderate
Review QIA (just received), reviewing meeting set up at the end of July,	2	2	4	Moderate

Better Care Fund Assurance Framework. V1 Quarter 4 2013/14

Version	Principle Risk 'What could prevent this objective being achieved and where was it identified'	Initial Assessment L= Likelihood I = Impact			Assessment of risk level - Low / Medium / High / Extreme Risk	Risk Appetite Level of exposure to the risk the CCG is willing to accept	Key Controls 'What controls / systems are in place to manage the risk'	Source of Assurance Where can we gain evidence (internal or external) that our controls / systems on which we are placing our reliance are effective?	Current Assessment L= Likelihood I = Impact			Assessment of risk level - Low / Medium / High / Extreme Risk	Action / Lead Name / Timescale 'Action to be taken'	Residual Target Risk Score (after actions completed)			Assessment of risk level - Low / Medium / High / Extreme Risk
		L	I	Rating					L	I	Rating			L	I	Rating	
Key Principle 1																	
Key Principle 2																	
Key Principle 3																	
Key Principle 4																	
Key Principle 5																	
	Impact on local system in particular DTOC of neighbouring Welsh Health Board policy	4	3	12	High		Limited as this point to individual relationships with Welsh commissioners and escaltion via accountable officers if required	Daily monitoring of DTOC for all commissioners received and issues escalated to LHBs if required	4	3	12	High	SCCG linking with Herefordshire to have joint meetings with Powys regarding interdependancies and cross border issues	3	3	9	High
	Shared providers with Telford & Wrekin CCG and differences in commissioning policy could cause operational issues for providers	4	3	12	High		Joint collaborative commissioner meetings in place and planned joint meetings with providers as their individual impact of BCF is more clearly defined.	Feedback from our providers via our contract review meetings	3	3	9	High	Timetable of joint meetings with providers to be arranged by mid April	3	2	6	Moderate
	Ensuring appropriate links between the Future Fit prgramme and the development of the BCF and Council redesign programme - otherwise could lead to a risk of fragmentation of services and the lack of a coherent vision for local services	3	4	12	High		Ensure progress and developments from Future Fit feed into the development of the BCF via the service transformation group. Local Authoity collegaues have a place on the FutureFit programme board. Health & Wellbeing Delivery Group also consists of CCG, council leads	New service specifications are jointly signed off by the council and CCG as appropriate	3	3	9	High	Service Tranformation Group to be set up from April 2014 across the health economy.	2	2	4	Moderate
	Financial implications of - rurality, Welsh Boarder issues (Net importer for A&E and MIU) Wales not coverd by BCF,	4	3	12	High		Financial allocations for both CCG's and LA are known. Draft Budgets approved by Boards/ Cabinet. BCF target allocation for 14/15 and 15/16 are known CCG QIPP targets for both years are known	Reports from Finance Sub group to the Health and Wellbeing Board	4	3	12	High	Final CCG and LA budgets for 14/15 andf 15/16 signed off by Board/ Cabinet. April 2014. BCF Finance and Performance sub group to be set up by the end of April 2014 with first reports available for June Health & Wellbeing Board	3	2	6	Moderate
	IT systems - Older systems in place that are not compatible with each other. Further ahead in primary care	3	3	9	High		Draft CCG IM&T Strategy. Joint CCG IM&T forum	Progress against IM&T Strategy (which includes collaborating with providers and the LA) reported to QPR	3	2	6	Moderate	Finalise and sign off IM&T Strategy by end of May 2014. Hold health Economy (inc LA) IT forumfor shared understanding of issues. June 2014	3	1	3	Low
	Recruitment and retention issues particularly for medical staff are a risk to transforming services and the workforce required to deliver them	3	4	12	high		Workforce forms a key strand of work under the FutureFit programme and the appropriatw links will be made between this and the development of work aligned to the BCF	Developments in relation to FutureFit will be presented regularly to both the Health & Wellbeing Board and the Health & Wellbeing Delivery Group	3	4	12	High	Workforce plans to be developed. Timescale to be agreed	3	4	12	High
	Plan doesn't address health inequalities across all client groups	3	3	9	High		Equality Impact Assessment to be completed on each service change	EIAs to be signed off will ensure all client groups are considered as required	3	2	6	Moderate	EIA to be a key stage in the individual service transformation plans	2	2	4	Moderate
	Developing different plans across Shropshire & Telford & Wrekin	3	3	9	High		Collaborative Commissioning Forum, Executive Discussion Group are forums where such plans can be discussed	Areas of difference will be identified via the collaborative commissioning group - some will be necessary due to differing rurality and demographics	3	3	9	High	BCF added as astanding item on the Collaborative Commissioning agenda	3	2	6	Moderate
	Implications of the Care Bill has several risks linked to BCF:- metric associated with admission rates to care homes will be impacted by the change in the eligible population, financial pressures of the care bill may impact on the council's ability to contribute to further integration	5	3	15	Extreme		Risk to this indicator and metric that admissions will increase not because of new admissions but because the financial threshold in the Care Bill will increase and make more people eligible for funded care	Position will be monitored by the Health and Wellbeing Delivery Group and its key sub groups	5	3	15	Extreme	Further guidance awaited from NHS England/ LGA	5	3	15	Extreme

	Unintended consequences of service change that affects quality	3	3	9	High		Complete a full quality impct assessment on evry proposed servcie change	Service Specification cannot be approved without an associated QIA signed of CCG, LA and provider (where appropriate)	2	2	4	Moderate	QIA to be a key stage in the individual service specification sign off process	2	1	2	Low
	BCF deliverables may not provide sufficient support to the costs of introducing the Care Bill.	4	4	16	Extreme		Mitigations to be confirmed following receipt of further guidance in order to address the following risks • Increased financial pressure for LA as more people are eligible for LA funded support • Additional social work assessments required and the cost of providing these • Increased number of deferred payments with potential impact on cash flow • Costs associated with providing additional information and advice • Increase in number of people in residential and nursing care homes as existing residents who fund their own care become eligible for LA funded care due to change in capital threshold. This will impact on the performance metric • The requirement to provide support and direct payments for carers and the financial impact of this • The financial impact and resources required in changing IT systems in order to manage an individual's care account • Resources and costs of staff training	Insufficient infoamtion available at present to define controls that will mitigste the risks identifed.	4	4	16	Extreme	The local Authority will lead on identifying the risks and how they may be mitigated . This will include consualtation with the independent care sector in order to identify the number of people who currently fund their own care, workforce planning and development, siupport required fro cars and IT resources required. With regard to tiemscales intial scoping wotk will be undertaken January 2014 to May 2014, with action plans developed, Howerver timescales will depend on enactment of the legislation in November and the level of guidance received pre and post enactment.	3	3	9	High
	Service transformation does not deliver efficiencies to support Health & Social Care delivery plans (Risk to delivery of QIPP)	4	4	16	Extreme		Monthly Supporting Delivery meetings of the CCG review the progress of QIPP. The delivery of QIPP is directly related to the availability of the full BCF fund in 15/16. Draft QIPP Plan fully identified and signed off by CCG Governing Body for 14/15 and a high levle plan for 15/16. provider engagement at an operational and strategic level on QIPP ambitions. Majority of QIPP signed off in provider contracts	QIPP monitoring thorugh the Supporting Delivery Group (QPR sub group)	4	4	16	Extreme	Sign off final QIPP plan at at April Board. April 2014. Continue with provider engagement through BCF and Supporting Delivery Forums. On going	3	3	9	High

ST- Sam Tilley
JD – Julie Davies
SC - Stephen Chandler
RH - Ruth Houghton
RT - Rod Thomson
RB - Ros bridges
DM - Donna McGrath

No change in risk level since previous report

Risk Level reduced since last report

Risk level increased since last report

Risk Matrix

Risk Matrix		Likelihood				
		1	2	3	4	5
		Rare	Unlikely	Possible	Likely	Almost certain
Consequence	5 Catastrophic	5	10	15	20	25
	4 Major	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Minor	2	4	6	8	10
	1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

		Low risk
		Moderate risk
		High risk
	15 - 25	Extreme risk

Association

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Shropshire Council		0	2,155,000	2,155,000
Shropshire CCG		9,358,613	19,296,000	19,296,000
BCF Total		**9,358,613**	***21,451,000***	***21,451,000***

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved,

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)	4,193,000	
	Maximum support needed for other	4,193,000	
Outcome 2	Planned savings (if targets fully		
	Maximum support needed for other services (if targets not achieved)		

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Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Maximising Independence: Hospital discarge/admission avoidance	LA	500,000				500000			
Increased social work capacity	LA	150,000				150000			
Handyman scheme	Voluntary sector	100,000				100000			
Carers support	Voluntary sector	250,000				250000			
Telecare	LA/ CCG	500,000				500000			
Crisis resolution	SSSFT	300,000				300000			
Enhancing prevention services (LTC)	Multiple	150,000				150000			
Think Local Act Personal	LA	163,726				163726			
Integrated Social Care & Healthcare Pathway	LA/CCG	675,000				675000			
Services for people with dementia	Multiple	600,000				600000			
Access to employment and leisure activities (LD)	LA	100,000				100000			
Locality Commissioning	Multiple	250,000				250000			
Improved care services monitoring (safeguarding	Multiple	50,000				50000			
Adults with LD	LA	300,000				300000			
Supported Living for LD & MH	LA	600,000				600000			
MH & LD Respite	LA/CCG	300,000				300000			
Supporitng people with enduring MH needs to prevent hospital admissions & support hosptal discharge	SSSFT	603,212				603212			
pathhouse s256 (Joint MH Service)	SSSFT	217,000				217000			
Integrated Community Service - ICS	Multiple	341,788				341788			
Integrated Community Service - ICS additional NR support to fye	Multiple	400,000				400000			
jointly funded staff s256	CCG/LA	140,000				140000			
Falls Prevention	SCHT	233,180				233180			
Continuing care respite	CCG	111,782				111782			
PD - Crossroads Care Attendants Scheme	Voluntary sector	13,890				13890			
Children and families - Monkmoor AFC Short	Voluntary sector	20,000				20000			
Children and families - Summer Playschemes	Voluntary sector	6,273				6273			
Children and families - Hope House	Voluntary sector	158,000				158000			
MH Carers Network	SSSFT	9,775				9775			
MH Carers Support	SSSFT	94,428				94428			
End of Life Care - Hospice at Home service	CCG	280,000				280000			

Association

England

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

In relation to Delayed Transfers of Care the benefit will be support to achieve the 95% target by improving patient flow. A balancing metric would be readmissions not increasing. In raltion to Emergency Admissions again the benefit would be to support achievment of the 95% target and to reduce Delayed Transfers of Care. In relation to both care home admissions and number of people successfully reabled at home the aim is to reduce the requirement for residential and nursing home provision by both strengthening community support avoiding admission but also being there to support discharge. The individual will be able to return to level of functioning or to have developed coping support following admission enabling them to return to their homes and communities.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

It is the intention in Shropshire to await further guidance regarding the national measure before finalising this entry. We would welcome early guidance to be able to finalise this.

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

The CSU Business Intelligence team will be providing regular reports to the Health and Wellbeing Board via the proposed Finance and Performance sub group

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Shropshire is served by only one HWB. However, due to the provider boundary issue highlighted earlier in this submission. Shropshire will consult with its neighbouring CCG in Telford & Wrekin regarding areas of commonality in planning and redesign

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	780.7	N/A	704.2
	Numerator	519		500
	Denominator	66475		71005
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	64.6	N/A	74.4
	Numerator	81		93
	Denominator	125		125
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	287.63	280.43	279.72
	Numerator	8579	6303	4215
	Denominator	248550	249742	251144
		April 12 - March 13	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	1590.81	1532.4	1532.6
	Numerator	4929	2385	2397
	Denominator	309842	311275	312791
		(TBC)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]		National metric TBC	N/A	
		(insert time period)		*(insert time period)*
Estimated Diagnosis Rate for People with Dementia - There is recognition that the numnerator is likely to increase due to the work we are doing locally around dementia. Clarification would be required regarding the timescale for perfomance	*Metric Value*	42%	48.20%	55%
	Numerator	4841		
	Denominator	2020		
		2011/12	*April to Sept 14/15*	*Oct 14 to March 15*

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Better Care Fund planning template – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

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

First Draft

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Shropshire Council**
Clinical Commissioning Groups	**Shropshire Clinical Commissioning Group**
Boundary Differences	**The Council and CCG share the same boundaries. However all our provider organisations are not co-terminus and work across Shropshire and Telford & Wrekin boundaries**
Date agreed at Health and Well-Being Board:	**12/2/14**
Date submitted:	**14/2/14**
Minimum required value of ITF pooled budget: 2014/15	**£6,151,000**
2015/16	**£21,451,000**
Total agreed value of pooled budget: 2014/15	**£9,358,613**
2015/16	**£21,451,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Shropshire Clinical Commissioning Group
By	Dr. Caron Morton
Position	Accountable Officer
Date	14.2.14

Signed on behalf of the Council	Shropshire Council
By	Stephen Chandler
Position	Director of Adult Services
Date	14.2.14

Signed on behalf of the Health and Wellbeing Board	Shropshire Health & Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Karen Calder
Date	14.2.14

First Draft

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

Within the financial template a comprehensive list of services included in the Fund has been set out for 2014/15. Providers were extensively involved with the development of these services. However, in relation to the Better Care Fund a specific provider workshop was held to set the scene and share plans for 14/15 highlighting key priority areas. In addition to the health providers present the independent care home and domicillary care sector were represented as well as the Vountary and Community sector A further, more detailed provider workshop has also been held to begin to shape plans for 2015/16 and regular provider meetings are now planned. Wider transformational work underway in Shropshire, set out later in this paper, also include comprehensive engagement elements on which we will draw. As part of this wider engagement and consultation as specific plans are developed we will include harder to reach groups through the Learning Disability Partnership Board and Carers Partnership Board as well as building on previously successful HWB engagement workshops with citizens and stakeholders

In addition the BCF is a standing agenda item at the Health and Wellbeing Board and is discussed as necessary at the local Chief Officers meeting which is attended fortnightly by Chief Officers from provider and commissioner agencies across Shropshire including the local Authority and neighbouring authority (who commission from the same hospital trust), SATH, SSSFT, RJAH and Shropshire Community Health

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Locally there is a comprehensive programme of service user, carer and clinical engagement across both the CCG and Council. As part of the Future Fit (Clinical Services Review) work across Shropshire and Telford & Wrekin there is a comprehensive programme of consultation and engagement which will act as the cornerstone of engagement regarding service redesign linked to this Fund. As above there has been extensive engagement with patients and the public in developing the services outlined in the financial template for 2014/15 as well as clinical engagement. A clinical lead has been appointed to oversee the development of the Better Care Fund

The Health and Wellbeing outcomes and priorities are based on the JSNA and an ongoing programme of consultation and engagement. This engagement over 2013 continued to test the relevance of the priorities for the population of Shropshire. The priorities outlined as part of this Better Care Fund are in strategic alignment with the HWB priorities and in alignment with the public and patients who we have had a continuing dialogue with over recent years. Details of this consultation can be found by following the link in section e) of this document. Further, as Healthwatch embeds its position within Shropshire, the Health and Wellbeing Board will work closely with Healthwatch and all our partners to ensure that we are fully engaging with our service users to conceive, design and implement service transformation

Some specific examples of the general programme of engagement work includes work with hard to reach groups, consultation on changes to service pathways, advocacy support and easy read materials.
Work on consultation and engagement will be on going and will include building on existing work in areas related to the Fund. Consultation and Engagement will take place within available resources and will be carried out via a range of methods/ media. Key areas that will be included within the consultation and engagement process will be:

- 7 day working including agreement on a definition of what this is in Shropshire – This is currently in development and a review of the current baseline position is underway across all providers and stakeholders including local authority partners and the independent care sector
- The Clinical Commissioning Group has already begun to factor the Fund into contract discussions with providers and this work will continue
- Making it Real Board – Making it Real (MIR) is a practical tool that has been developed nationally by service users and family carers. It is designed to be used with service users and family carers to help organisations check their progress with personalisation and community based support, to identify areas for change and develop actions. Shropshire Council are using Making it Real to assist in building on the progress made with the transformation of adults' social care through their Live Life Your Way initiative. The Making it Real outcomes will be the focus of Shropshire Council's approach for improving adult social care in the coming years and are also relevant to improving health outcomes

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- Patient and Public Engagement – developing awareness and opportunities to comment on and mould the development of the Fund will be built into existing arrangements for engagement across the Clinical Commissioning Group and Council, with plans for any specific early events agreed by the end of this financial year.

Two workshop events have already been health for health and Wellbeing Board members including representatives from Healthwatch and the Voluntary and Community Sector Assembly (VCSA). The Better Care Fund will be a specific item on the next VCSA Board meeting agenda.

e) Related documentation

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

Document or information title	Synopsis and links
BCF Joint Strategic Position paper	Joint Strategic Position paper V6.doc
BCF H&WBB workshop 1 slides	ITF workshop slides V2.ppt
BCF H&WBB workshop 2 slides	BCF workshop slides V3 STC Updated.ppt
BCF Governance	BCF Governance_final.ppt
BCF Plan on a Page	Better Care Fund plan on a page final.p
Job Description BCF	Job Description BCF.doc
Draft ToR Service Transformation Group	Draft ToR Service Transformation Grou
Final Draft ToR Finance Contracts and Performance Sub Group	Final Draft ToR Finance Contracts ar
Final Draft ToR HWB Delivery Group	Final Draft ToR HWB Delivery Group.doc
Provider workshop slides	BCF workshop slides - Provider consultatio

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H&WBB workshop 2 minutes	Workshop Number 2 Jan 2014.doc
Future Fit – Project Executive Plan	140120 Shrop CSR PEP V1 0_excl Appen
Dementia Strategy	DELIVERY_PLAN_Dec _2013_Revised[1][2]
LTC Strategy	Long Term Conditions Strategy F
JSNA	http://shropshire.gov.uk/joint-strategic-needs-assessment/
H&WB Strategy	http://www.shropshiretogether.org.uk/wp-content/uploads/2013/03/HWB_Strategy_210x210mm_FINAL-Hyperlink.pdf
Details of on going engagement and consultation on the JSNA and H&W priorities	http://www.shropshiretogether.org.uk/consultation/

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2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Our joint vision and aspirations for the BCF

As politicians, executives, clinicians and local residents of Shropshire we stand united behind the principle that we need to focus on what is best for Shropshire now and in the future.
Collectively both the local authority and CCG face the same two challenges:
How do we ensure improved services and outcomes for the people of Shropshire?
How do we make the current health and social care system financially sustainable into the future?
Both of these challenges encompass solutions where we focus on prevention of illness rather than treatment; where we care for patients and residents in the community more than we do within formal hospital settings; and where we focus on the correct level of care for the individual rather than placing patients in care settings that are of a higher dependency than their needs require.
They also require us to make radical changes to how we apportion our funding and on what services we focus our main resources.
What we agree on is that we can't keep doing the same things in the same way and expect to meet either of these challenges. We need to radically change how we deliver services and where we place our largest resources.

The Better Care Fund provides us with this opportunity.
By applying our joint aspirations set out in the Health and Wellbeing priority areas, alongside our individual organisational priority areas for investment and disinvestment we can start to make the changes that are required to make the health and social care economy sustainable.
What our service users will experience is more flexibility of provision, increased choice and more appropriate care settings being provided locally in their localities. They will also experience improved outcomes with better provision for long-term conditions and an agenda focused on prevention and ensuring higher quality of life years for our younger generations.
Outlined in the document below is how we will embark on the first two years which will lead to closer commissioning of services, integrated teams and a new focus on service provision at the correct level of care.

The Better Care Fund, whilst presenting significant challenges around developing more sophisticated arrangements for joint planning, sharing resources, (both financial and human across Shropshire CCG and Shropshire Council) and transforming services to create better outcomes for the population of Shropshire, also presents significant opportunities in these areas. The mature relationship between Shropshire Council and Shropshire CCG has proved to be a sound foundation from which to commence this work.

It is the aspiration of Shropshire Council and Shropshire CCG to utilise the opportunity the Fund presents to make transformational changes to the provision of local services which are founded on the best health and wellbeing outcomes for individuals. The context of other transformational activities locally around hospital provision and other developmental work around primary care and community services provides a suitable backdrop for this work to take shape. Workshops were held with Health and Wellbeing Board members and key stakeholder in November 2013 and January 2014 to discuss in detail and agree the local position in relation to implementation of the Fund. These workshops considered the guidance, financial analysis, current priorities and local context.

The outcome of these workshops was agreement that the focus of the Fund would be broadly around the themes of:

- Prevention
- Living Independently for Longer
- Long Term Conditions
- Managing and Supporting People in Crisis.

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It is important that the development of the Better Care Fund fundamentally supports the key priorities set out in the JSNA, the Health and Wellbeing Strategy (both of which can be found in Appendix 1) and other key commissioning and business plans. In addition developments must be mindful of the particular current health and social care context in Shropshire relating to the Clinical Services Review and complement its development as set out below. In addition to this, for the final iteration of this plan further detail will be provided regarding the role of prevention services and the inclusion of services for children and young people.

Within the local health economies throughout the West Midlands, East Midlands and East of England, the set of circumstances faced by the populations of Shropshire, Telford & Wrekin and Powys in relation to service reconfiguration are exceptional. It is in this context that the current need to realise major benefits from further integration of hospitals services takes place. The case for change is based on the patient benefits of new models of service which overcome some of the safety, quality and clinical sustainability concerns of current fragmented and duplicated services. A recent economic analysis of financial projections for the health economy, show that the severe financial constraints within which we have to operate compound the unique set of challenges we face.

In order to address these challenges and the need to develop a service strategy for the next 20 years, a large scale Clinical Services Review is underway – FutureFit. The outcome of this will be one of the most significant factors influencing the pattern and configuration of services over the next 5 years and beyond in Shropshire. The work on the Better Care Fund does not attempt to pre-empt this work but to compliment the direction of travel to develop high quality, sustainable health and social care service for the future. Furthermore , Shropshire Council and Shropshire CCG are both committed to a number of overarching principles and streams of work that will support the development of the Better Care Fund. These include developing community resilience through our Compassionate Communities and Community and Care Co-ordinator developments, implementing7 day services and identifying our most complex service users and wrapping services around them. We are also working closely with Public Health to develop the impact of our prevention services.

As a council Shropshire has stated its strategic aim is to ensure everything is as efficient as it can be, focusing on the customer, prevention and partnership. Arrangements which will ensure that the best possible outcomes for the local people of Shropshire

The council wants to deliver value for money for Shropshire people by commissioning outcomes, based on demand, working with our Elected Members. We want Shropshire's communities to be resilient, to take ownership of issues important to them and, with our support to develop their own resources to be able to flourish during this time of change and into the future.

We recognise that there are many communities, people and organisations who are as well, or better, placed to deliver the solutions and services which will help us to deliver on our vision. We also recognise that other organisations are sometimes better placed than the council to attract external funding and to deliver inward investment to Shropshire. That is why we see the council's role as that of a **commissioner** as opposed to a direct deliverer of services. This means that the council's relationship with our customers and communities will be to engage, listen and understand needs and demand whilst securing the best possible solution from those organisations who will be delivering services in future.

Demand for Adult Social Care rises each year, people are living longer and there are more people living with long term conditions, particularly dementia. There are also increasing numbers of young adults in transition to adult services with complex needs.

This increased demand for services occurs at the same time that the local Authority is under unprecedented financial pressure with an overall reduction in the finance settlement for Shropshire. At the same time there is increased public expectation of Adult Social Care and rightly an expectation of personalised and flexible support for those who are eligible for Adult Social Care.

In order to respond to the monumental challenges described whilst continuing to deliver high quality support to those in need, we will **need to radically change our approach** to the provision of ASC in Shropshire. If we want to maintain the level of access that we currently have for ASC we need to signal a more focused offer to everyone. Social care is often a vital part of enabling people to live independent lives

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but it is far from being the only component to enable people to live fulfilled lives. We must build and harness the contributions that communities can make to support themselves and the people living in them.

We need to build a more sustainable ASC system that promotes and maintains greater independence for most people which maximises the support available within local communities. We need to enable local communities to respond to the needs within them to enable them to support each other for longer so that higher level of statutory provision is available for those who need it. We need to change the relationship that adult social care has with the public and that fosters and promotes independence and self-management at every level. We need to ensure that we have different conversations with the public from the moment we first engage with them so that these expectations are understood, promoted and acted upon.

We will do this by

- Reducing dependence upon paid support and enabling and maximising individual independence.
- That the service will be responsive with quick decision making at the closest possible point to the person.
- Maximise the use of community resources and natural support and developing resilient communities.
- The local service will be determined by what that local community needs in relation to advice and information and direct intervention from adult social care.
- Facilitating key partnerships within local communities that maximise the use of natural support and universal services as well as developing services that meet the needs of local communities
- There is a focus on the use of volunteers and particularly those that have lived experience of using services.
- The service will focus upon supporting and enabling carers to continue with this vital role whilst establishing and maximising the use of peer support.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Early themes emerging from the FutureFit programme have identified the following areas where tangible differences will be evident for local people. The Better Care Fund will be instrumental in aiding in their delivery :

- Better clinical outcomes through bringing specialists together, treating a higher volume of cases routinely so as to maintain and grow skills
- Reduced morbidity and mortality through ensuring a greater degree of consultant-delivered clinical decision-making more hours of the day and more days of the week through bringing teams together to spread the load
- A pattern of services that by better meeting population needs, by delivering quality comparable with the best anywhere, by working through resilient clinical teams, can become highly attractive to the best workforce and can allow the rebuilding of staff morale
- Better adjacencies between services through redesign and bringing them together
- Improved environments for care
- A better match between need and levels of care through a systematic shift towards greater care in the community and in the home

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- A reduced dependence on hospitals as a fall-back for inadequate provision elsewhere and instead hospitals doing to the highest standards what they are really there to do (higher dependency care and technological care)
- A far more coordinated and integrated pattern of care, across the NHS and across other sectors such as social care and the voluntary sector, with reduced duplication and better placing of the patient at the centre of care

Moreover the aim locally is for the Better Care Fund to support the Health & Wellbeing priorities (below) as well as the JSNA priorities
1. Health inequalities are reduced
2. People are empowered to make better lifestyle and health choices for their own, and their family's health and wellbeing
3. Better emotional and mental health and wellbeing for all
4. Older people and those with long term conditions remain independent for longer
5. Health, social care and wellbeing services are accessible, good quality and 'seamless'.

It is also anticipated that the Fund will support improvements in the areas of the 5 key outcomes measures
- Reducing permanent admissions to residential and care homes;
- Improving Quality of Life indicators for service users and carers.
- Reducing non-elective hospital admissions, re-admissions and length of stay.
- Reducing delayed transfers of care
- Improving the effectiveness of reablement/rehabilitation services

Shropshire CCG's Outcome Ambitions for the coming year and associated 5 year trajectories (a summary of which are included as an embedded document in section e) are the first step in moving towards our overarching vision for local health and social care services outlined above and along with the monitoring of the key metrics submitted relating to the Better Care Fund itself, will provide an additional layer of monitoring data. The Local Authority will monitor performance against both national and local measures through the Adult Social Care Outcomes Framework and these together with the metrics submitted for the Better Care Fund will be reported on a regular basis by the contracts and performance group to the health and wellbeing delivery group

The Health and Wellbeing Board has agreed the following key themes for the Better Care Fund in Shropshire:
- Prevention
- Living Independently for Longer
- Long Term Conditions
- Managing and Supporting People in Crisis.

Further aims will look at increased reablement, sustainability measures and affordability, focused on reduced dependence of the population on social care and the urgent care element of health.

It is also anticipated that the Fund will deliver financial efficiencies by reducing duplication, economies of scale and having the right services in the right places meeting the right needs

In order to ensure Parity of Esteem for the local residents of Shropshire The CCG and Council are committed to improving outcomes and addressing health inequalities for people with mental health needs and mental and emotional wellbeing has been identified as a priority for Shropshire's Health and Wellbeing Board, with a particular emphasis on supporting people with dementia and the mental and emotional health and wellbeing of young people. In particular within the scope of the Better Care Fund plan 2014-2016 there is a commitment to Improving access to Pyshological Therapies (IAPT), improving diagnosis and support for people with Dementia, improving awareness and focus on the duties with the Mental Capacity Act and reviewing Crisis service provision.

The complexities and breadth of the work involved in fully developing and implementing the better Care Fund are significant and as an aide we have developed a Better Care Fund "Plan on a Page" which

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demonstrates the work that will sit under the Better Care Fund banner and its interdependencies and correlation.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The initial phase of work will establish those programmes of development that are already in train and where joint arrangements are already in place or are already being developed that can be supported to achieve impact in year 1. These will consider the geography and rurality of Shropshire, recognising that some work will need to be adapted to reflect variations in local need, as well as the performance requirements of the National Conditions, National Metrics set out above and locally agreed targets. Work will be in line with the strategic direction set out in the JSNA and Health and Wellbeing Strategy as well as the local Long Term Conditions Strategy and Dementia Strategy. This will include work around Reablement, Locality Commissioning priorities to meet the differing needs of communities, the Integrated Community Service and Long Term Conditions work streams

Those services identified for inclusion in the Fund in 2014/15 are identified as follows:

Prevention:

- Carers Support and Liaison
- Think Local Act Personal and citizen engagement
- Access to employment and leisure activities for people with Learning Disabilities
- Locality Commissioning
- Improved care service monitoring (safeguarding)
- Falls prevention

Living Independently for Longer

- Maximising Independence – Hospital discharge/ admission avoidance
- Handyman Scheme
- Telecare
- Support for Adults with learning Disabilities
- Supported Living for people with learning Disabilities/ Mental Health
- PATH House supported living
- Jointly funded staff to support learning disabilities services
- Community and Care Co-ordinators
- Continuing Care respite
- Crossroads care attendants scheme
- Children and families – short breaks/ Summer play schemes/ Hope House
  Mental Health Carers Network and Carers Support
- End of Life Care – Hospice at Home service
- Carers Link Workers
- Primary Care carers support worker
- Substance Misuse carers support
- Age UK
- Compassionate Communities

Long term Conditions (including Dementia)

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- Enhancing preventions services (LTC)
- Services for people with Dementia
- Supported Housing (The Willows, Oak Paddock, 64 Abbey Foregate)

Managing Patients in Crisis
- Crisis Resolution
- Integrated health and social care pathway
- Mental health and Learning Disabilities Respite
- Escalation beds
- Independent Living Partnership
- PATH House

Supporting People After Crisis
- Increased social work capacity
- Rehabilitation beds
- START (Short Term Assessment and Reablement Team)
- Home from Hospital
- Stroke Association
- Social work input to support early discharge
- Step down START beds
- Headway (Acquired Brain Injury Support)
- Integrated Care Service

Central to our local developments is out Integrated Community Service. ICS is a locality based health and social care, community and voluntary sector integrated team with responsibility for complex patients who require support to prevent an acute hospital admission or to facilitate discharge from an in-patient bed. The first phase of this service development began in Shrewsbury & Atcham in November 2013 focussing on early supported discharge but the next phases with include roll out to North and South localities and expansion of the scope of the service to include admissions avoidance.

The service aim is to provide a rapid response to care delivery in the right place at the right time to maximise a patient's independence deploying the optimum skill mix to ensure that the response provided is appropriate and proportionate to the assessed needs with the default position being for the patient to remain at, or return to, their home. The service will achieve and demonstrate integration through a new shared culture, mind-set, values, objectives, working processes and practice.

Phase two of our implementation of the Better Care Fund will look at longer term more fundamental transformation work. Detailed plans for this work and consideration of the full National Conditions, National Metrics and local indicator will be carried out during 2014/15 and recommendations for 2015/16 will be presented to the Health & Wellbeing Board in September 2014 for agreement. This will include a focus on prevention, assistive technology and information and advice supporting people to be more self reliant and resilient within their local communities

Shropshire Clinical Commissioning Group is working with partners including Shropshire Council and the Parents and Carers Council (PACC) to ensure that the SEND Reforms are implemented successfully in Shropshire and that there are improved outcomes for children and young people with SEN.
We are working in partnership to deliver the following by September 2014:

- A single assessment process for education, health and care which includes parents of children and young people with SEN in the assessment process
- Replacement of SEN statements and learning difficulty assessments with an education, health and care (EHC) plan for children and young people with SEN aged 0 to 25 years
- Introduction of the option of personal budgets for young people and parents of children with SEN
- A local offer which provides information about support that is available
- Joint commissioning arrangements to deliver integrated support for children and young people with SEN aged 0 – 25 years

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Post-September 2014, we will regularly review the success of the reforms locally including the local offer, commissioning arrangements and service budgets in order to offer increased personal budgets and ensure that services meet identified need.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

There are a number of future pressures that threaten to overwhelm health and social care services and Shropshire is no exception in this. Whilst more people are living longer, many people are spending more years in declining health. This places significant demand on health and social care services and highlights the importance of healthy lifestyles. Many of the causes of poor health and early death are largely preventable. Furthermore the population is ageing and we are a seeing significant increase in the number of people with long term conditions, coupled with rising public expectations. The resulting increase in demand combined with rising costs threatens the financial stability and sustainability of current health and social care provision.

Preserving the values that underpin a universal health service which is free at the point of use will mean fundamental changes to how we deliver and use health and care services in the future. In addition the social care services available from the Local Authority will require a fundamental redesign and new operating model to ensure that resources are available to meet the needs of those with most need. The new operating model currently being developed by Shropshire Council will see a greater focus on prevention and reablement as required by the Care Bill as well as developing individual and community capacity and resilience to ensure that scarce resources are allocated to those in greatest need

The Fund presents some financial challenges particularly in a context of diminishing budgets across the local health and social care economy in Shropshire. The final target allocations review for CCG's has been published and identifies Shropshire as currently being funded at 4.6% (£16m) above its fair share target. This has led to the CCG receiving the lowest amount of uplift available for 2014-15 and 2015-16 (along with 64% of other CCGs). Both the Clinical Commissioning group and the Council are exploring avenues for lobbying the Government regarding rural issues and the relevance of this in making funding decisions.

In particular it is anticipated that the Better Care Fund will support maximising the acute phase and the movement of the post acute phase into the community. As already highlighted the development of the Better Care Fund for 2015/16 will need to compliment the Clinical Service Review taking place locally and support a reduction in dependency level within the acute sector. This is based on the assumption that we will still achieve all the NHS targets

The recent Kings Fund paper, "Making the Best Use of the Better Care Fund" (January 2014) sets out a number of areas of focus in implementing the Better Care Fund, these are:
Primary Prevention
Self Care
Managing ambulatory care sensitive conditions
Risk stratification or predictive modelling
Falls prevention
Care co-ordination
Case management
Intermediate care, reablement and rehabilitation

Work is already underway in relation to all these areas, in particular the Long Term Conditions Strategy sets out the local commitment and plans around these areas of work. The implementation of the Better

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Care Fund will further assist this and there has been broad agreement via the Health and Wellbeing Board workshops with this. Further work will be undertaken to develop joined up plans with our neighbouring CCG in Telford & Wrekin between now and September 2014

Furthermore, the CCG and Council have been considering the implication of the Commissioning for Prevention Guidance and how this can be applied in Shropshire to have the most impact. The outcome of this work will be a key factor in our development of the workstreams associated with the Better Care Fund over the coming months.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Overall Strategic Governance will be provided via Shropshire Health and Wellbeing Board. Workshops have taken place with members of the Health and Wellbeing Board to agree governance principles. The details of the operational governance arrangements that sit beneath this have now been agreed by the Health and Wellbeing Board and can be found as an embedded document in section e along with their associated Terms of Reference

The day to day responsibility for the implementation of the plan, financial and performance monitoring will be the responsibility of the Health and Wellbeing Delivery Group and a joint appointment will be made to a Better Care Fund Manager post to support this. The Job Description for this post can also be found as an embedded document in section e.

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3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

The Local authority estimates, from working with local care providers, that around 40% of the care beds in Shropshire are occupied by people who fund their own care as their capital is above £23k. What is unknown is how many of these people are below or close to the new capital threshold being proposed by the care bill. A proportion of the BCF will have to be used to meet this increase in statutory responsibility. The number of people who self fund their own care from domicillary care providers is unknown and again the BCF may have to be used to meet this financial gap

In Shropshire the fund will protect expenditure on statutory services for people who are eligible for council funded support and who have needs assessed under the Fair Access to Care Criteria (FACS) as being either critical or substantial. The fund will also be used to protect services that support carers following the completion of a carers assessment. The level at which the eligibility criteria will be set through the Care Bill is as yet unknown and there could be an additional financial impact.

The CCG and the LA are committed to integrated care services that facilitate hospital discharge, prevent hospital admissions and reduce reliance on long term social care services and support people through targeted reablement and intensive short term support to remain living independently in their own homes and local communities. Both the CCG and LA are committed to enhancing and developing community capacity and community based support whilst ensuring that the most vulnerable and complex needs are met appropriately either singularly or jointly by the relevant partner

The underpinning measure of success in protecting adult services will be to ensure that the BCF supports the ASC transformation agenda central to which is a reduction in funding over the 3 year period of circa £25million.
The council is committed to delivering on its statutory responsibilities, which will change and grow as the Care and Support Bill is implemented and this may require changes to local policy, guidance and operating models. It has recognised the importance of a range of prevention and early intervention approaches including telecare, community equipment and reablement in keeping people independent.

The longer term demand management and enabling people to live independently has also been recognised by the council and the council is also focused on enabling communities and volunteers, and the social capital within communities to reduce demand on the public sector and developing a range of wider environmental place shaping schemes to enable people to live as independently as possible for as long as possible.

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Please explain how local social care services will be protected within your plans

In order to meet the demands of current and future social care support, the operating model defines the Adult Social Care approach in working with the individual, their family, the wider population to develop sustainable support, engagement with universal services, through to meeting complex levels of need and vulnerability through a personal budget.

The approach is based upon varied and localised interventions that are designed to promote independence. A person contacting the Council for support will be supported to develop personal resilience, guided through the differing interventions until a maximum state of independence has been reached. At this point a support plan, documenting how such independence will be maintained, will be completed.

In supporting people to reach a maximum state of independence the model aims to provide the most person centred and efficient experience possible.

As such the model asserts the following standards:

• People will only provide their personal details and circumstances once.
• A named point of contact will co-ordinate and be in place throughout any intervention.

• Personal choice, assets and skills will be the starting point of any support.
• Assessment and support plans are not duplicated or completed in isolation.
• A culture of resolution and customer satisfaction is at the centre of all we do.
• Support to Carers will be accessible and tailored to the needs of the carer.

b) 7 day services to support discharge
Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

7 day working is a requirement across the whole system and brings additional workforce challenges. As part of the FutureFit programme of work a full workforce review and plan will be a key part of the process and already there have been clinical engagement in these discussions.

The CCG have included in contracts with providers the requirement to include plans for 7 day services via the requirement for specific Service Development and Improvement Plans. The Health and Wellbeing Board recognises that access to services is a key issue for Shropshire and a priority within the Health & Wellbeing Strategy is improving access to services.

c) Data sharing
Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

The local authority is currently entering on care records the NHS number where this is known. From April 2014 all new users will be allocated the NHS number on the council Care First system.

The NHS number field will become mandatory in May 2014 once the NHS number matching service has been installed and tested.

The appropriate software applications have been purchased to enable access to the NHS number matching service.

By the end of October 2014 all processes will be in place, tested and live and the NHS number matching service will be used for all open clients. (“Open clients” are defined as those clients being in receipt of a service from adult social care).

Benchmarking with other local authorities is indicating > 80% match and use within 12 months. Subject to resources and the identification of any manual data tidy up required we will aim for this to be achieved in Shropshire by the end of December 2014.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Not yet established but there is a clear commitment to do so by October 2014 as described above

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Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Yes

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Yes

d) Joint assessment and accountable lead professional
Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

In 2013/14 the CCG supported the implementation of the enhanced service, risk profiling and care management. The CCG focus was on frail and vulnerable patients and practices were asked to identify those most at risk of loss of independence or admission to hospital. MDT meetings (including the voluntary sector) assessed the cause of that risk and developed a care plan to reduce that risk. Where appropriate a care coordinators (each aligned to a practice) was allocated to support these at risk individuals with their ongoing health & care needs.

Also in 2013/14 a Care Home Advanced Scheme has been introduced adopting pro-active care through active case management, care planning, anticipatory prescribing and multidisciplinary review for patients improving quality and outcomes as well as reducing unnecessary hospital admissions. This programme is supporting the 3,600 patients currently residing in care homes in Shropshire who have complex needs and use a large proportion of health and care provision in the county. The scheme supports increased medical input to care homes through risk stratification of residents that may be at risk of hospitalisations and GP input through a care planning/ case management approach and multidisciplinary team review. The key aims include:

- Identification and risk stratification of residents in care homes at highest risk of hospitalisation
- Developing a care plan using an MDT approach
- Employing consistent documentation to ‘manage me here’.
- Planned regular visits
- Medication reviews
- Flagging every patient with the Out of Hours service.
- Significant event analysis in the event of an unplanned admission or intervention

This work is being further developed and will be part of the plan for 14/15 outlined below.

In 2014/15 the Local Authority and CCG intend to build upon this foundation through implementation of the Admission Avoidance DES. Practices will work with their MDT to case manage 2% of the population most at risk of admission. Initially the focus will be on:

- The last year of life from all causes
- Frail & vulnerable individuals including those with dementia
- Patients in care homes
- Patients with Diabetes, COPD and Heart Failure (our 3 priority LTCS for 14/15)

First Draft

To date MDTs have been identifying individuals at risk of admission through computer searches, PARR data, local intelligence and opportunistically. The CSU is intending to provide a Risk Stratification tool in the coming months which will further support this process.

The accountable professional for these patients will be the GP. Where the patient would benefit from care coordination/key worker these will be allocated through the care planning process. The care coordinator could be a specialist nurse in COPD, Heart Failure or Diabetes, a community and care coordinator, a social worker, care homes staff, clinical nurse specialist in palliative care, community matron, district nurse or a member of the practice team. This will be dependent on the needs of the individual and the decision of the MDT. Work is in train to enable this process which will both support individuals and integrate care.

The CSU is supporting the CCG and LA in the development of a series of interdependent, self-populating templates which will support and guide the practices in delivering the 2% case management. Local and national guidance will be linked to the templates and an integral care plan will be printed off for patients and their carers. Further development includes moving toward a shared electronic care plan or record between all those involved in the care of an individual, accessible to the patient and carer.

It is recognised that many of these individuals have multiple reasons to be at risk. These reasons span health, social, housing, care needs, advocacy needs, isolation and loneliness. The Health Economy is developing a one stop shop for assessment in line with the NSF for older people Single Assessment Process. This assessment process will be delivered in locality bases or in the patient's own home. The process will be coordinated and supported by the voluntary sector.

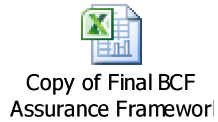
Work is in train with the Commissioning Support Service to develop an IT solution to support this single assessment process.

Work is also in development in relation to a single integrated assessment for children which will be in place by September 2014

First Draft

4) RISKS

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



First Draft

Shropshire and Telford & Wrekin Clinical Commissioning Groups

Draft Strategic Plan

2014/15 – 2018/19

Version control

Version	Date	File name	Status
1.0	16.3.2014	5 year plan_draft_160314	Incomplete draft for review/further work
2.0	21.3.2014	5 year plan_draft_210314	Largely complete draft for review by CCG board members
3.0	22.03.14	5 year plan_draft 220314	Draft prior to 4/4 submission
4.0	26.3.2014	5 year plan_draft 260314	Draft prior to 4/4 submission – for HWBB

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Foreword

This plan has been prepared by Shropshire and Telford & Wrekin Clinical Commissioning Groups (CCGs) to meet the requirements of the NHS England planning guidance *Everyone Counts: Planning for Patients 2014/15 to 2018/19.*

The vision for the transformation of service models set out in this plan draws heavily on the clinical design work stream of the NHS Future Fit programme, through which local partners are working to address some of the strategic challenges facing the health and social care system. This has, in turn, drawn on the strategy, service redesign and pathway development that CCGs have been leading over recent years, working closely with patients, providers and partners, including the two Health and Wellbeing Boards.

Over the coming months these service models will be subject to extensive clinical and public engagement both to test the principles and to develop the more granular detail which will be needed both inform an option appraisal for the configuration of hospital services and to develop transformation plans for those elements of the models which are not dependent on major changes to hospital configuration.

This draft strategy must be read in the context of the Future Fit programme: the opportunities for improvement have been clearly articulated; the case for change is widely accepted within the clinical community, by patient and public representatives, by partner organisations and by the Joint Health Overview Scrutiny Committee; and programme structures have been put in place to develop the clinical vision and new models of care which will form the cornerstone for the transformation of health and care services in Shropshire.

As a plan developed at a point in time, this document does not describe in detail the transformation service models which we will be implementing as this detailed work has not yet been completed. That does not mean that there are no plans for change, and specific service improvement plans, consistent with the vision described in this strategic plan, are included in the CCG's respective Operational Plans for 2014/15 – 2015/16. It is, however, through the Future Fit programme that the over-arching strategy and transformational service models will be develop. The final version of this Strategic Plan, which CCGs are required to prepare by 30 June 2014, will start to articulate this greater detail and plans for implementation.

CM/DE

Shropshire/Telford & Wrekin – People and Place

1. The Shropshire/Telford & Wrekin (STW) area is served by Shropshire Clinical Commissioning Group (44 GP practices), based in Shrewsbury and by the Telford and Wrekin Clinical Commissioning Group (22 GP practices), based in Telford. Clinical Commissioning Groups are responsible for commissioning the following services:
   - Community health services
   - GP out of hours services
   - Ambulance services
   - Mental health services
   - Specialist health services for people with learning disabilities
   - Acute hospital services

2. **Telford and Wrekin Clinical Commissioning Group** serves a population of approximately 172,000, which is mainly centered on the new town of Telford but covers the surrounding rural areas and towns including Newport. It has co-terminus boundaries with Telford Borough Council and there are strong partnership links between the two bodies in health and social care.

3. **Shropshire Clinical Commissioning Group** serves a population of approximately 302,000. Shropshire is a large rural county. The county town of Shrewsbury is central to the county with a number of market towns geographically spread across the area. Shropshire Clinical Commissioning Group has co-terminus boundaries with Shropshire Council and the two agencies work closely together.

4. Specialised services, primary care, services, offender healthcare and services for members of the Armed Forces are commissioned by **NHS England**.

5. **South Staffordshire and Shropshire Healthcare NHS Foundation Trust** provide adult and older people's mental health services in the county. Multidisciplinary and multi-agency teams work in partnership with local councils and closely with the voluntary sector, and independent and private organisations to promote the independence, rehabilitation, social inclusion and recovery of people with a mental illness. Facilities include the Redwoods Centre in Shrewsbury which opened in 2012 and provides 80 adult mental health beds for Shropshire, Telford and Wrekin and Powys and 23 low secure beds for the West Midlands.

6. The **Shrewsbury and Telford Hospital NHS Trust** (SaTH) is the main provider of district general hospital services for half a million people living in Shropshire, Telford and Wrekin and mid Wales, Services are delivered from two main acute sites: Royal Shrewsbury Hospital (RSH) in Shrewsbury and the Princess Royal Hospital (PRH) in Telford. Both hospitals provide a wide range of acute hospital services including accident and emergency, outpatients, diagnostics, inpatient medical care and critical care. Total bed capacity across the two hospitals is 819.

7. The **Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust** (RJAH) is a leading orthopaedic centre of excellence. The Trust provides a

comprehensive range of musculoskeletal surgical, medical and rehabilitation services; locally, regionally and nationally from a single site hospital based in Oswestry, Shropshire, close to the border with Wales. As such, the Trust serves the people of England and Wales, as well as acting as a national healthcare provider. It also hosts some local services which support the communities in and around Oswestry.

8. **Shropshire Community Health NHS Trust** provides community health services to people across Shropshire and Telford and Wrekin in their own homes, local clinics, health centres and GP surgeries. These services include Minor Injury Units, community nursing, health visiting, school nursing, podiatry, physiotherapy, occupational therapy, support to patients with diabetes, respiratory conditions and other long-term health problems. In addition, it provides a range of children's services, including specialist child and adolescent mental health services. Shropshire's four community hospitals have a total of 113 beds.

9. Of the 66 **GP practices** across Shropshire and Telford and Wrekin, 44 are in Shropshire and 22 in Telford and Wrekin. Local practices have recently formed a **GP Federation**. **Walk in Centres** are located in Shrewsbury, Telford town centre and at the Princess Royal Hospital. **Shropshire Doctors Co-operative Ltd (Shropdoc)** provides out of hours primary care services to 600,000 patients in Shropshire, Telford and Wrekin and Powys. NHS England hold contracts with X [DN: to be added] dental practices and Y [DN: to be added] pharmacies across the STW area.

10. The STW area is served by the two **Unitary Councils** of Shropshire and Telford and Wrekin that have responsibility for delivery and oversight of a range of social care and support and for some health related provision for adults and children. There are 74 Councillors in Shropshire Council and 54 in Telford & Wrekin Council.

11. Health and Wellbeing Boards (HWBB) are in place in both councils. Established under the Health and Social Care Act 2012, they are a key part of broader plans to modernise the way NHS and social care services work together.

12. Whilst Shropshire and Telford & Wrekin have distinct Health and Wellbeing Strategies there are common themes that run throughout both: reducing health inequalities, supporting people to live independently, lifestyle and health choices and emotional health and wellbeing. The table below sets out the priorities within each Strategy and their correlation around these themes:

	Reducing Health Inequalities	Supporting People to Live Independently	Lifestyle and Health Choices	Emotional Health and Wellbeing
Telford & Wrekin	• Improve life expectancy and reduce health inequalities	• Support people to live independently	• Reduce excess weight in children and adults • Reduce teenage pregnancy • Reduce the number of people who smoke • Reduce the misuse of drugs and alcohol	• Support people with Dementia • Improve adult and children's carers' health and wellbeing • Support people with Autism • Improve emotional health and wellbeing
Shropshire	• Health inequalities are reduced • Health, Social Care and wellbeing services are accessible, good quality and 'seamless'	• Older people and those with Long Term Conditions will remain independent for longer	• People are empowered to make better lifestyle and health choices for their own and their families health and wellbeing	• Better emotional mental health and wellbeing for all

13. Both Health and Wellbeing strategies describe how resources will be targeted to areas of greatest need and outline how they will be delivered in partnership by a whole range of organisations across the private, public and voluntary and community sectors.

The Case for Change

An Opportunity for Improvement

14. There are already some very good health services in Shropshire, Telford and Wrekin. They have developed over many years to try to best meet the needs and expectations of the populations served, including that of Mid-Wales. Nevertheless, when we look at the changing needs of the population now and that forecast for the coming years; when we look at the quality standards that we should aspire to for our population, as medicine becomes ever more sophisticated; and when we look at the economic environment that the NHS must live within; then it becomes obvious that the time has come to look again at how we design services so we can meet the needs of our population and provide excellent healthcare services for the next 20 years.

15. When considering the pattern of services currently provided, our local clinicians and indeed many of those members of the public who have responded to the recent Call to Action consultation, accept that there is a case for making significant change provided there is no predetermination and that there is full engagement in thinking through the options. They see the opportunity for:

- Better clinical outcomes through bringing specialists together, treating a higher volume of cases routinely so as to maintain and grow skills
- Reduced morbidity and mortality through ensuring a greater degree of consultant-delivered clinical decision-making more hours of the day and more days of the week through bringing teams together to spread the load
- A pattern of services that by better meeting population needs, by delivering quality comparable with the best anywhere, by working through resilient clinical teams, can become highly attractive to the best workforce and can allow the rebuilding of staff morale
- Better adjacencies between services through redesign and bringing them together
- Improved environments for care
- A better match between need and levels of care through a systematic shift towards greater care in the community and in the home
- A reduced dependence on hospitals as a fall-back for inadequate provision elsewhere and instead hospitals doing to the highest standards what they are really there to do (higher dependency care and technological care)
- A far more coordinated and integrated pattern of care, across the NHS and across other sectors such as social care and the voluntary sector, with reduced duplication and better placing of the patient at the centre of care

16. They see the need and the potential to do this in ways which recognise absolutely the differing needs and issues facing our most dispersed rural populations and our urban populations too. This then is the positive case for change - the opportunity to improve the quality of care we provide to our changing population.

A challenge to be addressed

17. Our local clinicians and respondents to the Call to Action also see this opportunity to systematically improve care as being a necessary response to how we address the many challenges faced by the service as it moves forward into the second and third decades of the 21st century. These challenges are set out below - they are largely outside our control and we have to adapt our services to meet them:

18. **Changes in our population profile.** The remarkable and welcome improvement in the life expectancy of older people that has been experienced across the UK in recent years is particularly pronounced in Shropshire where the population over 65 has increased by 25% in just 10 years. There will continue to be expansion of Telford, with the addition of an estimated 20,000 new homes over the next 10 years with an estimated population increase as a result in the order of 50,000. The demography of Telford has changed over the past 10 years and now is more reflective in age of the national picture. This growth is forecast to continue over the next decade and more. As a result the pattern of demand for services has shifted with greater need for the type of services that can support frailer people, often with multiple long-term conditions, to continue to live with dignity and independence at home and in the community.

19. **Changing patterns of illness.** Long-term conditions are on the rise as well, due to changing lifestyles. The means we need to move the emphasis away from services that support short-term, episodic illness and infections towards services that support earlier interventions to improve health and deliver sustained continuing support, again in the community. Telford and Wrekin has high premature mortality when compared to the national figures, demonstrated in the table below.

		HLE (years) 2010-12	
		Telford & Wrekin CCG	**England**
At Birth	**Males**	61.2	63.5
	Females	61.8	64.8
At age 65	**Males**	8.0	9.2
	Females	8.2	9.7

In particular premature deaths from cancer and CVD are higher than the national average, particularly in men.

20. **Higher expectations.** Quite rightly, the population demands the highest quality of care and also a greater convenience of care, designed around the realities of their daily lives. For both reasons, there is a push towards 7-day provision or extended hours of some services, and both of these require a redesign of how we work given the inevitability of resource constraints.

21. **Clinical standards and developments in medical technology.** Specialisation in medical and other clinical training has brought with it significant advances as medical technology and capability have increased over the years. But it also brings challenges. It is no longer acceptable nor possible to staff services with generalists or juniors and the evidence shows, that for particularly serious conditions, to do so risks poorer outcomes. Staff are, of course, aware of this. If they are working in services that, for whatever reason, cannot meet accepted professional standards, morale falls and staff may seek to move somewhere that can offer these standards. It is also far more difficult to attract new staff to work in such a service. Clinicians are a scarce and valuable resource. We must seek to deploy them to greatest effect.

22. **Economic challenges.** The NHS budget has grown year on year for the first 60 years of its life ……in one decade across the turn of the 21st century its budget doubled in real terms. But now the world economy and the UK economy within that is in a different place. The NHS will at best have a static budget going forward. And yet the changing patterns of population and resultant need, the increasing costs of ever improving medical technology, the difficulties in simply driving constant productivity improvements in a service that is 75% staff costs and that works to deliver care to people through people, mean that without changing the basic pattern of services then costs will rapidly outstrip available resources and services will face the chaos that always arises from deficit crises.

23. **Opportunity costs in quality of service.** In Shropshire and Telford and Wrekin the inherited pattern of services, especially hospital services, across multiple sites means that services are struggling to avoid fragmentation and are incurring additional costs of duplication and additional pressures in funding. The clinical and financial sustainability of acute hospital services has been a concern for more than a decade. Shropshire has a large enough population to support a full range of acute general hospital services, but splitting these services over two sites is increasingly difficult to maintain without compromising the quality and safety of the service. Most pressingly, the Acute Trust currently runs two full A&E departments and does not have a consultant delivered service 16 hours/day 7 days a week. Even without achieving Royal College standards the Trust currently has particular medical workforce recruitment issues around A&E services, stroke, critical care and anaesthetic cover. All of these services are currently delivered on two sites though stroke services have recently been brought together on an interim basis. This latter move has delivered measurable improvements in clinical outcomes.

24. **Impact on accessing services for populations living in two urban centres and much more sparsely populated rural communities.** In Shropshire, Telford and Wrekin there are distinctive populations. Particular factors include our responsibility for meeting the health needs of sparsely populated rural areas in the county, and that services provided in our geography can also be essential to people in parts of Wales. Improved and timely access to services is a very real issue and one which the public sees as a high priority. We have a network of provision across Community Hospitals that can be part of the redesign of services to increase local care.

Patient Engagement in the Development of Our Strategy

25. In November 2013 we ran a major consultation exercise with public and clinicians under the national Call to Action for the NHS. Information about the Call to Action – how we ran it, who responded and what they said – can be found at http://www.shropshireccg.nhs.uk/call-to-action.

26. The response was very clear in saying that the public wanted full engagement in thinking through options for the future and that nothing should be predetermined. Nevertheless, in the light of the factors described above, there was real consensus between public and clinicians about the following:

- An acceptance of there being a case for making significant change;
- A belief that this should be clinically-led and with extensive public involvement
- A belief that there were real opportunities to better support people in managing their own health and to provide more excellent care in the community and at home;
- An agreement that hospitals are currently misused. This is not deliberate but as a result of poor design of the overall system and the lack of well understood and properly resourced alternatives;
- A belief that it is possible to design a new pattern of services that can offer excellence in meeting the distinctive and particular needs of the rural and urban populations of this geography - but if we are to succeed we must avoid being constrained by history, habit and politics.

27. A key message about the design of services was that it needs to be radical and sustainable: a 5-10 year long term plan should be informed by:

    - Clinicians driving clinically sensible change
    - A clear understanding of demand and capacity
    - Clinical safety
    - “Form follows function” and is not compromised by current building stock
    - The use of technological solutions
    - Simpler assessments to allow easier navigation by clinicians, NHS staff and patients

28. The high level of patient and public involvement that we achieved in the Call to Action will be continued as we develop and implement the service transformation which we need to make to achieve the ambitions that we are setting for the future of health and healthcare in Shropshire and Telford & Wrekin.

29. We will ensure that there is a clear “you said, we did” model in place to demonstrate how patient and public involvement has helped to shape the development and implementation of our plans.

Our (Emerging) Vision for Service Transformation

30. The vision for service transformation described below is drawn from the initial output from the Future Fit clinical design work. Following the Call to Action surveys and events[1], a Clinical Reference Group comprising 50 senior clinicians from health and social care, along with patient representatives, met on November 20th 2013 to receive the results, from which a case for change was established and whole system design principles were debated and agreed:

- Home is normal.
- The level of care should match the level of need and unnecessary escalation of care should be avoided.
- A commitment to 7 day working as part of an integrated local health economy approach.
- Recognition that a commitment to quality and safety is paramount for clinicians (in part contrast to the public emphasis on accessibility as the key parameter of quality – especially to primary care – that was evident from the "call to action" responses.
- The need to get the system right for the next 10-20 years.

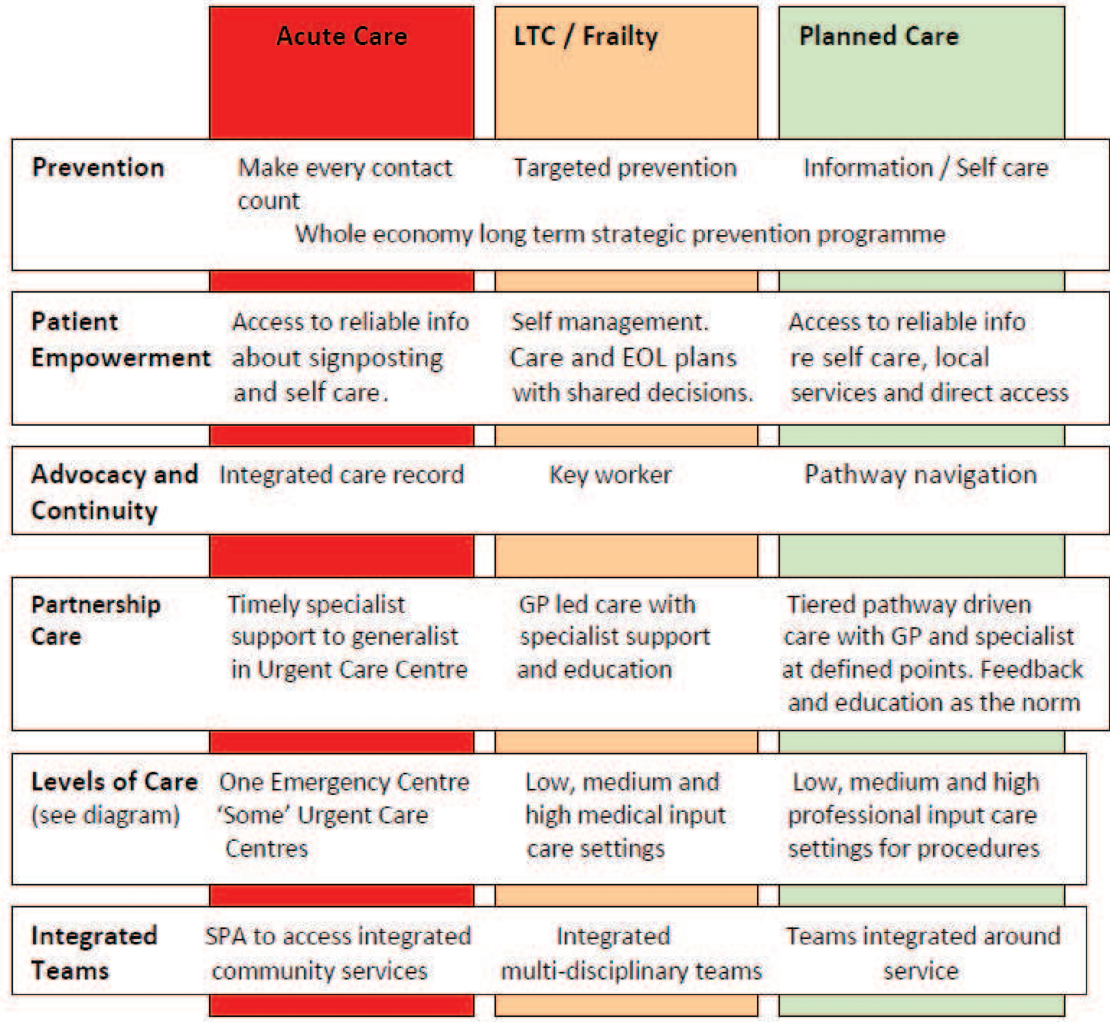
31. The Clinical Reference Group met again on January 29th 2014, during which it confirmed the output from the first meeting, suggested what success would look like and how to measure it and discussed the clinical and design principles applicable to the three main areas of health care delivery:

- Acute and Episodic Care
- Long Term Conditions / Frailty, and
- Planned Care.

32. Three subgroups were formed to consider these areas further; each subgroup comprising approximately 30 clinicians from health and social care along with patient representatives. They each met for six hours during February 2014 to add more detail to the design and clinical principles, to establish high level models of care in each area and to begin a process of sense checking, testing and refinement of the models.

33. The figure below presents a high-level representation of the key elements of models of these models of care. The full document is available at [DN: insert URL].

[1] Described in more detail in paragraph X [DN: to be completed] below



34. In addition to the three core service models the initial output of the clinical design work identifies cross-cutting these which will be given equally high priority and focus in the further development of the strategy and its implementation:

35. **Embedding compassion and healthy relationships.** Although compassionate care requires the right attitude, this must be translated into action and supported in system design and team working practices. Every member of a team must have clearly understood roles and responsibilities, especially when working within complex systems and environments. However, over-definition of roles, especially when restricted to one care setting, can prevent professionals 'going the extra mile' to ensure compassionate care and seamless patient journeys. Named key workers or responsible clinicians will improve co-ordination of care for vulnerable people. Values based recruitment will become the norm and compassionate attitudes, behaviours and relationships will be more visible throughout the whole organisation.

36. **Rural and Urban solutions.** The problems of providing equality of access and quality of care to rural populations will be partially mitigated by achieving greater care in the community. Care provided by teams around the patient with home as the default can be provided equitably in both urban and rural settings. Access to services

that require travel clearly require better transport solutions, but there is also a balance to be achieved between the advantages of providing truly local services for all levels of care and the better outcomes and reduced cost of providing care at larger scale in fewer units.

37. **Workforce issues** Many parts of the health and social care workforce are in crisis. A full workforce review and plan is required as part of, or alongside the Future Fit programme in order to resolve this. 7 day working is a requirement across the whole system and brings additional workforce challenges.

38. **Co-ordination, integrated and consistency across the whole system There is universal agreement that** improving the co-ordination, integration and consistency of care delivered across the whole economy is a necessary precondition for achieving sustainable improvements in quality and safety. The will to do this is evident, it is the barriers to it that require systematic identification and removal. These include a fragmented organisational structure, multiple incompatible IT systems, 'old fashioned' commissioning mechanisms and an overwhelming administrative burden.

39. **Delivering effective high quality care with no extra money** Financial austerity is one of the key drivers for radical change. There is a need to move beyond organisational interests so that funding follows the patient. Pragmatism is required to find the 'key enablers' of change to concentrate our limited resources.

40. **Social Care** Health and social care are clearly interdependent and should be designed to reflect this. There is currently an anomaly which makes closer integration difficult in that social care is means tested whilst health care is always free. To achieve integrated working, health and social care should run parallel and share risk, not run in series as is mostly the case at the moment. No-one enters the social care system without a health problem and currently both systems focus on those most in need and pay much less attention to prevention and self care. Although there is no statutory obligation for Local Authorities to invest in prevention, there was a clear consensus that health and social care must tackle prevention, education and patient empowerment to increase self-reliance together. Both Shropshire CCG and Telford & Wrekin CCG have developed ambitious plans as part of the Better Care Fund with the respective Local Authorities to deliver integration across health and social care, with a greater emphasis on care closer to home and self care/management.

41. **Mental Health** There was unanimous agreement that mental health should be integrated with primary, community and acute health care. The models of care described in the three main areas of Acute, LTC and Planned Care were all contributed to by mental health professionals and further detailing will demonstrate more clearly the potential for closer integration. Partnership care in particular was felt to be a model which was equally applicable to mental health services. Psychological management of all LTCs should be 'part of the day job' and, within the context of partnership care, mental health specialists should have a greater role in education and upskilling of generalists. Young people have particularly stressed the need for support for problems with stress and self harm.

42. **Children** This area needs further exploration, but initial views were that there is a lack of psychological and family support. There are big gaps, such as Autism (now 1:80) and age transitions. Obesity is not being systematically tackled. GPs and others are become more and more risk averse around children and paediatric training for GPs should be mandatory. Partnership care is an excellent model for Paediatrics.

43. **Therapeutics** Clinicians recognised that a whole system and strategic approach to therapeutics was required and that the importance of this was mostly under-estimated.

44. The Future Fit Programme Board[2] received this initial output at its meeting on 10th March and agreed that it would now be subject, during Phase II of the programme, to extensive testing and refinement:

    - A process of refinement, through a number of cycles, using patient scenarios, patient characteristics and flow volumes and financial impact
    - A further review of the evidence base around each component of the model
    - External clinical assurance from an expert clinical team overseen by the West Midlands Clinical Senate
    - Clinical engagement will be deepened, both by continuing involvement of the clinicians in the clinical referenced group and subgroups and through events such as webinars and meetings, designed to reach 2/3 of the clinical workforce.
    - Patient representatives and patient groups will continue to be involved and co-creating at every stage of the process.

45. The more detailed clinical vision developed through this further work be included within the final Strategic Plan submission in June.

[2] The Future Fit programme is described in more detail in paragraph101 below

Improving Outcomes

46. Locally both CCGs have patients and the quality of care that they experience at the centre of their work. We believe that by measuring outcomes rather than units of activity we will have ambitions that are meaningful across health, social care and most importantly our patients. As we continue our work locally with patient participation groups and Healthwatch we intend to develop the use of health outcomes as measures of success for the delivery of good quality health and special care services that meet the needs of our patients and their carers. These local measures will vary across Shropshire and Telford & Wrekin CCGs based on the specific needs of their local populations and our differing degrees of rurality.

National Outcome Ambition	Outcome Indicator	SHROPSHIRE CCG		TELFORD CCG	
		Current performance	5yr ambition	Current performance	5yr ambition
Securing additional years of life for the people of England with treatable mental and physical conditions	*Potential years of life lost from conditions considered amenable to healthcare: adults, children and young people*	1960.7 (2012) DSR per 100,000 population Above average compared to national	*Awaiting feedback from area team due to year on year variability*		
Improving the health related quality of life of the 15+ people with one or more long-term condition, including mental health conditions	*Health related quality of life for people with long-term conditions*	73.7	75.5		

Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	*Unplanned hospitalisation for chronic ambulatory care sensitive conditions*	557.8 (2012)DSR per 100,000 population Best quartile compared to national and CfV CCG group	Maintain position		
	Unplanned hospitalisation for asthma, diabetes end epilepsy in under 19s.	335 (2012) DSR per 100,000 population- below average	15% improvement		
	Emergency admissions for acute conditions that should not usually require hospital admission	986.8 (2012) DSR per 100,000 population Best quartile compared to national and CfV CCG group	Maintain position		
	Emergency admissions for children with lower respiratory tract infections	423.8 (2012) DSR per 100,000 population	7% improvement		
	Composite measure -	1516.7 (2012) DSR per 100,000 population	Maintain position		

		Best quartile compared to national and CfV CCG group			
Increasing the proportion of older people living independently at home following discharge from hospital	*No indicator available – please see section below.*				
Increasing the number of people with mental and physical health conditions having a positive experience of hospital care	*Patient experience of hospital care*	158.6 (2012) DSR per 100,000 population	14 % improvement		
Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community	*Awaiting feedback from area team as CCGs can only see performance on OOH experience*	4.5 (2012) in best quartile (OOH)	Maintain position (OOH)		

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Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	*Indicator in development – please see section below.*				
Local Outcome Ambition	Outcome Indicator	SHROPSHIRE CCG		TELFORD CCG	
Enhancing quality of life for people with dementia	*Estimated Diagnosis Rate for People with Dementia*	42%	TBA		
Improving functional ability in people with long-term conditions	*People with COPD & MRC Dyspnoea scale >=3 referred to pulmonary rehab programme*	Baseline being determined for Q4 2013/14	20% improvement by March 2015 TBA improvement by March 2018		
Reducing premature deaths in people with learning disabilities	*The % uptake of health checks for adults with learning disabilities*	53.9%	60% by March 2014 TBA by March 2018		

The following national ambitions have been set but have yet to have indicators agreed. Locally we have set the following ambitions linked to work already started:-

Increasing the proportion of older people living independently at home following discharge from hospital
In Shropshire the ambition has been set within the Better Care Fund that the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services will increase by 15% between March 2013 and June 2015. This will be a direct measure of the effectiveness of our new Integrated Community Service piloted during the recent winter period and planned for further roll out and development over the next 6-9 months.

In Telford ……***to be completed***.

Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care
To be completed

47. Both CCGs have started working with Health and Wellbeing Board partners to strengthen **commissioning for prevention**. This is identified as a priority in both Better Care Fund submissions and CCG Operational Plans set out in more detail how each CCG is implementing the 5 steps recommended in the "commissioning for prevention" report.

48. Tackling **health inequalities** is a priority for both CCGs. People living in the most deprived fifth of the population, particularly men are significantly more likely to have lower life expectancy and higher premature mortality than the average. However, different population groups have different experiences of health inequalities: young women from the most deprived areas are more likely to smoke in pregnancy and not breastfeed their babies, mental illness is more likely to be experienced by vulnerable groups (e.g. looked after children) and physical inactivity and prevalence of disease is more likely to be experienced by older age groups. Men with severe mental illness die 20 years younger than average and for women with severe mental illness it is 15 years. 42% of all tobacco is smoked by those with mental health problems and this group also have higher levels of obesity.

49. **Telford and Wrekin** as a whole is relatively deprived with certain areas (such as Malinslee and Woodside) ranked within the top 10% most deprived nationally (Index of Multiple Deprivation, 2010). Almost a third of Telford & Wrekin's young people live in areas ranked in the most deprived nationally.

50. Whilst **Shropshire**, overall, is less relatively deprived compared to national comparators, the same health inequalities gradient applies to the population within the county, with those who are more deprived consistently having more ill-health and lower life expectancy than those who are less deprived. Shropshire also has a relatively older population and will have an increasingly ageing population over the next five years; therefore it is likely that the prevalence of disease will increase.

51. Shropshire is also a large, sparsely populated rural county which creates particular challenges in relation to health inequalities. Smaller pockets of deprivation may not be apparent at the aggregate population levels at which comparative information is compiled so that **rural deprivation** is less visible within this data. A rural health survey undertaken recently for the Shropshire Health and Wellbeing Board identified access to services and fuel poverty as issues of particular priority for people living in rural areas.

52. CCG Operating Plans include more detail on the actions which are being taken to implement the 5 five most cost effect high impact interventions recommended by the National Audit Office report on health inequalities.

53. Shropshire and Telford & Wrekin CCGs jointly led the implementation of the **Equality Delivery System (EDS)** across the local health community, establishing an Equality Delivery Steering Group with broad representation, including community interest groups, local NHS Trust and the Local Authorities. A similar approach is being planned to ensure the effective implementation of EDS2. We will be working with the community interest groups to start a dialogue of how we are meeting the EDS2 goals and work with them to identify areas for development over the next four years.

54. **Parity of Esteem** Both CCGs are committed to improving outcomes and addressing health inequalities for people with mental health needs. Mental and emotional health has been identified as a priority area for both Health and Wellbeing Boards, with a particular emphasis on supporting people with dementia and the mental and emotional health and wellbeing of young people. In the recent Call to Action, this was identified by young people as their highest priority.

55. CCG Operational plans include more detail regarding the implementation of the specific priorities arising from the Royal College of Psychiatrists report Whole Person Care: From rhetoric to reality and the recent Department of Health Closing the gap report.

56. A major investment and service transformation programme for local **mental health services** was approved in 2009. This has seen the opening of a new in-patient facility (The Redwoods Centre) and investment in community mental health services. Commissioners are working with South Staffordshire Foundation Trust to undertake a review achievement against the benefits realisation plan for this programme to inform the commissioning of these services.

57. The emerging vision for service transformation includes a clear view from local clinical leaders that mental health should be integrated with primary, community and

acute health care (paragraph 41 above). The implications of this principle for service design will be refined in the next phase of the Future Fit programme.

Patient Services

58. Both CCGs have put the **engagement of citizens** in their care, in the design of services and in commissioner decision-making at the heart of their everyday business. CCG committees are established which review the work programmes and activities of the CCGs to ensure that patients and the public are being effectively engaged in all aspects of the commissioning process. Support is provided to patient and public representatives to enable them to engage effectively in this work.

59. The CCGs led a major local engagement process as part of the national Call to Action programme. Almost 3,000 responses were received and the Call to Action process was brought together at a conference in November 2013 at which the Chief Executive of NHS England was the keynote speaker. Key messages from the Call to Action – from the public and from local clinicians – are shaping the Future Fit programme. There is strong representation from patient groups on the Programme Board and a substantial programme of public and patient engagement will ensure that there is meaningful and authentic citizen participation in the design of the plans and decision-making process.

60. There is a strong network of practice patient participation groups (PPGs) which provide a strong foundation for public engagement. CCGs have also been working closely with Healthwatch organisations and building wide networks of engagement to include PPGs, voluntary sector organisations, disease specific groups, groups based in particular localities, disease specific groups and young people.

61. Engagement with young people includes the development of Youth Champions. The aim is for these young people to become active and valued partners, working with service providers and commissioners, to jointly deliver better health and wellbeing outcomes. In addition to the benefits for our organisations and wider communities, the young people taking part will individually benefit through improved confidence and a sense of pride in their achievements.

62. Further information on the specific approaches of each CCG are set out in the CCGs' Operational Plan submissions.

63. **Wider primary care, provided at scale.** The contribution that primary care will be asked to make to the transformation of health and care services is central to the clinical vision and models of care that are being developed as part of the Future Fit programme (paragraphs 26 -40 above).

64. NHS England Area Teams are responsible for commissioning primary care services. The Shropshire and Staffordshire Area Team have established a group to develop a collaborative approach to the commissioning of primary care services and CCGs will support the Area Team through this group on this important area of work.

65. A GP Federation has been established by local practices. The Federation has developed plans to pilot the provision of primary care services at a 'cluster of

practices' level, to improve access, including seven day working. A bid has been made to the Prime Minister's Challenge Fund to support this proposal. Whether or not this bid is successful, the CCGs will work with the Federation to identify opportunities to enhance the primary care offer to patients.

66. Out of Hours services are provided by Shropshire Doctors, whose members comprise local GPs. Out of hours primary care is therefore provided almost exclusively by GPs who work in local practices. This supports the effective engagement of local primary care in the work of the Urgent Care Working Group. The Local Medical Committee is also represented on the Urgent Care Working Group.

67. **A modern model of integrated care.** Long term conditions is one of three core elements of the service model for health care delivery which is being developed by the Future Fit clinical design. Collaborative working and service integration are central to the high level model of care which is included in the initial output from this work and will be subject to further review and refinement in phase two of the programme.

68. Each of the CCGs has established strategies and plans for long term conditions. These are consistent with the high level models produced by the Future Fit programme and the development and implementation of existing priorities will continue alongside the Future Fit programme. Both CCG strategies focus on developing care closer to home and the establishment of integrated care teams based on clusters of GP practices. It is anticipated that this approach will result in a reduction of admissions to acute hospital beds.

69. CCG Operating Plans include more detail on the actions which are being taken to improve services for people with long term conditions and ensure that people with multiple long term conditions are offered a fully integrated experience of support and care.

70. **Urgent and emergency care** is one of three core elements of the service model for health care delivery which is being developed by the Future Fit clinical design. The principles and model of care which have been presented in the initial output from the Future Fit programme are fully consistent with the vision set out in the Phase One report from the Urgent and Emergency Care Review.

71. An analysis of the urgent and emergency care system was commissioned by partners in the urgent care system in 2013 and formed the basis of the working programme of the Urgent Care Working Group in 2013/14. This has enabled partners on Urgent Care Working Group to establish a shared understanding of patient flows, services and facilities and population needs which will inform decisions around the establishment of an urgent and emergency care network during 2014/15.

72. Early discussions have been held with partners across the Shropshire and Staffordshire area regarding the footprint of the urgent and emergency care network.

73. **Planned care** is one of three core elements of the service model for health care delivery which is being developed by the Future Fit clinical design. The model of care which is being developed through this work is aiming to create a less complex and fragmented system that will improve quality (outcomes and patient experience) and achieve improvements in productivity.

74. Elements of productivity improvement that have already been implemented for at least some specialties/pathways include greater utilisation of advice and guidance, new pathways for GP access to diagnostics, new community-based services as an alternative to hospital care, promoting day case surgery and the implementation of enhanced recovery.

75. CCG Operating Plans include more detail on the actions which are being taken to improve productivity in planned care, working towards the ambition to improve productivity by 20% within 5 years.

76. **Specialised services** are commissioned by NHS England. CCGs have not been informed of any specific changes to commissioning plans in relation to specialised services which will impact on the STW health community and need to be taken into account in the formulation of the CCGs' strategic and operational plans.

77. Both CCGs will continue to monitor **access to services** and patient experience for all commissioned services and seek, within available resources, to improve access to services where that is required to meet patient needs.

78. **Examples of improvements** to access developed over the last year include the development of community ophthalmology services, the development of community cardiology service in Telford, the development of a community pain service, the introduction of tele-dermatolgy and a new portal – 'compass' – for children's services in Shropshire.

79. The Call to Action identified **access to General Practice** as a top priority for patients.

80. Both CCGs are committed to meeting **NHS constitution standards** for access to services. These include standards in relation to:

- referral to treatment times for planned care
- diagnostic test waiting times
- cancer services
- A&E waiting time standard
- Category A ambulance calls

81. CCG Operating Plans include more detail on the plans which are in place to ensure that performance against these targets will be maintained and, where performance during 2013/14 has not met the standards, what action is being taken to improve performance to the standard required.

Quality

82. Both CCGs have established robust systems and processes to ensure commissioned services that are compassionate, high quality, safe, effective and good value for money and that individuals have a positive experience of their care delivery wherever that may be and whoever may deliver it.

83. Establishing clear and ambitious quality improvements for patients and challenging areas of poor performance and mediocrity is a priority.

84. Effective collaboration across CCGs including shared CQR meetings and enter and view arrangements are in place. These arrangements ensure systematic review and triangulation of patient safety and experience data for all locally commissioned services. This approach promotes initiatives to support positive engagement and shared learning with providers and partner organisations including local authorities, regulators bodies such as Health Watch and CQC.

85. The CCGs have established a single process for local analysis and triangulation of information from Serious Incidents and NHS-to-NHS concerns. This allows the opportunity to improve the quality and safety of services by identifying and reviewing proposed actions to reduce/ eliminate poor practice and share learning for improvement.

86. The review of maternity services jointly by the CCGs enabled a review of service user experiences of maternal care, at each stage of the mother's journey. As a result of this review agreed actions across partnership organisations are being implemented. In addition this work will be used to inform the future strategy for maternity services in line with the 'Future Fit' programme.

87. A hosted arrangement for Safeguarding and Infection Prevention and Control teams has successfully been implemented across both CCGs. This has ensured a shared approach to effectively utilising limited expertise and resources. Opportunities for similar arrangements with other partner commissioning organisations will continue to be explored.

88. A Promise to Learn - a commitment to act (National Advisory Group on the Safety of patients in England, 2013 p4) will continue to underpin the CCGs' principles and values approach to quality. We will:

    - Place the quality of patient care, especially patient safety, above all other aims;
    - Engage and empower, and hear patients and carers at all times;
    - Foster whole-heartedly the growth and development of all staff, including their ability and support to improve processes in which they work; and
    - Embrace transparency unequivocally and everywhere, in the service of accountability, trust and the growth of Knowledge.

89. The CCGs have their own frameworks for improvement and assurance which consistently review if the relevant Board's actions have resulted in an improvement in the delivery of commissioned services for patients, clinicians and staff.

90. There is a shared commitment to create and maintain a culture of continuous quality improvement, openness, transparency and candour across the healthcare system.

91. A health economy *Harm Free Care* group has been sponsored by both CCGs and local providers with contribution from local patient group representatives. The key areas of work have included pressure ulcer reduction, falls, Catheter acquired urinary Tract infections (Cauti's), VTE, Patient Involvement, Nutrition. This has also been one of the main vehicles for embedding the NHS 6cs initiative "Developing our culture of compassionate care" - Care, Communication, Competence, Courage and Compassion, Commitment across the local health care system to enable the national vision for nursing, midwifery and caregivers is implemented and monitored.

92. The need for high quality urgent and emergency care services outside of hospital across the seven day week is being addressed through a review of ambulance service provision, taking account of both urban and rural communities across the geography, and in the development of integrated community services. Local out-of-hours GP services offer a high standard of care and are well regarded by the local population. New national guidance is expected in relation to the NHS 111 and will inform a re-procurement of the NHS 111 service. The CCGs are working with SaTH regarding the requirement to meet the Seven Day Service Clinical Standards by 2016/17. Achieving all of these standards will be very challenging for SaTH because of its two site working.

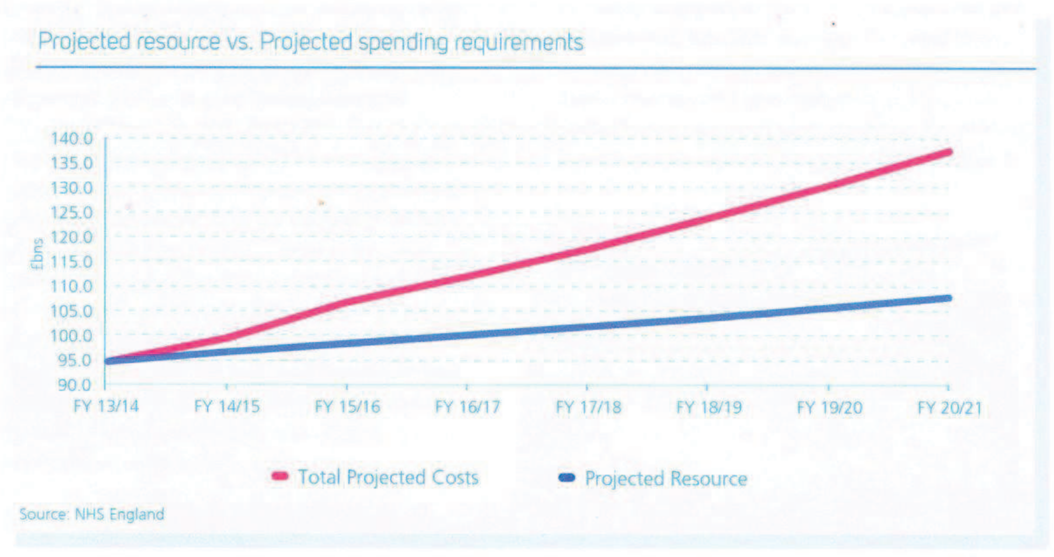
93. Continuous monitoring of staff experiences and the establishment of clear areas for quality improvement in workforce metrics within commissioned services will continue to support the need to ensure the integration of future workforce requirements.

94. The CCGs aim to continue to create an environment that does not accept mediocre or poor practice or service delivery but also works in a supportive way with all commissioned services to continuously improve service quality and patient experience.

95. National guidance sets out the responsibility CCGs have in relation to improving quality in primary care. To achieve these aims both CCGs must work in close partnership with local Practices and the NHS England Area Team on every level.

Sustainability

96. NHS England's "A call to Action" document acknowledged that the NHS had succeeded in achieving £20bn in efficiency savings by 2015 but set out a further challenge for £30bn savings by 2021 as a result of an ageing society, changing burden of disease, lifestyle risk factors in the young, rising expectations and increased costs.



97. Locally both CCGS have collaborated with all health system providers to establish the likely resources available to fund care in future years alongside the likely cost pressures including demographic and non-demographic demand to establish the scale of the health economy future financial challenge. The Finance Executives of Shropshire CCG, Telford & Wrekin CCG, Robert Jones & Agnes Hunt FT, SaTH and Shropshire Community Trust have met and shared current financial positions, forecasts and assumptions.

98. The key planning assumptions that have been applied are in line with the commissioning organisations planning assumptions and Medium Term Financial Strategies and are shown in the tables below:

Telford & Wrekin CCG

Description	Type	2014/15	2015/16	2016/17	2017/18	2018/19
Allocation Growth (+%)	Programme	2.14%	1.70%	1.83%	1.73%	1.73%
	Running Costs	-0.14%	-10.23%	0.00%	0.00%	0.00%
Gross Provider Efficiency (-%)	Acute	-4.00%	-4.00%	-4.00%	-4.00%	-4.00%
	Non Acute	-4.00%	-4.00%	-4.00%	-4.00%	-4.00%
Provider Inflation (+%)	Acute	2.60%	2.90%	4.40%	3.40%	3.30%
	Non Acute	2.30%	2.20%	3.00%	3.40%	3.40%

Demographic Growth (+/- %)		1.54%	1.47%	1.45%	1.54%	1.55%
Non-Demographic Growth (+/- %)	Acute	0.50%	2.30%	2.20%	2.20%	2.50%
	CHC	0.00%	3.50%	3.50%	3.50%	3.50%
	Prescribing	7.00%	7.00%	7.00%	7.00%	7.00%
	Other Non Acute	0.50%	2.30%	2.20%	2.20%	2.50%

Shropshire CCG

Description	**Type**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Allocation Growth (+%)	Programme	2.14%	1.70%	1.80%	1.70%	1.70%
	Running Costs	-0.62%	-10.33%	1.07%	0.00%	0.00%
Gross Provider Efficiency (-%)	Acute	-4.00%	-4.00%	-4.00%	-4.00%	-4.00%
	Non Acute	-4.00%	-4.00%	-4.00%	-4.00%	-4.00%
Provider Inflation (+%)	Acute	2.60%	2.90%	4.40%	3.40%	3.30%
	Non Acute	2.20%	2.90%	3.60%	3.40%	3.40%
Demographic Growth (+/- %)		4.00%	0.49%	0.49%	0.49%	0.49%
Non-Demographic Growth (+/- %)	Acute	0.00%	0.00%	0.00%	0.00%	0.00%
	CHC	0.00%	2.00%	2.00%	2.00%	2.00%
	Prescribing	4.00%	4.00%	4.00%	4.00%	4.00%
	Other Non Acute	0.00%	0.00%	0.00%	0.00%	0.00%

99. The shared consensus within the health system is that the 2014/15 affordability envelope presents a £28m financial gap challenge for the health system. This will increase year on year by c£13m across the health economy to present a challenge of £106m by 2021 if no action is taken to address it. It is anticipated that, in addition to the overall financial gap there will be a further movement between points of delivery as a result of the implementation of the Better Care Fund which will have the impact of reducing the financial envelope for SaTH from a combined value of £205.2m in 13-14 to a combined value of £188.9m in 2018/19.

100. Commissioning and provider organisations are collaborating to address this gap through congruence of benchmarking (e.g. Right Care Right Value, Anytown) service transformation strategies (Urgent Care, Planned Care, Long Term Conditions and medicines management), business plans and Medium Term Financial Strategies.

Delivering Service Transformation

101. Future Fit is a collaborative programme through which health and care partners across Shropshire, Telford & Wrekin and the area of Powys which looks to Shrewsbury and Telford Hospital as its main provider of acute hospital services, are working together to address some of the strategic challenges set out in this plan (paragraphs 18-25). Membership of the programme board includes Shropshire and Telford and Wrekin CCGs, Powys Local Health Board, Shropshire Doctors, a general practice representative, Shrewsbury and Telford Hospital NHS Trust, Shropshire Community Health NHS Trust, Shropshire and South Staffordshire Foundation Trust, Robert Jones and Agnes Hunt Foundation Trust, West Midlands Ambulance Service, Shropshire and Telford & Wrekin Councils, Shropshire and Telford & Wrekin Healthwatch, Montgomeryshire Community Health Council, patient representatives from each commissioning area. The programme is also developing strong links with the Joint Health Overview and Scrutiny Committee and with both Health and Wellbeing Boards and is commissioner led in line with NHS England planning guidance.

102. The programme's remit includes the development of:

    - A high level clinical vision (the first output of which forms the basis of the emerging vision for service transformation presented in this plan)
    - Models of care
    - Activity projections for hospital and community services
    - Whole LHE financial models

    All of these outputs will be completed within phase 2 of the programme, which is scheduled to be completed by [DN: insert when confirmed]. Subsequently the programme will undertake an option appraisal to identify a preferred option for the configuration of acute and community hospital services which will best support the agreed clinical vision and models of care, develop a full business case and manage the implementation of capital infrastructure developments and associated service changes.

103. The creation of the programme demonstrates a recognition across the health and care system of the case for changes and a commitment to work together to create a sustainable future for healthcare for Shropshire and Telford & Wrekin. Programme support and governance structures have been put in place to ensure that the management of the programme meets best practice standards and there will be external assurance of the process and key products from the programme. This includes the involvement of the West Midlands Clinical Senate to review the clinical models, the formal assurance role of NHS England, OGC Gateway reviews at appropriate points throughout the programme and oversight by Shropshire and Telford and Wrekin Councils' Joint Health Overview and Scrutiny Committee.

104. There are a number of other key structures in place through which partners in the health and care system plan and implement service transformation. In particular:

- Health & Wellbeing Boards
- Urgent Care Working Group
- Planning Care Working Group
- Long Term Conditions Strategy Groups for each CCG area.

105. One of the key tasks during Phase 2 of the programme will be to identify which elements of the new models of care are dependent on major changes to hospital configuration (which will be managed through the subsequent phases of the programme) and which can be implemented – whether fully or in part – within the current hospital configuration. We will then review the contribution that current improvement interventions will make to the implementation of the new models of care agreed through the Future Fit programme and identify areas where further work is needed. From this, a comprehensive programme of improvement interventions will be developed aligned with Future Fit clinical models and activity and financial plans.

106. Responsibility for delivering elements of the programme of improvement interventions that fall outside the core remit of the Future Fit programme will need to be clearly defined and managed through appropriate delivery and governance structures. For those improvement interventions that require investment in integrated health and social care services it is likely that Health and Wellbeing Boards will take lead responsibility for commissioning service transformation through the Better Care Fund. We would anticipate also that the Urgent and Planned Care Working Groups and the Long Term Conditions Steering Groups will also have a key role to play. This will be the subject of further work prior to next submission of the Strategic Plan in June 2014.

107. Organisation specific priorities and key risks to delivery of the strategic plan will be incorporated into the final plan submission in June.

A Shared Commitment

108. In 2013, Shropshire and Telford & Wrekin CCGs, alongside their main providers and local authority partners, agreed a **Health & Social Care Partnership Compact**, which set out a vision and principles for collaborative working. This was incorporated into the Principles of Joint Working set out in the Future Fit Programme Execution Plan.

109. **Key principles** were agreed which "have become, and must remain, central to the operational planning and delivery of transformational change across the health and social economy". These principles are:

- The central role of attitudes, behaviours and relationships
- Healthy stakeholder organisations which are capable of large scale change
- Enduring full stakeholder involvement
- Clinical engagement at the heart of the change process
- Working across organisational boundaries
- Developing integrated teams

110. The following **Principles of Collaborative Working** are set out in the Compact:

- We will seek authentic savings – making changes which reduce costs through higher quality, service redesign and real productivity. We will seek to avoid making changes which save costs in one part of the system only to result in equal or greater costs to another organisation.

- We will share the financial risk of making agreed system-wide changes which form part of our work programme, using an open-book approach to assess the costs and benefits of system and service change to individual organisations with the aim of reallocating resources across the health and care system to reflect impacts arising from the changes.

- We will make shared decisions about which major whole-system innovations to roll-out at scale, recognising that any innovation may not always favour all parties and that at times some individual sacrifice for the common good will be necessary.

- We will share appropriate information and records where that facilitates improved outcomes for the people we serve.

- We will take collective responsibility for making progress towards our shared strategic vision and will agree a shared set of objectives and measures of success through which we will individually and collectively hold ourselves to account.
- We will commit our organisations to a programme of collaborative work, to be agreed through the Shropshire, Telford and Wrekin Chief Officers Group. We will provide the necessary resources to individual projects and

programmes and ensure senior clinical and executive participation and leadership, usually through existing groups and structures.

- We will share in the overall governance of the work, through individual boards and jointly through the Chief Officers Group.

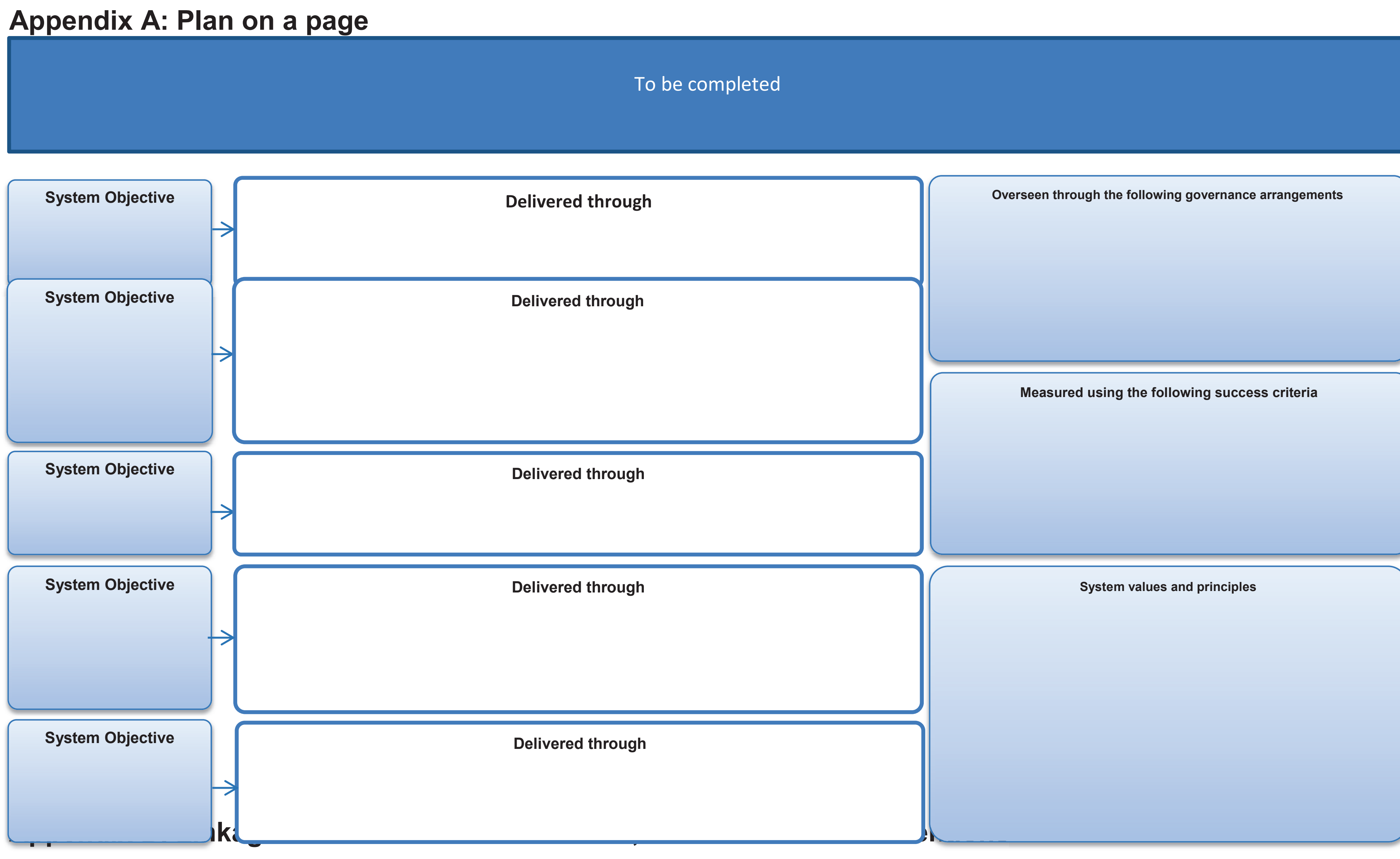
- We will share organisational plans and be transparent about budgets, costs, activity and utilisation data where that is required to enable the best joint decision making and the agreement of three-year financial strategies for each part of the health and social care system and for the system overall.

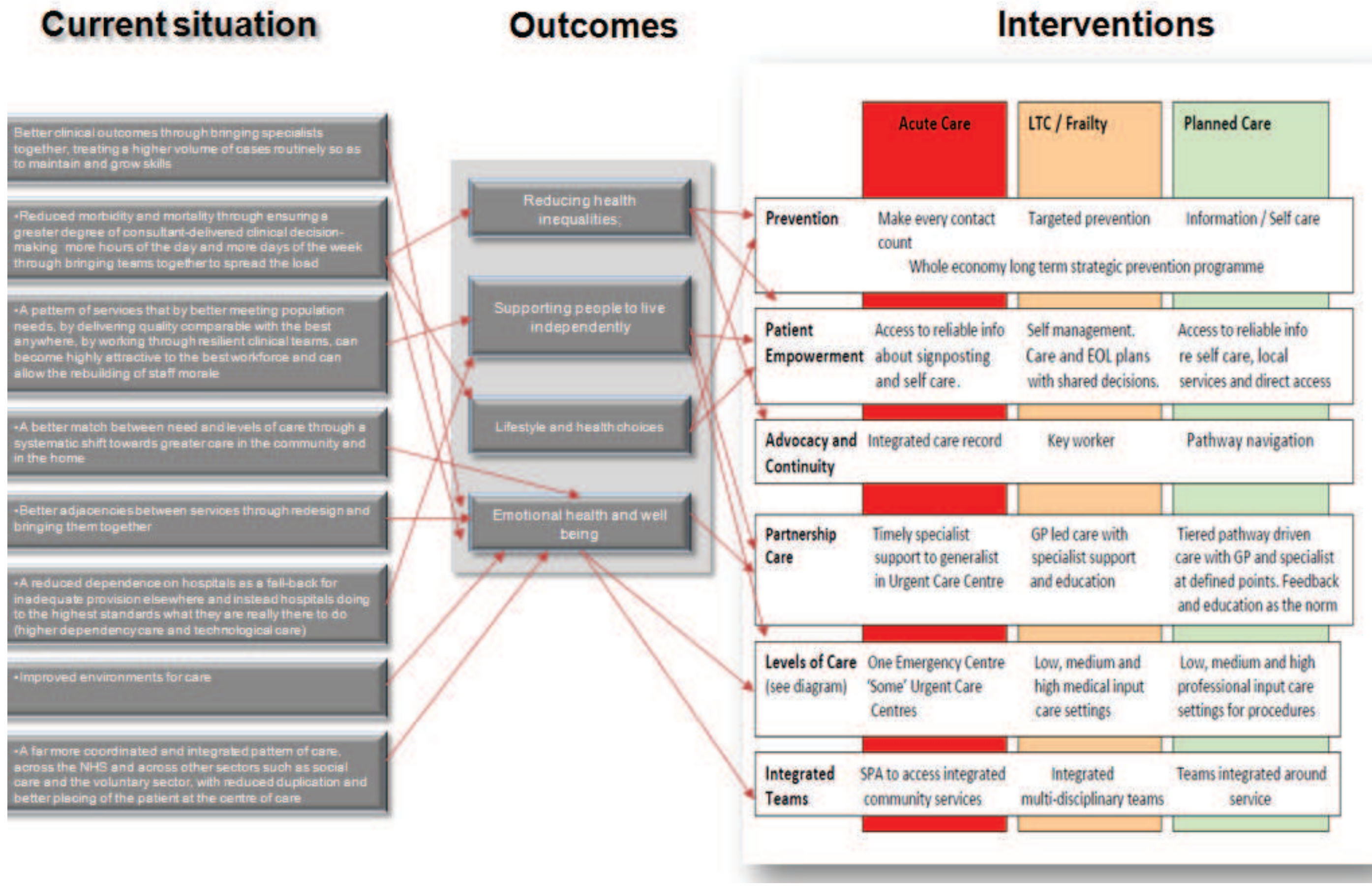
- We will respect the need for individual organisations to pursue their own objectives alongside these whole system objectives. We recognise that aspects of the system will be subject to competition, whether through national policy or local decisions made by commissioners, and that this may in some circumstances limit the information which an individual organisation is willing or able to share. All efforts will be made to minimise the risk that this might compromise achievement of the objectives of this Compact.

- We will remain mindful of the impact we may have on other providers within our wider health economy not represented in this compact agreement.

- This Compact will support and complement the wider strategic role of Health and Wellbeing Boards in setting health and well-being strategies for Local Authority areas and overseeing achievement against them.

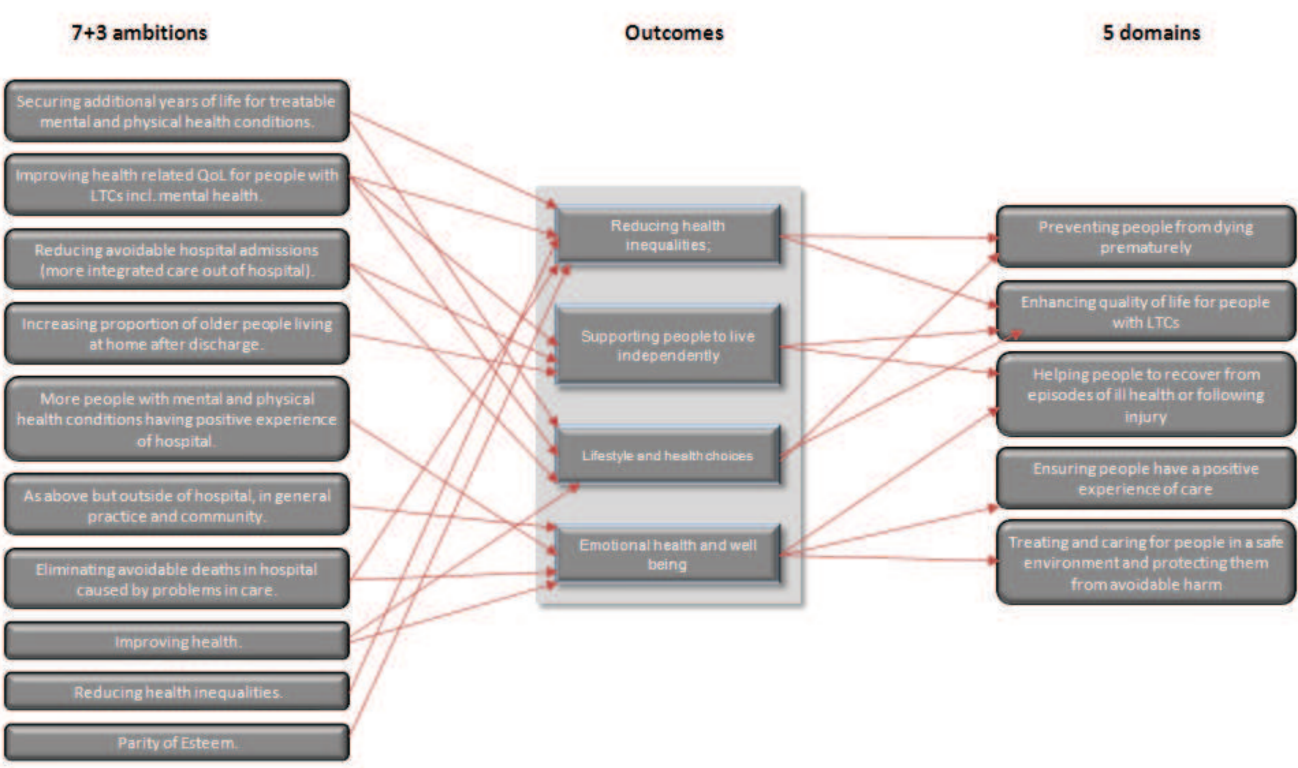
Appendix A: Plan on a page





We have ensure that our outcomes are aligned to achieving improvements based on the current situation, future needs and the necessary interventions to deliver the necessary changes

Appendix C: Our outcomes in the context of the ambitions and domains



There are clear linkages between the ambitions, our defined outcomes and the 5 domains

Appendix D: Correlation between out strategy document and key requirements of NHS England

Requirement	Primary description
5 domains	
5 outcome areas	
7 day working	
A modern model of integrated care	
A step-change in the productivity of elective care	
Ambitions and outcomes	
Clinician engagement	
Community and patient engagement	
Context	
Data and analytics	
Do the objectives and interventions take into consideration the current state?	
Does the two year detailed operational plan submitted provide the necessary foundations to deliver the strategic vision described here?	
Does this correlate to the Commissioning for Value packs and other benchmarking materials?	
Enabler - Access	
Enabler - Innovation	
Enabler - Quality	
Enabler - Value / Finance / Sustainability	
Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care	
Has an assessment of the current state been undertaken? Have opportunities and challenges been identified and agreed?	
How does the five year vision address Delivering a sustainable NHS for future generations?	
How does the five year vision address Improving health outcomes in alignment with the seven ambitions	
How does the five year vision address Reducing health inequalities?	
How does the vision include the six characteristics of a high quality and sustainable system and transformational service models highlighted in the guidance?	
How does your plan for the Better Care Fund align/fit with your 5 year strategic vision?	
Is there a clear 'you said, we did' framework in place to show those that engaged how their perspective and feedback has been included?	
IT	
Leadership	
Organisational development	
Parity of esteem	
Prevention	
Self care and self management	
Specialised services concentrated in centres of excellence (as relevant to the locality)	
Who has signed up to the strategic vision? How have the health and wellbeing boards been involved in developing and signing off the plan?	
Wider primary care, provided at scale	

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Clinical Design Workstream

A Report of Output

November 2013 -March 2014

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1. Introduction

The Clinical Design workstream was established in November 2013 and used the results from the patients' and clinicians' Call to Action survey and meetings as a starting point for its work. From this, it has established an approach to ensure that the future of hospital and community services are considered within the context of the whole system. It has embedded a process which maximises patient and clinician engagement and co-creation, and agreed that there is a compelling case for change. It has also considered the clinical and design principles applicable to the whole system and key components within it, examined the national and international evidence base and formulated high level models of care across the whole system which have undergone some initial testing.

The output up to this point, together with a summary of next steps, is described fully in the following report and is summarised in the illustration overleaf.

2. Scope of the Clinical Design workstream

The design of high quality, safe, efficient and sustainable hospital services must be done within the context of a coherent and deliverable whole system plan. So, although the scope of the FutureFit programme is confined to the future of acute and community hospital services, the clinical design work stream is required to consider the health and social economy as a whole and establish models of care which fully integrate all services within it. The success of FutureFit is likely to depend on achieving whole system transformational change. This has significant implications for commissioners as well as the organisations, services and workforce that currently lie beyond the scope of this programme.

Reablement	Increased Levels of Care for LTC	Levels of Care Planned care	Acute and Episodic Care
Reablement at home • Integrated teams • Generic workers • Voluntary sector involvement • Ambulatory reablement in community facility as an option? • Return to original level of care • Updated care plan	**Low Medical Input** • 'Hospital at home' • Low acuity exacerbation • Low medical input but high care input • Team around patient • Sustainable community support	**Low Professional Input** •Multiple centres for day case/minors •Basic diagnostics (Xray/USS) •Access to therapies	
Reablement in community • Intensive rehabilitation • 'Step down' • Co-ordinated EDD and discharge planning • Resolving exacerbation requiring additional care? • Social issues to be resolved? • Permanent higher level of care required?	**Medium Medical Input** **['Health Hub' Community beds]** • Medium acuity exacerbation • 'Step up' • Integrated Acute and Community services • Designated and resourced private sector beds • Potential urgent care centre adjacencies	**Medium Professional Input** •One or two local centres for intermediates/ day case (may or may not be co-located with high input centre) •Diagnostics (USS/CT/MRI/Nuclear etc.)	**'Some' Urgent Care Centres**
	High Medical Input • One high acuity centre • 7 day maximum LOS • Early supported discharge **0 day LOS** • Ambulatory care • Subacute frailty assessment **3 day LOS** • Frailty • Assessment units **Mental Health Beds** • Medico-legal place of safety	**High Professional Input** •One centre for majors (co-located with but separate from emergency centre) • HDU • Diagnostics (USS/CT/MRI/Nuclear etc.) •Referrals out of area for cardiac, neuro, etc.	**One Emergency Centre**

3. Process

Following the Call to Action surveys and events, a Clinical Reference Group comprising 50 senior clinicians from health and social care, along with patient representatives, met on November 20th 2013 to receive the results, from which a case for change was established and whole system design principles were debated and agreed.

The Clinical Reference Group met again on January 29th 2014, during which it confirmed the output from the first meeting, suggested what success would look like and how to measure it and discussed the clinical and design principles applicable to the three main areas of health care delivery:

- Acute and Episodic Care;
- Long Term Conditions / Frailty, and;
- Planned Care.

Three subgroups were formed to consider these areas further; each subgroup comprising approximately 30 clinicians from health and social care along with patient representatives. They each met for six hours during February 2014 to add more detail to the design and clinical principles, to establish high level models of care in each area and to begin a process of sense checking, testing and refinement of the models.

The core Clinical Design workstream, reporting to the Programme Team, has planned and overseen this process and will remain responsible for the next steps described at the conclusion of this report.

4. The Case for Change

4.1 Background

There are already some very good health services in Shropshire, Telford and Wrekin. They have developed over many years to try to best meet the needs and expectations of the populations served, including that of Mid-Wales. Nevertheless, when we look at the changing needs of the population now and that forecast for the coming years; when we look at the quality standards that we should aspire to for our population, as medicine becomes ever more sophisticated; and when we look at the economic environment that the NHS must live within; then it becomes obvious that the time has come to look again at how we design services so we can meet the needs of our population and provide excellent healthcare services for the next 20 years.

When considering the pattern of services currently provided, our local clinicians and indeed many of those members of the public who have responded to the recent Call to Action consultation, accept that there is a case for making significant change provided there is no predetermination and that there is full engagement in thinking through the options. They see the opportunity for:

- Better clinical outcomes through bringing specialists together, treating a higher volume of cases routinely so as to maintain and grow skills
- Reduced morbidity and mortality through ensuring a greater degree of consultant-delivered clinical decision-making more hours of the day and more days of the week through bringing teams together to spread the load
- A pattern of services that by better meeting population needs, by delivering quality comparable with the best anywhere, by working through resilient clinical teams, can become highly attractive to the best workforce and can allow the rebuilding of staff morale
- Better adjacencies between services through redesign and bringing them together
- Improved environments for care
- A better match between need and levels of care through a systematic shift towards greater care in the community and in the home
- A reduced dependence on hospitals as a fall-back for inadequate provision elsewhere and instead hospitals doing to the highest standards what they are really there to do (higher dependency care and technological care)
- A far more coordinated and integrated pattern of care, across the NHS and across other sectors such as social care and the voluntary sector, with reduced duplication and better placing of the patient at the centre of care

They see the need and the potential to do this in ways which recognise absolutely the differing needs and issues facing our most dispersed rural populations and our urban populations too.

This then is the positive case for change - the opportunity to improve the quality of care we provide to our changing population.

4.2 The Challenges

Our local clinicians and respondents to the Call to Action also see this opportunity to systematically improve care as being a necessary response to how we address the many challenges faced by the service as it moves forward into the second and third decades of the 21st century.

These challenges are set out below - they are largely outside our control and we have to adapt our services to meet them:

4.2.1 Changes in our population profile

The remarkable and welcome improvement in the life expectancy of older people that has been experienced across the UK in recent years is particularly pronounced in Shropshire where the population over 65 has increased by 25% in just 10 years. This growth is forecast to continue over the next decade and more. As a result the pattern of demand for services has shifted with greater need for the type of services that can support frailer people, often with multiple long-term conditions, to continue to live with dignity and independence at home and in the community.

4.2.2 Changing patterns of illness

Long-term conditions are on the rise as well, due to changing lifestyles. The means we need to move the emphasis away from services that support short-term, episodic illness

and infections towards services that support earlier interventions to improve health and deliver sustained continuing support, again in the community.

4.2.3 Higher expectations

Quite rightly, the population demands the highest quality of care and also a greater convenience of care, designed around the realities of their daily lives. For both reasons, there is a push towards 7-day provision or extended hours of some services, and both of these require a redesign of how we work given the inevitability of resource constraints.

4.2.4 Clinical standards and developments in medical technology

Specialisation in medical and other clinical training has brought with it significant advances as medical technology and capability have increased over the years. But it also brings challenges. It is no longer acceptable nor possible to staff services with generalists or juniors and the evidence shows, that for particularly serious conditions, to do so risks poorer outcomes. Staff are, of course, aware of this. If they are working in services that, for whatever reason, cannot meet accepted professional standards, morale falls and staff may seek to move somewhere that can offer these standards. It is also far more difficult to attract new staff to work in such a service. Clinicians are a scarce and valuable resource. We must seek to deploy them to greatest effect.

4.2.5 Economic challenges

The NHS budget has grown year on year for the first 60 years of its life ......in one decade across the turn of the 21st century its budget doubled in real terms. But now the world economy and the UK economy within that is in a different place. The NHS will at best have a static budget going forward. And yet the changing patterns of population and resultant need, the increasing costs of ever improving medical technology, the difficulties in simply driving constant productivity improvements in a service that is 75% staff costs and that works to deliver care to people through people, mean that without changing the basic pattern of services then costs will rapidly outstrip available resources and services will face the chaos that always arises from deficit crises.

4.2.6 Opportunity costs in quality of service

In Shropshire and Telford and Wrekin the inherited pattern of services, especially hospital services, across multiple sites means that services are struggling to avoid fragmentation and are incurring additional costs of duplication and additional pressures in funding. The clinical and financial sustainability of acute hospital services has been a concern for more than a decade. Shropshire has a large enough population to support a full range of acute general hospital services, but splitting these services over two sites is increasingly difficult to maintain without compromising the quality and safety of the service.

Most pressingly, the Acute Trust currently runs two full A&E departments and does not have a consultant delivered service 16 hours/day 7 days a week. Even without achieving Royal College standards the Trust currently has particular medical workforce recruitment issues around A&E services, stroke, critical care and anaesthetic cover. All of these services are currently delivered on two sites though stroke services have recently been brought together on an interim basis. This latter move has delivered measurable improvements in clinical outcomes.

4.2.7 Impact on accessing services for populations living in two urban centres and much more sparsely populated rural communities

In Shropshire, Telford and Wrekin there are distinctive populations. Particular factors include our responsibility for meeting the health needs of sparsely populated rural areas in the county, and that services provided in our geography can also be essential to people in parts of Wales. Improved and timely access to services is a very real issue and one which the public sees as a high priority. We have a network of provision across Community Hospitals that can be part of the redesign of services to increase local care.

5. Acute and Episodic Care

5.1 Key Principles

5.1.1 Care close to home

An enhanced and integrated education and prevention programme, driven by a commitment to wellbeing as a primary health, social, economic, political and cultural aim, without which the sustainability and quality of services in the future will be seriously threatened. This is discussed further in the LTC section.

Easy access to understandable and trustworthy information about self care options and local services, combined with clear signposting to points of access appropriate for the level of urgent or emergency care required.

A single point of access for professionals to navigate patients to a wider range of integrated and community based services.

Urgent (not emergency) care delivered by expert community generalists as a default, with prompt access to specialist advice and opinion when required.

5.1 2 A needs led service

Patient access to urgent and emergency care should be dependant on the level of care they require. Quality, safety and achieving the best outcomes will come before choice. Services will be rationalised so they are more consistent in their quality and the services they offer. This will make it easier to effectively triage, signpost and brand to ensure more appropriate attendances at the right point of care, which should be the least intensive level required to fully meet every patient’s needs in order to maximise efficiency and reduce iatrogenic harm.

5.1.3 Integrated care

Integrated care records are a necessary component of an integrated health and social care system and their development should be of the highest priority. Patients regard them as a reasonable proxy for continuity of care.

Agreed pathways of care should run seamlessly across the whole system and span whole patient journeys. They should be consistent across all localities, 7 days a week. Local variation due to rurality should not obstruct integration.

There should be smooth transitions between levels of care. Providers should define their transitions as carefully as their core business.

Holistic assessments should be the default in all care settings.

5.1.4 Care by experts

An early expert opinion should be available from senior clinicians in all settings. A principle of right care first time: 'triage – diagnose – treat / palliate' should be the default.

An education, training and workforce review will be required and new roles developed in order to provide expert opinions in all settings 7 days a week.

5.1.5 Consistent and consolidated services

A single high acuity emergency centre, providing expert specialist and generalist led services, will provide multiple clinical benefits. It will consolidate resources, improve teamwork and integration, improve quality and safety, allow more effective generalist support in lower acuity settings and provide an economy of scale and high volumes of care to maximise expertise and improve outcomes.

'Some' community based urgent care centres, staffed by expert generalists with easy access to specialist support, will provide services closer to home but at a sufficient scale to ensure consistent, effective and sustainable 'modular' services.

5.1.6 Sustainable systems

The 'critical mass' of urgent and emergency care delivered by one emergency centre and 'some' urgent care centres will enhance recruitment and retention of staff.

Continuous monitoring and learning should be embedded to allow service evolution and improvements and to develop predictive forward planning.

Commitment to this model of care should be long term.

5.2 Model of Care for Acute and Episodic Care

5.2.1 Patient Flows

An internet 'patient portal', available on all platforms, will provide easy, trustworthy and localised information regarding self help, advice and signposting. This will include and integrate health, social and voluntary sector information.

A 'Smart' Single point of telephone access (111) will intelligently triage all requests for urgent care (defined as requests for same day assessment) and signpost patients to the right point of care, including the capacity to make appointments at their GP practice if less urgent, or at one of the urgent care centres. This service will be linked to a live demand and capacity management system to improve patient flow.

As a default, LTC urgent care should be 'planned' as active case management will detect exacerbation at an early stage.

There will be increased signposting to local pharmacies for low level urgent care advice and treatment. Pharmacies will 'cluster' with GP practices and develop closer working relationships.

5.2.2 One Emergency Centre

A single, fully equipped and staffed high acuity emergency centre with consolidated technical and professional resources delivering high quality emergency medical care 24hrs 7 days a week. A combination of expert generalists (Acute physicians, COE consultants and new roles etc) and specialists (ED consultants and specialists) will provide early expert opinions at all times. It will serve as a trauma centre with a co-located critical care unit. Other adjacencies include facilities for ambulatory care and assessment units with multi-disciplinary teams (including mental health) specifically dealing with patients suitable for 0 day length of stay pathways (ambulatory care) and <3 day length of stay (LTC and frailty syndromes). There will be also be full and immediately accessible diagnostic facilities, blood bank and pharmacy.

Access will be via 999 ambulance or co-located urgent care centre.

A single emergency centre will improve safety and quality of care and focus resources to improve teamwork. Integration and consolidation of the workforce will promote better working practices both within the unit and in providing support to generalists in lower acuity settings. Improved trust and relationships across different care settings will be embedded through partnership care and rotating / posts, some in new roles designed to promote integrated care and whole system pathways.

5.2.3 'Some' Urgent Care Centres

Multiple units provided at 'cluster' GP practice level of 'modular' and consistent design to provide low and medium levels of urgent medical and care input. Some diagnostic facilities and a pharmacy will be available on site. Co-located with a range of mental health, community and voluntary sector services, GP Out of Hours, and in some centres medium acuity beds. Timely expert generalist opinion available 7 days. One Urgent Care Centre (UCC) will be co-located with the Emergency Centre and receive all the 'walk in' patients who will not be able to access the Emergency Centre unless transferred by a clinician from the UCC. Urgent Care Centres will be staffed by a combination of advanced practitioners and GPs from the 'cluster' of practices surrounding it. From a GP practice perspective, urgent care will be provided at cluster level, whilst LTC management and other non urgent work will remain at practice level. Continuity of care at urgent care centres will be achieved through integrated care records, whilst continuity of care for patients with LTCs will be through a named clinician or keyworker (in addition to integrated care records).

5.2.4 Partnership Care

Specialist support will be easily and quickly available to support generalists in lower acuity care settings, including urgent care centres. This will be in the context of the development of partnership care across all care settings with a re-definition of generalist and specialist roles to include a greater teaching and learning component to increase generic skills and improve the consistency of care. Communication

between professionals will be frequent and direct (not via a third party) which will improve working relationships, feedback and learning. This model is described in more detail in the LTC section.

5.2.5 Professional Navigation

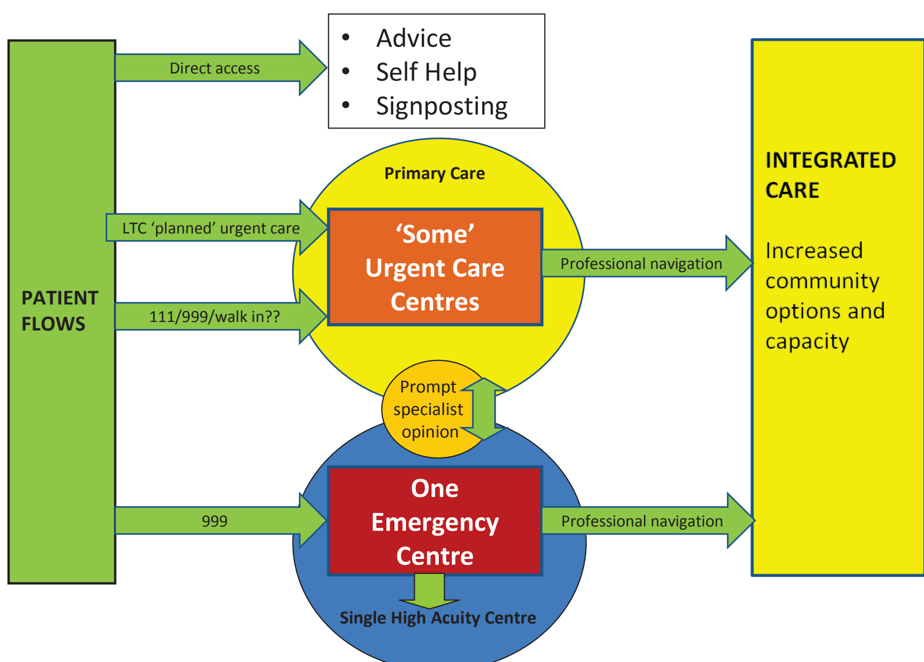
There will be a single point of access (SPA) for professionals to arrange further care and support for patients following their urgent or emergency care contact. This SPA will act as a portal to a wide range of community based integrated care options. For complex care issues, the SPA will initiate contact but care planning will then be finalised through direct conversation between professionals. For simple care issues, a ‘handover’ will be managed through the SPA service with integrated care records serving as a valid proxy for continuity of care.

5.2.6 Integrated Community Care

Urgent and emergency care will be delivered in the context of whole system integration. Services will be provided by teams around the patient, not by a series of independent professionals working within their own organisations and professional boundaries. Community capacity will be built to keep people at home and out of hospital, deliver reablement in the community, enhance the role and involvement of primary care and consistently deliver the right care in the right place by the right staff. Access to these services will be available from all points of patient contact via the SPA. This is further discussed in the LTC section.

5.3 Diagrams of the Acute and Episodic model of care

Acute/Episodic – Identifying Flows



'Some UCCs'

Primary Care & Community Services

Urgent Care Centre

GP OOH

Therapies

Diagnostics

Mental Health?

Social Care?

Voluntary Sector?

Beds??

'One EC'

Emergency Centre

Specialties

Critical Care

Assessment Units

Diagnostics

GP OOH?

Primary Care

Urgent Care Centre

6. Long Term Conditions and Frailty

6.1 Key Principles

6.1.1 Enable patient responsibility for prevention, self care, maintenance and accessing appropriate care

Enabling patient responsibility should be embedded in all models of care. Although there is mixed evidence of short term impact on admissions and cost, there is an overwhelming case for empowering citizens and communities to be co-responsible for managing their lives and social environment, whatever their health status.

Many long term conditions are preventable and systematic secondary prevention shows improved outcomes. The medium and long term potential for reduction in health and social care demand is great.

Targeted prevention activities in social care have demonstrated impact although there is currently no statutory obligation for Local Authorities to invest in prevention.

Public Health and all other stakeholders must be involved and particular focus is required for hard to reach groups. The prevention agenda should form part of the school curriculum.

Behaviour change, education and support will often be more effective and sustainable if delivered by peers rather than professionals.

Self management of Long Term Conditions is at an early stage of development with little hard evidence as yet to support significant investment. It is the view of the clinicians locally however that it is aligned with the principles of citizen empowerment and community mobilisation as well as the emergence of assistive technology, self care should be a central component of LTC management.

People with co-morbidities and who are frail have less capacity for self management and require a different approach, especially when they are ill. Frailty syndromes are now recognised as an independent risk of worse outcomes and do not fit well into pathway driven care which the patient can be co-responsible for. They require a named key worker or responsible clinician with whom they can share decisions and who can act as their advocate. This is also the case for other vulnerable groups such as people with learning difficulties.

6.1.2 Generalist care as a default, with partnership care between generalists and specialists and clearly defined indications for specialist care

Generalists perform holistic assessments as a default and should be available in all care settings. Workforce planning and redesign will increase the number of generalists, many of whom will also develop specialist skills. This includes GPs, community health professionals and acute care clinicians. They will be responsible for initial assessment as well as the co-ordination and continuity of care for the majority of patients.

Specialists will offer timely response to support generalist care. They will assume greater responsibility for education and learning to improve the generic skills of generalists in all care settings. They will continue to be responsible for the care of the most complex patients.

Partnership care between generalists and specialists will become the norm with a more dynamic and greater range of options to share the care of patients through meaningful and direct conversation, interaction and information flow. This will allow the care of a greater proportion of patients to be managed by generalists in a community setting with targeted specialist input when required. Resources must shift to support this.

Partnership care will be developed across the whole health and social economy. The integrated health and social care of a patient will be provided 'in parallel' (not 'in series' as is currently the case) with shared risk management.

Better relationships will allow 'honest feedback' and more effective mutual and case based learning.

Age transitions, especially in mental health and paediatric care are currently a problem which will be resolved when continuity of care is managed by a community generalist working across all age groups.

Integrated care records are a key requirement for partnership care.

6.1.3 Provide a better match between needs and levels of care through a systematic shift towards greater care in the community

People prefer to be cared for in their own home whenever possible, even when they are ill.

Too much care is currently provided at levels of care which are higher than patients require to meet their needs. This is not only resource inefficient, but also increases the risk of iatrogenic harm. Up to 30% (?) of people admitted to acute hospitals could be managed safely and effectively in a different care setting and at a lower level of care.

Patients cared for at home remain connected to their family and carers. Community support remains continuous and the patient is less likely to 'decompensate' by being cared for in a bed based acute environment which is also much more stressful. Individualised care can be delivered more easily by integrated teams. The potentially difficult and harmful transitions from home to hospital and back again are removed. Performing an accurate and holistic assessment of needs is much more difficult when a patient is not in their usual living environment.

Home will not be the right place to care for everyone who is ill. Some of course require high levels of care in an acute hospital bed, but other alternatives must be provided that offer a 'medium' level of care.

Community capacity must be built to accommodate this shift. The required shift in resources to achieve this poses a challenge. It is not necessarily cheaper to provide care at home when intensive input is required.

6.1.4 Move from reactive to proactive care, including risk stratification, care planning, early detection and intervention and 'planned' urgent care

The evidence base supports the provision of proactive care for a number of specific conditions but does not yet show improved outcomes for people with multiple co-morbidities and frailty. Nevertheless, the new GP contract and local clinician consensus both support a move to providing more proactive care. Clinical experience strongly suggests that it reduces the number and severity of crises and gives reassurance to patients, families and carers that they know what to do and who to contact in the early stages of exacerbation.

There is uncertainty about what percentage of the 'at risk' population would benefit from active case management. It is important not to shift resources into ineffective interventions and targeted proactive care will remain preferable until the evidence base is clearer.

6.1.5 Provide timely response to exacerbation and ensure enhanced recovery and rapid reablement with a minimum time spent in acute care settings

Integrated multi-disciplinary teams are needed to address all the issues, both in community and acute settings and care must remain joined up at all times.

An exacerbation related to an existing LTC should not require admission, but may require diagnostics.

Once in hospital, the LTC tends to be ignored in preference to the exacerbation and the patient has an 'asymmetric' experience of their assessment and care because of this. Holistic assessment as a default will address this.

Discharge planning must start at the time of admission, and patients think this should be done by the ward staff caring for them, not a separate team. Provide Estimated Dates of Discharge for all patients soon after admission.

Standardise simple discharge processes and provide bespoke planning for complex discharges.

Employ strategic operational planning to maximise 0 day length of stay (ambulatory care and <3 day length of stay (frailty teams) in acute settings.

'Discharge to assess' as default once medical condition stabilised. Reablement at home where possible and in community setting if not. Aim to return patient to original level of care.

Resolve governance issues around free NHS and assessed social care which currently inhibit integrated care.

6.1.6 Diagnose and plan the last year of life and stop sending people to hospital to die.

Once fully embedded, End of Life (EOL) care will become part of 'the day job' but this will require care co-ordination and equity of care for all terminal conditions. EOL care is currently unstructured and patchily commissioned. To improve this, a consolidated EOL package will provide better care and reduce costs. A roving palliative care team would be effective and cost efficient.

6.2 Model of Care for LTC

6.2.1 Prevention

An economy wide prevention strategy driven by a commitment to wellbeing as a primary health, social, economic, political and cultural aim.

Targeted primary prevention across all health and social care settings employing 'make very contact count' and upskilling the workforce in behavioural and motivational change techniques.

Systematic secondary prevention.

6.2.2 Partnership Care

Primary care generalists (mainly GPs) retain continuing responsibility for care and co-ordination with rapid access to specialist support as required.

A menu of options to facilitate timely and personal communication between generalist and specialist to share decisions and improve care planning for patients at all levels of acuity: routine, urgent, emergency and end of life.

Clinical conversations, mutual learning and honest feedback will improve working relationships and the quality of care.

Direct access for generalists to pathway driven diagnostics to reduce unnecessary secondary care referrals.

Specialists will continue to manage and be responsible for the continuing care of a smaller number of the most complex patients, but with a greater responsibility for education and upskilling the generalist workforce.

6.2.3 Self Management and Care Planning

Upscale self management programmes and combine with care planning as a routine for anyone with an LTC.

Active case management for those at high risk, targeted initially to those conditions where benefit is evidenced.

Upscale peer and community support programmes

6.2.4 Integrated teams

Integrated multi-disciplinary teams providing case management, timely response to exacerbation and facilitating discharge.

Strong links with primary care, 'teams around the practice' aligned with 'teams around the patient'.

Specialist skills linked to and augmented by integration with acute care specialists.

Sustainability achieved through generic upskilling across professional boundaries, using individual specialist skills as the teaching resource.

Embed continuous learning and review within the teams to ensure maximum effect from integration

6.2.5 Increased Levels of Care

Timely and appropriate response to exacerbation through a 'tiered' increase in level of care:

- Low medical input provided by a 'hospital at home service' for minor exacerbations where short term additional care and rehabilitation at home allows the patient to continue living independently. With effective case management and early detection of exacerbation, this level of care will be appropriate for an increasing proportion of people with LTC exacerbations.

- Medium medical input provided in a community setting, but not in the patient's home. 'Step up' higher intensity care and rehabilitation can be combined with more frequent and expert medical input to hasten recovery with the aim of returning to the original level of care. Integration of care in these settings with care provided in acute settings will improve quality and flow.

- High medical input provided in a single high acuity unit with a consolidated and integrated workforce as described in the key principles.

6.2.6 Reablement and rehabilitation

Discharge to assess as the default from acute care settings.

Reablement at home as the preferred option with the aim of a rapid return to the original level of care and the withdrawal of additional care and support.

Reablement in a community setting but not at home for those patients with slow to resolve exacerbations, people who will not return to their original level of care, including those awaiting care home placements. Aligned with 'step up' processes, an EDD and discharge planning will be standard for 'step down', using the same or similar criteria to those employed in acute care settings.

Identify and fill gaps e.g. neuro rehabilitation.

6.3 Diagram of the Long Term Conditions model of care

Long Term Conditions Model of Care

Reablement

Reablement at home
- Integrated teams
- Generic workers
- Voluntary sector involvement
- Ambulatory reablement in community facility as an option?
- Return to original level of care
- Updated care plan

Reablement in community
- Intensive rehabilitation
- 'Step down'
- Co-ordinated EDD and discharge planning
- Resolving exacerbation requiring additional care?
- Social issues to be resolved?
- Permanent higher level of care required?

Discharge to Assess

Increased Levels of Care

Low Medical Input
- 'Hospital at home'
- Low acuity exacerbation
- Low medical input but high care input
- Team around patient
- Sustainable community support

Medium Medical Input
['Health Hub' Community beds]
- Medium acuity exacerbation
- 'Step up'
- Integrated Acute and Community services
- Designated and resourced private sector beds
- Potential urgent care centre adjacencies

High Medical Input
- One high acuity centre
- 7 day maximum LOS
- Early supported discharge

0 day LOS
- Ambulatory care
- Subacute frailty assessment

3 day LOS
- Frailty
- Assessment units

Mental Health Beds
- Medico-legal place of safety

Patient with LTC
- Targeted prevention
- Early detection
- Self management
- Key worker / named responsible clinician
- Integrated care record

Integrated Teams
- Case management
- Timely response to exacerbation
- Facilitated discharge
- Holistic care
- Generic skills
- Continuity through personal care

Generalist Care
- Primary and community workforce
- Holistic assessment
- Continuing patient responsibility
- Continuity of care
- Community care co-ordination

Partnership Care
- Generalist as co-ordinator
- Specialist support when required
- Direct communication
- Shared decisions
- Mutual learning
- Health and Social Care
- All services and levels of care

Specialist Care
- Concentrated workforce on one site
- Integrated specialist teams
- Supporting care in lower acuity setting
- Emphasis on education and upskilling

futurefit
Shaping healthcare together

7. Planned Care

For the purposes of this report, planned care is defined as care that is non urgent and accessed either directly by the patient or through referral from a generalist to a specialist. LTC management includes much planned care and some urgent care is 'planned' if it is referred to a same next day clinic.

7.1 Key Principles

7.1.1 Patient empowerment and navigation

The current planned care system is complex, fragmented and difficult to navigate. It disempowers and frustrates patients who then seek professional help to signpost and navigate when this should not be necessary. The initial referral has benefitted from RAS and TRACS, but their role does not extend beyond making the first appointment.

Patients want easy access to understandable and trustworthy information about self care options and local services to which they can gain direct access as well as information that guides them to seek professional help when necessary.

Patients find it understandably hard to distinguish 'want' from 'need' and, although clear information will resolve some of this, they often require professional expertise to distinguish between the two.

Once referred, patients want to clear information about what is going to happen next and the timescale they should expect.

Navigation through the planned care system should be patient focused and facilitate self navigation wherever possible

Professional or peer advocacy to assist in navigation should be the exception rather than the rule.

Some patient groups (e.g. people with learning disabilities) should be offered pro-active advocacy.

7.1.2 Pathways

Planned care should be largely pathway driven, with as few stages as possible to minimise error and delay.

Pathways will vary in type and complexity depending on the degree of diagnostic uncertainty and treatment options. Patients should be able to gain access to the simplest 'out of hospital' and diagnostic pathways without the need for a professional referral, whilst the most complex will require expert specialist decision making at an early stage because of diagnostic uncertainty.

7.1.3 Partnership care
Aligned with the principles described in acute and LTC care, a richer and more dynamic conversation between referring generalist and specialist will result in higher quality referrals, better outcomes and mutual learning.

7.1.4 Levels of care
In planned care, this is about 'who does what where?' There is a compelling evidence base for a tiered arrangement of treatment centres, with the most complex and risky surgery being performed in a site co-located with a critical care unit, but the majority not requiring this. Separate treatment centres for routine surgery can also benefit from being designed and delivered through a different business model.

There is a 'critical mass' issue to consider when planning the number of treatment centres. For minor surgery, this is less of an issue, although the skill of the operator still influences the outcome, whereas for intermediate treatment centres outcomes are influenced by volumes – the larger the number, generally the better the result.

7.2 Model of care

7.2.1 Patient portal
Facilitated self management through a web based patient portal which provides trustworthy localised information about common conditions, when to seek professional help, options for self management and direct access to simple therapies and diagnostics

7.2.2 Pathways
Systematic design, approval and implementation of whole system pathways driving the majority of planned care. A tiered model:

- patient self referral and self management
- diagnosis or symptom complex known with direct GP / generalist access to the pathway
- diagnosis or symptom complex unknown requiring expert specialist decision making early in the pathway.

Reduce stages in all pathways to improve quality and safety and reduce errors. 'Optimise' patients prior to referral as a routine. Referral made by most appropriate professional (e.g. could be physio for arthroplasty). Patient choice expressed at time of referral assisted by navigator and / or PROMS data. Eliminate duplicated diagnostics. Provide expert opinion at first out patient appointment, preferably from the surgeon who will be performing the procedure. Date of surgery agreed immediately after first out patient appointment. Single multi-disciplinary pre-op assessment to include anaesthetist, physio and social worker. Admit on day of surgery. Enhanced recovery with the shortest possible LOS. Out patient follow up in the community as appropriate.

7.2.3 Navigation

A simpler planned care system requires less navigation. Patients should have access to updated information about their stage of the planned care journey and be able to self navigate as a default. Some advocacy will be required which the RAS and TRACS teams may be able to provide. In more complex and serious situations, or when a patient has special needs, then a navigator / advocate will be required. This could be a peer group volunteer, specialist nurse, therapist, GP or other professional.

7.2.4 Levels of Care

Three tiers of treatment:

- Low professional input. Multiple centres for day case / minors, basic diagnostics and access to therapies
- Medium professional input. One or two centres for intermediates / day case. Beds available for low / medium risk orthopaedics. May or may not be co-located with high input centre. Advanced diagnostics (USS/CT/MRI/Nuclear etc)
- High professional input. One centre for majors, co-located but operating separately from single emergency centre. Co-located HDU. Advanced diagnostics. Potential for repatriation of out of area specialist surgery, e.g. cardiac, neuro etc.

7.3 Diagram of Planned Care model of care.

PATIENTS
- Education
- Information
- Prevention

Facilitated self management:
- IT/Map of Medicine
- Expert Patients
- Voluntary groups

- Patient
- Peer worker
- Specialist Nurse
- Therapist
- GP
- IT

System Navigators

INFORMED DIRECT ACCESS

Diagnosis known (simple)

Diagnosis unknown (complex)

PRIMARY CARE

Skill mix
Unit size

Self Help
- Guided self care

Low Professional Input
- Multiple centres for day case/minors
- Basic diagnostics (Xray/USS)
- Access to therapies

Medium Professional Input
- One or two local centres for intermediates/ day case (may or may not be co-located with high input centre)
- Diagnostics (USS/CT/MRI/Nuclear etc.)

High Professional Input
- One centre for majors (co-located with but separate from emergency centre)
  - HDU
  - Diagnostics (USS/CT/MRI/Nuclear etc.)
- Referrals out of area for cardiac, neuro, etc.

Communication

Information/Education

8. Cross cutting themes

A number of important cross cutting themes have emerged in all the clinical meetings thus far. The following is a summary of discussion from different clinical meetings.

8.1 Embedding compassion and healthy relationships

Although compassionate care requires the right attitude, this must be translated into action and supported in system design and team working practices. Every member of a team must have clearly understood roles and responsibilities, especially when working within complex systems and environments. However, over-definition of roles, especially when restricted to one care setting, can prevent professionals 'going the extra mile' to ensure compassionate care and seamless patient journeys.

Named key workers or responsible clinicians will improve co-ordination of care for vulnerable people.

Values based recruitment will become the norm and compassionate attitudes, behaviours and relationships will be more visible throughout the whole organisation.

8.2 Rural and Urban solutions

The problems of providing equality of access and quality of care to rural populations will be partially mitigated by achieving greater care in the community. Care provided by teams around the patient with home as the default can be provided equitably in both urban and rural settings. Access to services that require travel clearly require better transport solutions, but there is also a balance to be achieved between the advantages of providing truly local services for all levels of care and the better outcomes and reduced cost of providing care at larger scale in fewer units.

8.3 Workforce issues

Many parts of the health and social care workforce are in crisis. A full workforce review and plan is required as part of, or alongside the FutureFit programme in order to resolve this. 7 day working is a requirement across the whole system and brings additional workforce challenges.

Local clinicians expressed some strong views about potential components of the solution:

- Consolidate services to make posts more attractive by improving the quality of work, gaining more experience working in larger units, offering better rotations through fully staffed co-located departments and services, all in an improved working environment.
- Fill medical rotas to fit the available workforce and fill the gaps with new roles (Advanced practitioner, Emergency Nurse Practitioner, Physicians assistant etc.).

- Prototype and implement rotating (and split) posts through different care settings to improve mutual learning, understanding and trust, provide better risk management, encourage better use of shared protocols, pathways, training opportunities and shared documentation and improve consistency and quality of care through generic upskilling.
- Improve recruitment and retention of staff through more effective succession planning and better role development and CPD
- Gain academic status by establishing an economy wide link to university and other education and training programmes to attract people to come to Shropshire to train and work.

8.4 Co-ordination, integrated and consistency across the whole system

There is universal agreement that improving the co-ordination, integration and consistency of care delivered across the whole economy is a necessary precondition for achieving sustainable improvements in quality and safety. The will to do this is evident, it is the barriers to it that require systematic identification and removal. These include a fragmented organisational structure, multiple incompatible IT systems, 'old fashioned' commissioning mechanisms and an overwhelming administrative burden. 'Any capable provider' and private sector tendering is also a potential barrier.

'Siloed' care does not incentivise clinicians to 'go the extra mile', and professionals are increasingly reluctant to fill gaps in care if it is not within their defined role. Clinicians should have more control over appointment systems.

8.5 Delivering effective high quality care with no extra money

Financial austerity is one of the key drivers for radical change. There is a need to move beyond organisational interests so that funding follows the patient. Pragmatism is required to find the 'key enablers' of change to concentrate our limited resources.

Currently, the status quo is incentivised with the need for organisations to show a surplus contributing to this.

'Disruptive' change is required to overcome the NIMBY (not in my backyard) problem.

From the clinical perspective, there was a clear case for unifying health and social care funding and to integrate acute and community care.

8.6 Social Care

Health and social care are clearly interdependent and should be designed to reflect this. There is currently an anomaly which makes closer integration difficult in that social care is means tested whilst health care is always free. To achieve integrated

working, health and social care should run parallel and share risk, not run in series as is mostly the case at the moment. No-one enters the social care system without a health problem and currently both systems focus on those most in need and pay much less attention to prevention and self care. Although there is no statutory obligation for Local Authorities to invest in prevention, there was a clear consensus that health and social care must tackle prevention, education and patient empowerment to increase self reliance together. The Better Care Fund is a potential vehicle for this, but concern was expressed that, because its not new money, the opportunity would be missed.

The financial challenge in social care provision attracted specific comment and some suggestions to mitigate its effect were made:

- Increase community and carer input
- ensure more patients return to the same rather than a higher level of care
- manage patient and public expectations
- provide more education and information about options
- incorporate the voluntary sector as a core component of care provision
- implement the models of care described in this report which deliver timely response and intervention, enhanced recovery, early supported discharge and reablement

8.7 Mental Health

There was unanimous agreement that mental health should be integrated with primary, community and acute health care. The models of care described in the three main areas of Acute, LTC and Planned Care were all contributed to by mental health professionals and further detailing will demonstrate more clearly the potential for closer integration.

Partnership care in particular was felt to be a model which was equally applicable to mental health services. Psychological management of all LTCs should be 'part of the day job' and, within the context of partnership care, mental health specialists should have a greater role in education and upskilling of generalists. Young people have particularly stressed the need for support for problems with stress and self harm.

The RAID model of liaison in the acute sector was felt to be a good one, but it needed further development, especially in regard to education and training (the RAID effect)

8.8 Children

This area needs further exploration, but initial comments are: there is a lack of psychological and family support. There are big gaps, such as Autism (now 1:80) and

age transitions. Obesity is not being systematically tackled. GPs and others are become more and more risk averse around children, Paediatric training for GPs should be mandatory. Partnership care is an excellent model for Paediatrics.

8.9 Therapeutics

Clinicians recognised that a whole system and strategic approach to therapeutics was required and that the importance of this was mostly under-estimated. Community pharmacies are not clustered with GP practices and do not have a defined working relationship with them. Community pharmacies can take a bigger role in minor urgent care and also in routine / repeat prescribing. They would need access to integrated care records to do this. Their impact in minor urgent care would be increased if some OTC medicines were free to stop unnecessary diversion to GPs. All pharmacies should have consistent and longer opening hours. In the acute sector, everyone should have a medication review <24hrs after admission. Evidence that if they are on 4 or more meds then 2 need changing due to acute presentation. These reviews should also apply to lower risk groups – often only the highest risk patients get them. More work with patients at home (e.g. the HARMS scheme) would add value (hoarding, poor compliance etc). There are too many admissions for technical therapeutics which could be done at home or in a community setting. There is little co-ordination of medication across care settings, dressings are a particular example.

9. Whole system synergies

There are a number of key principles and components of models of care which were repeated in slightly different but synergistic forms across all three care areas:

Whole system synergies

Reablement

Reablement at home
- Integrated teams
- Generic workers
- Voluntary sector involvement
- Ambulatory reablement in community facility as an option?
- Return to original level of care
- Updated care plan

Reablement in community
- Intensive rehabilitation
- 'Step down'
- Co-ordinated EDD and discharge planning
- Resolving exacerbation requiring additional care?
- Social issues to be resolved?
- Permanent higher level of care required?

Increased Levels of Care for LTC

Low Medical Input
- 'Hospital at home'
- Low acuity exacerbation
- Low medical input but high care input
- Team around patient
- Sustainable community support

Medium Medical Input
['Health Hub' Community beds]
- Medium acuity exacerbation
- 'Step up'
- Integrated Acute and Community services
- Designated and resourced private sector beds
- Potential urgent care centre adjacencies

High Medical Input
- One high acuity centre
- 7 day maximum LOS
- Early supported discharge

0 day LOS
- Ambulatory care
- Subacute frailty assessment

3 day LOS
- Frailty
- Assessment units

Mental Health Beds
- Medico-legal place of safety

Levels of Care Planned care

Low Professional Input
- Multiple centres for day case/minors
- Basic diagnostics (Xray/USS)
- Access to therapies

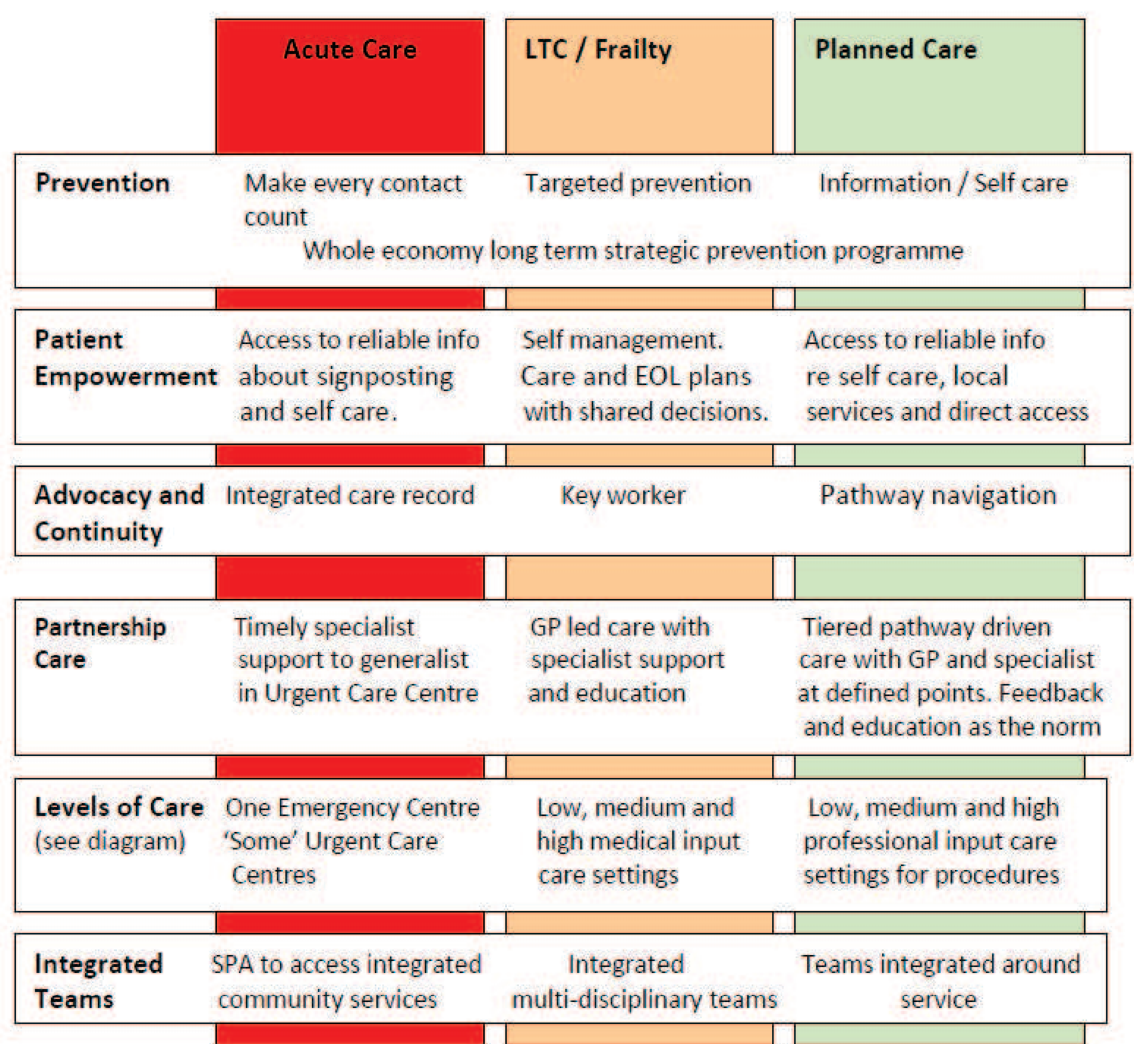
Medium Professional Input
- One or two local centres for intermediates/ day case (may or may not be co-located with high input centre)
- Diagnostics (USS/CT/MRI/Nuclear etc.)

High Professional Input
- One centre for majors (co-located with but separate from emergency centre)
  - HDU
  - Diagnostics (USS/CT/MRI/Nuclear etc.)
- Referrals out of area for cardiac, neuro, etc.

Acute and Episodic Care

'Some' Urgent Care Centres

One Emergency Centre



	Acute Care	LTC / Frailty	Planned Care
Prevention	Make every contact count	Targeted prevention	Information / Self care
	Whole economy long term strategic prevention programme		
Patient Empowerment	Access to reliable info about signposting and self care.	Self management. Care and EOL plans with shared decisions.	Access to reliable info re self care, local services and direct access
Advocacy and Continuity	Integrated care record	Key worker	Pathway navigation
Partnership Care	Timely specialist support to generalist in Urgent Care Centre	GP led care with specialist support and education	Tiered pathway driven care with GP and specialist at defined points. Feedback and education as the norm
Levels of Care (see diagram)	One Emergency Centre 'Some' Urgent Care Centres	Low, medium and high medical input care settings	Low, medium and high professional input care settings for procedures
Integrated Teams	SPA to access integrated community services	Integrated multi-disciplinary teams	Teams integrated around service

10. Next steps

This report details the output of the clinical design work stream over the first 3 months of its activity. The models of care are emerging but are still at a high level.

A process of refinement will continue through a number of cycles where they will be repeatedly tested using patient scenarios, patient characteristics and flow volumes and financial impact.

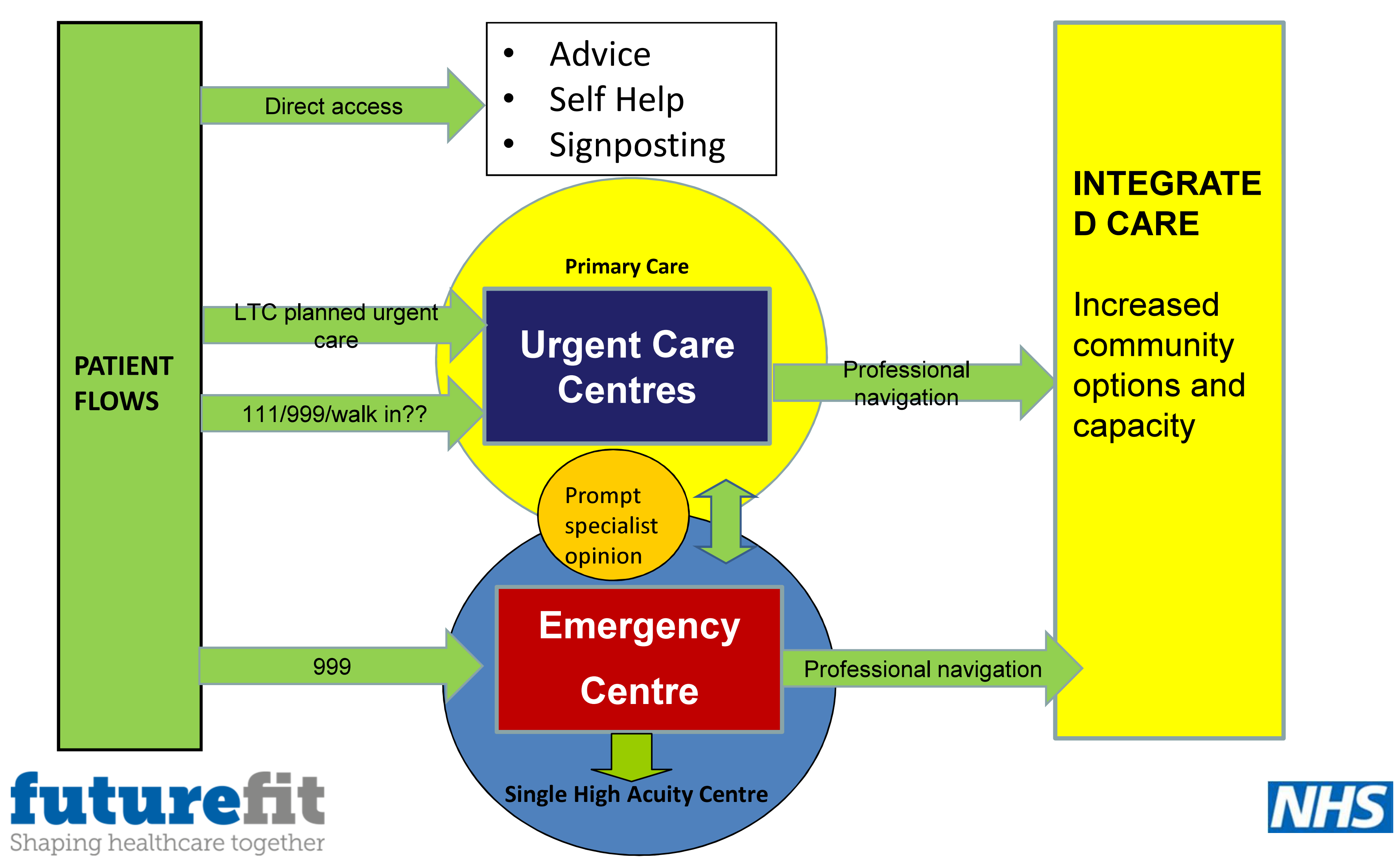
A further detailed review of the evidence base around each component of the model will be undertaken.

External clinical assurance will be sought from an expert clinical team overseen by the West Midlands Clinical Senate.

Clinical engagement will be deepened, both by continuing involvement of the clinicians in the clinical reference group and subgroups, and through events, such as webinars and meetings, designed to reach 2/3 of the clinical workforce of Shropshire and Telford & Wrekin.

Patient representatives and patient groups will continue to be involved and co-creating at every stage of the process.

Acute/Episodic – Identifying Flows



Long Term Conditions Model of care

Reablement and Rehabilitation

Reablement / Rehab at home

- Integrated teams
- Generic workers
- Voluntary sector involvement
- Ambulatory reablement in community facility as an option?
- Return to original level of care
- Updated care plan

Reablement / Rehab in community

- Intensive rehabilitation
- 'Step down'
- Co-ordinated EDD and discharge planning
- Resolving exacerbation requiring additional care?
- Social issues to be resolved?
- Permanent higher level of care required?

Discharge to Assess

Increased Levels of Care

Low Medical Input

- 'Hospital at home'
- Low acuity exacerbation
- Low medical input but high care input
- Team around patient
- Sustainable community support
- Single assessment / DAART

Medium Medical Input
['Health Hub' Community beds]

- Medium acuity exacerbation
- 'Step up'
- Integrated Acute and Community services
- Designated and resourced private sector beds
- Potential urgent care centre adjacencies
- Single assessment / DAART

High Medical Input

- One high acuity centre
- 7 day maximum LOS
- Early supported discharge

0 day LOS

- Ambulatory care
- Subacute frailty assessment

3 day LOS

- Frailty
- Assessment units

Mental Health Beds

- Medico-legal place of safety

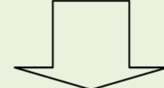
Patient with LTC

- Targeted prevention
- Early detection
- Self management
- Key worker / named responsible clinician
- Integrated care record

Integrated Care

Integrated Teams

- Case management
- Timely response to exacerbation
- Facilitated discharge
- Holistic care
- Generic skills
- Continuity through personal care



Generalist Care

- Primary and community workforce
- Holistic assessment
- Continuing patient responsibility
- Continuity of care
- Community care co-ordination

Partnership Care

- Generalist as co-ordinator
- Specialist support when required
- Direct communication
- Shared decisions
- Mutual learning
- Health and Social Care
- All services and levels of care

Specialist Care

- Concentrated workforce on one site
- Integrated specialist teams
- Supporting care in lower acuity setting
- Emphasis on education and upskilling

- Patient
- Peer worker
- Specialist Nurse
- Therapist
- GP
- IT

System Navigators

PATIENTS

- Education
- Information
- Prevention

Facilitated self managemen t:

- IT/Map of Medicine
- Expert Patients
- Voluntary groups

INFORMED DIRECT ACCESS

Diagnosis known (simple)

Diagnosis unknown (complex)

PRIMARY CARE

Skill mix
Unit size

Self Help

- Guided self care

Low Professional Input

- Multiple centres for day case/minors
- Basic diagnostics (Xray/USS)
- Access to therapies

Medium Professional Input

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- Referrals out of area for cardiac,

Communication

Information/Education

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