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

Date: 19 March 2015

Committee:
Health and Wellbeing Board

Date: **Friday, 27 March 2015**
Time: **9.30 am**
Venue: **Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND**

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

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

Members of Health and Wellbeing Board

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

To receive apologies for absence and any substitutions that have been 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 Minutes (Pages 1 - 8)

To approve as a correct record the Minutes of the previous meeting held on 20 February 2015 which are attached.

Contact Karen Nixon on 01743 252724.

4 Public Question Time

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

5 QUALITY & PERFORMANCE

6 Update Report on Year of Physical Activity Plans (Pages 9 - 10)

A report is attached.

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

7 FOR DECISION/RATIFICATION

8 Heatsavers - Shropshire Evaluation

A report will follow.

Contact Andy Begley, Head of Adult Social Care Operations tel 01743 252421.

9 **Shropshire CCG 2 Year Plan** (Pages 11 - 70)

A report is attached.

Contact Paul Tulley, Shropshire CCG 01743 277500.

10 **Shropshire Pharmaceutical Needs Assessment (PNA)** (Pages 71 - 74)

A report is attached.

Contact Emma Sandbach, Public Health Specialist, Intelligence, Tel 01743 253967.

11 **Communication and Engagement Strategy and Action Plan Update** (Pages 75 - 88)

A report is attached.

Contact Jane Randall-Smith, Chief Officer, Healthwatch, Tel 01743 342183.

12 **FOR INFORMATION**

13 **Children's Trust Report** (Pages 89 - 96)

A report is attached.

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

14 **NHS Future Fit Short List** (Pages 97 - 108)

A report is attached.

Contact Paul Tulley, Shropshire CCG, Tel 01743 277500.

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Shropshire Council

Committee and Date

Health and Wellbeing Board

27 March 2015

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 20 FEBRUARY 2015 9.30 AM – 12 NOON

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

Present
Councillor Karen Calder (Chairman)
Councillor Ann Hartley, Professor Rod Thomson, Karen Bradshaw, Dr Helen Herritty, Paul Tulley, Jackie Jeffrey, Councillor Tim Barker (Substitute for Councillor Lee Chapman), Carole Hall (Substitute for Jayne Randall-Smith)

Safer Stronger Communities:
Frances Darling, David McWilliam, Jayne Randall, Tom Currie, George Branch, Barbara Stafford-Cairns, John Das-Gupta, Irfan Ghani, Angela Parton, Andrew Gough, Chris Jensen, Louise Jones.

Also Present
Councillors Madge Shineton, Gerald Dakin and Dave Tremellen, Ruth Houghton, Sam Tilley, Kerrie Allwood.

94 **Apologies for Absence and Substitutions**

Apologies for absence were received from Councillor Lee Chapman, Stephen Chandler, Dr Caron Morton, Dr Bill Gowans and Jane Randall-Smith.

Councillor Tim Barker substituted for Councillor Lee Chapman, Carole Hall substituted for Jayne Randall-Smith (Healthwatch) and Ruth Houghton substituted for Stephen Chandler.

95 **Disclosable Pecuniary Interests**

Members were 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.

96 **Minutes**

RESOLVED:
That the Minutes of the meeting held on 20 January 2015 be approved as a correct record and signed by the Chairman, subject to the following:

That the fifth bullet point of Minute 91.3 be amended to read 'To strengthen Governance arrangements…'

Matters Arising
Paul Tulley would be updating the Board in relation to the Co-Commissioning of Primary Care later on in the meeting.

In relation to urgent care (Minute 85.4), the Chairman confirmed that responses to the letters had been circulated to Members of the Board and that an informal meeting had been arranged between the Health and Wellbeing Board and the local health economy leaders, including Peter Herring, on 2 March 2015.

97 **Public Question Time**

There were no public questions, statements or petitions received.

98 **QUALITY & PERFORMANCE**

99 **Better Care Fund - Partnership Agreement**

99.1 The Head of Social Care Efficiency & Improvement introduced a report, copy attached to the signed minutes, which set out the Better Care Fund Partnership Agreement. The Better Care Fund Manager amplified on the report and explained that the Partnership Agreement was between Shropshire Council and Shropshire CCG to support delivery of the Better Care Fund.

99.2 A template provided by NHS England and the Local Government Association had been used to complete the agreement which had been presented to Shropshire Council Directors, the CCG Quality, Performance and Resources Committee, the CCG Board and the Council's Cabinet and had been signed off subject to some minor amendments. It needed to go back to the CCG Board and Cabinet and would also come back to this Board.

99.3 The Chairman commented that this Partnership Agreement had formalised a very good working relationship between the Council and the CCG and she thanked the Officers for a job well done.

99.4 The Chief Operating Officer explained that the issue of a Conflict of Interest Policy had not been resolved and further work was required. It had not been formally agreed which Policy would apply to this Board. In response, the Better Care Fund Manager reported that work was ongoing and needed to be concluded by the end of March.

99.5 **RESOLVED:**

a. That final amendments be agreed by the Health & Wellbeing Delivery Group in cooperation with the Portfolio Holder for Adult Social Care and the CCG Clinical

Lead for the Better Care Fund and reported back to the Health and Wellbeing Board at its next meeting on 27 March 2015.

b. That the agreement be reviewed by the Health & Wellbeing Delivery Group and the findings reported to the Health and Wellbeing Board in 6 months' time.

100 **Co-commissioning Update**

100.1 The Chief Operating Officer gave a verbal update. He informed the Board that the CCG's application for delegated authority from NHS England for Primary Care Co-commissioning had been approved, limited to GPs this year 2015/16. NHS England had retained some aspects around payments, individual practitioners etc and there was some ambiguity around who would be responsible for premises. He explained that there would be a new Primary Care Committee to manage those delegated responsibilities. Currently the resources to do the job sat with NHS England and detailed discussions had not yet taken place around which resources would transfer to the CCG in order to manage these responsibilities. In response to a query about how GPs felt about Co-commissioning, the Chief Operating Officer explained that GP views had been sought and although not entirely enthusiastically it was supported.

100.2 The Chief Operating Officer updated the Board in relation to the Primary Care Infrastructure Fund of £1 billion which all GP practices had been invited to bid into. £250 million was available during 2015/16. All bids needed to be in by 16 February 2015 and decisions would be made by the end of March 2015. A number of practices in Shropshire had put bids in and it was hoped that some would be successful. In response to a query the Chief Operating Officer informed the Board of the criteria for the bidding.

100.3 In response to a query about the role of NHS England on the Health and Wellbeing Board, the Chief Operating Officer explained that following a management restructure locality directors had been appointed and from the 1 April 2015 Shropshire would share one with Telford and two CCGs in Derbyshire. Once their new structures were in place a formal discussion about its role on the Board could take place.

100.4 The Board discussed and agreed what it felt was appropriate input from NHS England. As NHS England continued to be a formal statutory member of the Board and as NHS England continued to commission local services for pharmacy, prisons, special commissioning, armed forces and more, the Board felt that NHS England should continue to have a presence on the Board. The Chairman requested that the Board write to NHS England setting out its requirements and what was expected of them.

100.5 **RESOLVED:**

a. that the Board write to NHS England setting out its requirements and expectations of NHS England going forward.

b. that details about Co-commissioning be bought back to a future meeting of the Board.

101 JOINT MEETING WITH SAFER STRONGER

102 Local Government Declaration on Tobacco Control and NHS Statement of Support for Tobacco Control

102.1 The Director of Public Health introduced and amplified a report, copy attached to the signed minutes, which set out the Local Government Declaration on Tobacco Control and the NHS Statement of Support for Tobacco Control. The Local Government Declaration was a statement of the Council's commitment to ensure tobacco control was part of its mainstream public health work and that it took comprehensive action to address the harm from smoking. The NHS statement enables the health community to show their support for tobacco control and to fulfil ongoing commitments to tackle the harm caused by smoking.

102.2 The Director of Public Health explained that as well as a health issue, it was also an issue for the Criminal Justice system, who dealt with a range of issues including the supply of no duty paid tobacco and illicit tobacco. In response to a query the Service Manager - Safer & Stronger Communities explained that it was very difficult to say how prevalent illicit tobacco sales were nationally and regionally. Any intelligence received was acted upon however this did not seem to stop the problem. Public Protection in conjunction with the Police were working to get more information about sources of illicit tobacco in order to make more of an impact, however this was not an easy task.

102.3 **RESOLVED:**

a. That the Health and Wellbeing Board consider the content of the Local Government Declaration on Tobacco Control and the NHS Statement of Support for Tobacco Control.

b. That Shropshire Council and all NHS Organisations be requested to sign up to the Declaration and NHS Statement of Support for Tobacco Control.

103 Safer Stronger Priorities

103.1 The Team Manager - Safer Communities Coordination introduced and amplified a report, copy attached to the signed minutes, which set out the Safer Stronger Communities Partnership Priorities alongside those of the Health and Wellbeing Board, Children's Trust and Shropshire Safeguarding Children's Board. It was hoped that the Safer Stronger Communities Board and the Health and Wellbeing Board could work together more closely to tackle their priorities and share resources more effectively.

103.2 It was agreed to consider Agenda items 11 (Substance Misuse), 12 (VCS Criminal Justice Forum of Interest Key Priorities) and 13 (Mental Health Services update) before coming back to the recommendations contained within this report.

103. Having considered the presentations and discussions from the meeting, the Board **RESOLVED** that:

a. the Health and Wellbeing Board consider Substance Misuse as part of the Health and Wellbeing Strategy Refresh.

b. Information sharing protocols across partners be reviewed and specific actions taken to provide information sharing with regards to illegal highs and harm reduction (as discussed in paragraph 104.4).

c. the development of a Criminal Justice Mental Health pathway be considered (see paragraph 105).

d. future joint meetings take place twice yearly.

104 **Substance Misuse**

104.1 The DAAT (Drug & Alcohol Action Team) Manager introduced and amplified a report, copy attached to the signed minutes, which set out current activity to respond to local drug and alcohol issues. She drew attention to the three key areas of work, the retender of the community substance misuse services, developing a local response to the increasing use of novel psychoactive substances (legal highs) and the 'Blue Light Project' which explored how treatment resistant drinkers could be better managed.

104.2 In response to a query about substance misuse, the DAAT Manager explained that the service did have links with homelessness groups and had looked at what could be done to help support the rough sleepers in Shrewsbury. In relation to legal highs, she reported that she was currently awaiting a response in relation to hospital admission rates. It was felt that information from West Midlands Ambulance Service would also be useful to understand rates of ambulance call outs that did not go to hospital.

104.3 In response to a query about the responsibility of shop keepers, the DAAT Manager explained that if the legislation was contravened then an enforcement order could be made. The Service Manager - Safer & Stronger Communities informed the meeting of a piece of work being done nationally to engage with sellers. She explained however that it was very difficult because if a retailer were to acknowledge there was an issue then they would be aware that they were not meeting the requirements of the legislation (i.e. selling products for human consumption).

104.4 A detailed discussion ensued in relation to information sharing and the Director of Public Health agreed to take this forward as Chairman of the Safer Stronger Partnership. It was felt that if a working solution could be found to bring information together, this could be a model for other information sharing.

104.5 The DAAT Manager explained that if dependent drinkers were managed in a different way this could lead to better outcomes for the patient and less impact on public services. High level strategic buy in was requested.

104.6 **RESOLVED:**

a. That the local response to drug and alcohol misuse and how this is changing through current work and initiatives be noted.

b. That the areas of development as proposed in 3.9 to respond to Novel Psychoactive Substances and treatment of resistant drinkers be discussed.

c. That a local media campaign regarding illegal highs be developed.

d. That the Health and Wellbeing Board consider drug and alcohol misuse as a key priority.

e. That the Blue Light project be supported at all levels.

105 **VCS Criminal Justice Forum of Interest Key Priorities**

105.1 The Operations Director, YSS introduced and amplified a report, copy attached to the signed minutes, which looked at the work of the Criminal Justice Forum. The Forum brought together a number of agencies who took a coordinated approach to tackling a range of cross cutting issues including mental health, unemployment, substance misuse and homelessness in order to try to reduce the health and criminal justice impact.

105.2 The Operations Director wished to bring to the attention of both the Health and Wellbeing Board and the Safer Strong Communities Board the needs of these people and the need to work in partnership to address their needs. It was suggested that as part of the retendering process for the Substance Misuse Services, discussions should be had with Mental Health colleagues about how to include issues around mental health as part of the service specification.

105.3 The Head of National Probation Services in West Mercia drew attention to Public Health England's publication 'The Balancing Act' which highlighted the points raised by the Operations Director. He agreed to send a link to this document to all Members.

105.4 The Head of Social Care Efficiency & Improvement informed the meeting that the Care Act places a statutory duty to provide services for the social care and health needs of offenders in prison, focussing on prevention and wellbeing. The implications of this would be considered as part of the Care Act implementation and reported to the Health and Wellbeing Board.

105.5 **RESOLVED:**

a. that the Safer Stronger Communities and the Health and Wellbeing Boards take steps to ensure that a more holistic approach is taken for the commissioning for mental health and substance misuse, in particular.

b. That a Criminal Justice Mental Health Crisis Care pathway be considered for development.

106 **Mental Health Services Update (to include S136)**

106.1 The Commissioning Lead – Mental Health and Learning Disability introduced and amplified a report, copy attached to the signed minutes, which provided a brief summary of the Mental Health services commissioned by Shropshire CCG and summarised the future commissioning intentions of Shropshire CCG for 2015/16.

106.2 In response to a query about whether the right engagement between the CCG, Substance Misuse Services and Criminal Justice Forum was taking place, the DAAT Manager felt that more work was needed to develop those relationships.

106.3 The Chairman thanked the Commissioning Lead for her very helpful paper which provided a good starting point to understand what mental health looked like in Shropshire.

106.4 **RESOLVED:**

a. That the Substance Misuse Commissioner and Mental Health Commissioner discuss the Substance Misuse retender process for Mental Health inclusion in the specification.

b. That the Mental Health Commissioner provide more information to the Safer Stronger Communities on the Criminal Justice Liaison Group.

Signed …… (Chairman)

Date:

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Health and Wellbeing Board
27th March, 2015

UPDATE REPORT ON YEAR OF PHYSICAL ACTIVITY

Responsible Officer Miranda Ashwell, Public health programme Lead, Help2Change
Email: miranda.ashwell@help2changeshropshire.nhs.uk :

1. Summary

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

In November 2014 the Health and Wellbeing Board agreed that 2015 be the Year of Physical Activity, with the objective of raising the profile of the physical activity to engage all sectors in long-term collaborative working to 'turn the tide of physical inactivity' in the Shropshire population.
The Health and Wellbeing Board agreed that 2015 be a planning year in which to produce a HWBB Physical Activity Strategy based on Public Health England's national evidence- based framework for physical activity, 'Every Body Active Every Day'

1.1 A Health and Wellbeing launch event is to be held on 28th April, with invitations extended to commissioners and providers in health, transport, planning, education, leisure and voluntary sectors. The event will be based on the four Everybody Active Every Day domains; Active Society, Moving Professionals, Active Environment and Moving at Scale.

The event aims to gain the commitment of organisations and services to

- Work collaboratively in the short, medium and long term to address physical inactivity in Shropshire by embedding physical activity into the fabric of daily life.
- Develop their part of the shared local HWBB 'Everybody Active Everyday' strategy and associated action planning.
- Agreeing a shared cross - sector Shropshire mass participation campaign to be delivered as a short term outcome of the Year of Physical Activity

To date 50 confirmed bookings.

1.2 Communication campaign to raise awareness of sedentary behaviour piloted with Shropshire Council staff. 'Get Britain Standing' national campaign to be promoted through all partners.

2. Recommendations

The following recommendations have been approved by the Health and Wellbeing Board:

- The Health and Wellbeing Board to make its 2015 a 'Year of Physical Activity ' to address physical inactivity as a major risk to health
- That the approach of the 2015 Year of Physical Activity be based on 'Everybody Active Everyday' principles and structure.
- Organisations to assess their contribution to the physical activity agenda based on the 'Everybody Active Every Day' options.
- That the Year of Physical Activity action to be based on optimising opportunities across organisations, departments and services, within existing resources

No further recommendations

REPORT

3. Risk Assessment and Opportunities Appraisal

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

N/A

4. Financial Implications

N/A

5. Background

See PHE England national framework for physical activity Everybody Active Every day

6. Additional Information

7. Conclusions

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

Agenda item 9

SHROPSHIRE CCG TWO YEAR PLAN

Responsible Officer Paul Tulley, Chief Operating Officer, Shropshire Clinical Commissioning Group
Email: Paul. Tulley@shropshireccg.nhs.uk Tel: 01743 277500

1. Summary

1.1 The following report summarises NHS England's planning requirements and Shropshire CCGs progress in meeting these requirements via the development of a refreshed 2 year plan

2. Recommendations

2.1 The Board is asked to:
- Note the content of the attached Shropshire CCG draft 2 year plan
- Note that this is a draft plan for final submission to NHS England in early April 2015 and that this plan will be further developed to address feedback received from NHS England and other key stakeholders
- Note the statutory duties of the Health & Wellbeing Board in relation to alignment of CCG plans and the Health & Wellbeing Strategy
- Agree there is appropriate alignment between Shropshire CCG's 2 year plan and Shropshire's Health & Wellbeing Strategy

REPORT

3. Risk Assessment and Opportunities Appraisal

3.1 There is no specific risk assessment and opportunities appraisal associated with the development of the two year plan document

4. Financial Implications

4.1 There are no specific financial implications associated with the development of the two year plan document.

5. Background

5.1. NHS England requires CCGs to have in place strategic plans which set out its response to the NHS Mandate and current planning guidance regarding how it will deliver its objectives both, nationally and locally determined.

5.2. The Planning Guidance, "Everyone Counts: Planning for Patients 2014/15-2018/19" published in December 2013 sets out the requirements for CCGs to develop two year operational plans. These plans were in place for April 2014. The updated "Forward View into Action" published in December 2014 required that a refresh of the second year of this two year plan be undertaken. Both NHS England documents can be found on their website at: http://www.england.nhs.uk/tag/planning-guidance/

5.3. Shropshire CCG is currently developing its two year plan and final submission of this plan to NHS England is required in early April 2015

5.4. The Health & Social Care Act 2012 contains a number of duties, aimed at aligning CCG commissioning plans with Health & Wellbeing Strategies, in particular:

5.5. CCGs must involve each relevant Health and Wellbeing Board when preparing their commissioning plan or making revisions to their commissioning plans that they consider significant. In particular, they must give the Health and Wellbeing Board a draft of the plan and consult it as to whether it considers the draft plan has taken proper account of each Health & Wellbeing Strategy published by the Board which relates to the period (or any part of the period) to which the plan relates.

5.6. The Health and Wellbeing Board must provide its opinion and its final opinion must be included in the published commissioning plan.

6. Additional Information

6.1 The first milestone in relation to the plan was submission of a first draft to the NHS Area Team on 27 February. The draft plan submitted is attached for information. Feedback has been received as follows:

- Ensure achievements of the last 12 months are noted in the plan
- Request to include further detail on 7 day working
- Request to include further detail on primary and secondary prevention work and links with Public Health on this workstream, including quantifiable ambitions for 2015/16
- Request to include further detail around demand and capacity analysis and the use and benefit of winter resilience monies
- Request for further detail in relation to mental health including challenges in achieving the IAPT and Dementia targets and how these will be overcome
- Request for more detail regarding the arrangements with NHS England for primary Care co-commissioning
- Request for constitutional metrics to be set out as an appendix
- Request for our Commissioning Intentions to be included as an appendix

7. Conclusions

7.1 The attached draft plan sets out the operational commitments for the CCG over the 2015/16 period. It is in draft form and will be further developed for final submission in early April 2014. The Health & Wellbeing Board is asked to support the content of the draft plan and its development to incorporate the areas set out above and agree that there is appropriate alignment between this plan and Shropshire's Health & Wellbeing Strategy

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) **No Background papers, all current information included in attached paper.**
Cabinet Member (Portfolio Holder) Karen Calder
Local Member All
Appendices Draft Operational Plan 2015 – 16; NHS Shropshire Clinical Commissioning Group

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NHS Shropshire Clinical Commissioning Group

Draft Operational Plan

2015 - 2016

27.2.15 submission

Shropshire Clinical Commissioning Group

Draft Operational Plan

2015 - 2016

Submission details	Which organisation(s) are completing this submission?	Shropshire Clinical Commissioning Group	
	In case of enquiry, please provide a contact name and contact details	Sam Tilley Head of Planning & Partnerships Shropshire Clinical Commissioning Group (CCG) Tel: 01743 277500 E-mail: samantha.tilley@shropshireccg.nhs.uk Website: www.shropshire.nhs.uk Address: William Farr House Site, Mytton Oak Road, Shrewsbury, Shropshire, SY3 8XL	

Contents

Patient Experience Compassion in practice Staff satisfaction Seven Day services Safeguarding Research & Innovation Financial Resilience	

Appendix A: Plan on a page…….

Introduction

This Operational Plan has been prepared to meet the requirements of the NHS England planning guidance *Everyone Counts: Planning for Patients 2014/15 to 2018/19, The Forward View into Action and Supplementary Information for Commissioner Planning 2015/16.* It should be read in the context of the Strategic Plan, Better Care Fund Plan and Future Fit documentation

The information contained in the following narrative supports Shropshire CCG's submission of the following planning templates:

- LTFM
- Unify Submission
- Better Care Fund narrative and metrics

This document contains a description of our approach to delivering the planning fundamentals. Further detailed delivery plans to support this submission include the CCG's Mandate and internal Operating Plan in draft form.

1) Supporting Narrative LTFM

The financial plan for Shropshire CCG meets the business rules required by the "Everyone Counts" planning guidance as follows; - 1% surplus - 0.5% contingency - 0.5% non-recurrent expenditure .

The CCG's QIPP target for 15-16 amounts to 2.6% of the CCGs Programme Budget. The programme is drawn together from the following sources; benchmarking information which illustrated that the CCG is an outlier for Orthopaedic expenditure and Cancers and Tumours. - full year effect of successful schemes implemented during 2014-15 (e.g. Integrated community service, care home extended service) and planned care schemes (e.g. tele dermatology, community based urology services and advice and guidance) - Reviewing procedures of limited clinical value and consultant to consultant referrals to ensure the CCG is maximising the opportunities they provide - further known opportunities to reduce Prescribing expenditure - New schemes identified as a result of 5 year strategy development (Dementia, urgent care, LTC, Better Care Fund).

The commissioning Intentions of the CCG for 15-16 fall out of the CCGs strategies for Urgent Care, Long Term Conditions, Medicines Management, Planned Care and the Health and Wellbeing Board Strategy. Each Intention includes information on which provider contract it affects and whether it is a service review, a service development, an activity change and/or QIPP scheme. This ensures that service financial and activity plans are linked.

Similarly the baseline activity used to roll forward the provider contracts is costed to ensure it is affordable within the financial envelope available. The baseline activity is based on month 07 14-15 extrapolated to year end and adjusted to ensure that seasonal adjustments and part year service changes are fully taken into account. **2) <u>Supporting Narrative – Unify Submission</u>** Shropshire CCG Board undertook a dedicated Board workshop to review the Outcome Ambition requirements of the Unify submission. The CSU's Outcome Benchmarking report was considered in deciding Outcome Ambitions targets and trajectories, with input from Public Health where necessary. Quality Premium targets were also considered and the recommendations to the Health & Wellbeing Board were agreed. These recommendations were submitted to and agreed by the Health & Wellbeing Board on 27 March 2015.	
Planning Fundamentals	**Planning Guidance descriptors**
Delivery Across the 5 domains and 7 outcome measures	
This section is largely dependent on the CCG agreeing its outcome ambitions for 2015/16. Work has been undertaken with Board members to review trajectories and current performance. The CCG's position will eb agreed at its Board meeting in March to inform this section of the plan for its final draft **The CCG is awaiting publication of further information regarding the Quality Premium Payment indicators for 2015/16**	• Your understanding of your current position on outcomes as set out in the NHS Outcomes Framework • The actions you need to take to improve outcomes
Improving Health	
In November 2013 NHS England Published "Commissioning For Prevention" as part of the Call to Action suite of documents. This guidance set out a five step framework intended to help CCG's think about how to commission for effective prevention and identify and analyse the top health problems in conjunction with their Local Authority and Public Health.	• Working with HWB partners, your planned outcomes from taking the five

Shropshire's response to this guidance developed in 2014/15 highlights that Shropshire leaders recognise the need for health and care services to shift their focus from 'fixing disease' towards 'maintaining health' and identifies the potential for local partners to work together through the Health & Wellbeing Board to address this issue. The response document sets out those areas that warranted further attention within primary, secondary and tertiary prevention as set out below: <u>Primary Prevention</u> • Smoking cessation • Prevention of Obesity and promotion of physical activity • Reducing alcohol related harm <u>Secondary Prevention</u> • Cardio Vascular Disease • Atrial fibrillation • Impaired glucose intolerance and type 2 diabetes • Fragility fractures <u>Tertiary Prevention</u> • Cardiac Rehabilitation • Chronic Kidney Disease • Care – Co-ordination The introduction of the Better Care Fund has been the primary focus for the development of integrated prevention work and Shropshire's Better Care Fund Plan sets out a 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. It also require us to make radical changes to how we apportion our funding and on what services we focus our scarce resources and on building community capacity and resilience to help people and communities help themselves. It requires us to work even better together. A key theme within our plan is prevention focusing on empowering people to make better lifestyle and health choices for their own and their families health and wellbeing, preventing the prevalence of ill health and the need for intervention. A multi agency prevention Steering group has been set up to oversee this work and report into the BCF structure. In particular phase one implementation will focus on Integrated Falls Prevention, including a focus on fragility fractures, from April 2015. Phase two work will be developed early in 2015/16 and will focus on the supporting role of developing better shared prevention data and the necessary systems to support this and developing services focusing on cardio vascular disease Further to this we will continue to work with the local authority on the healthy choices programme, in particular the Healthy Shropshire Website and the Help2Change programme.	steps recommended in the "commissioning for prevention" report • Set out significant additional actions the CCG will take to improve the physical and mental health & wellbeing of their staff

A review of our Health & Wellbeing Strategy, to be completed in early 2015 will create a refreshed set of collective ambitions around prevention activities to meet the particular needs of the Shropshire population and will highlight the specific areas where the CCG can support Public Health colleagues and the Health & Wellbeing Board in meeting its objectives in this regard.

Within 2015/16 the CCG will also be reviewing further the prevention areas identified above to ensure the appropriate focus within CCG planning and redesign

Further detail to be included regarding CCG links with PH and the delivery of primary prevention programmes

Working with our staff

The CCG supports and will actively participate in Shropshire Health & Wellbeing Board's year of physical activity for 2015.

The CCG Board has been updated on significant organisational development actions which have taken place to improve the physical and mental health and wellbeing of staff. This includes:

Induction: A CCG induction pack has been produced, which consists of a slide pack and induction checklist. The slide pack includes an overview of the NHS structure both locally and nationally; the CCG's structure and Governing Body; links to key information and useful contacts. The slide pack continues to be developed but has been used for a number of new starters and has been published to the staff intranet, ShropShare, where it will be further developed and updated. The checklist has also been used for a number of new starters but is currently still in draft format until all of the accompanying documents have been developed. This has also been published to ShropShare.

Mentoring and Coaching: In the work done to identify the CCG's Organisational Development priorities, mentoring and coaching was highlighted as one of the areas of priority. The CCG is currently exploring a coaching programme for line mangers to enable them to support and develop staff. It is anticipated that the programme will be provided twice a year and delivered by an 'in house' expert.

Communications and engagement with staff and members: The CCG has worked hard to develop its communications channels and has established a series of well-read newsletters; a re-invigorated monthly Staff Briefing process (which also includes OD discussions); an informal 'Staff Car Park' group which aims to discuss little things that can make big differences to staff and the Mandate launch which took place across the localities in Shropshire.

Staff Survey: A six-monthly staff survey has been introduced that helps check the temperature of the organisation an identify short-term issues and potential long-term directions of travel.

Training and Development: The CCG continues to ensure that all staff complete relevant mandatory training as well as developing bespoke training courses for specific staff groups, such as: Safeguarding, Prevent training, Mental Capacity Act training and Dignity and Respect training.

Reducing Health Inequalities

Those in the poorest communities experience the worst health, largely due to the impact of social conditions on preventable risk factors. For example, about half the differences in male death rates by socioeconomic status can be accounted for by differences in smoking rates. To reduce premature mortality, narrow inequalities and improve health, there is a need to tackle both the preventable causes of ill health and the 'causes of the causes' (see Figure 1).

Fig. 1
The causes of health inequalities
Source: National Audit Office

Health is about more than just the absence of disease, it includes a sense of wellbeing and the ability to achieve one's goals. It follows that health can be strongly influenced by factors such as housing, education, income and crime. Shifting the emphasis from management of illness towards maintenance of health will require a concerted effort at every level of society, including national as well as local action. That said, there are many assets for local communities to build upon, and much that can be achieved by joining the 'jigsaw pieces' together from the bottom up. Two broad approaches are needed to embed prevention locally (see Figure 2):

Strengthening locality-based assets to create 'healthy places' and 'healthy communities'

Motivating and supporting positive health behaviours and self-care

- Identification of the groups of people in your area that have a worse outcomes and experience of care, and your plans to close the gap
- Implementation of the five most cost-effective high impact interventions recommended by the NAO report on health inequalities
- Implementing EDS2
- Examination of how the organisation compares against the first NHS Workforce Race Equality Standard
- All NHS employers and Boards must examine themselves against NHS workforce race equality standards

In last year's Operational Plan the CCG set out the following local position:

The Shropshire JSNA and Health and Wellbeing Strategy have identified groups of people in the populations that have worse health outcomes compared to the average. 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. For example 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 there are higher levels of obesity.

Shropshire has an ageing population; therefore it is likely that prevalence of disease will rise. This prevalence is not spread equally with those in more deprived areas more likely to have higher prevalence of disease and from an earlier age than those in more affluent areas.

Shropshire is also a large, sparsely populated rural county where equal access to services is often not possible due to geographical distance. This is important when planning health care interventions.

Therefore, although there are certain groups in Shropshire's population that have worse outcomes than others, this varies depending on the health outcome and will need consideration when planning an intervention.

Shropshire CCG's position in relation to addressing Health Inequalities is unchanged from 2014/15 in terms of the focus on the population profile. Therefore the focus and principles of the overarching work streams remain the same, along with our commitment to working with our partners and the Health & Wellbeing Board on a long terms footprint if reducing health inequalities is to be achieved.

Much of the work set out in the Improving Health section above will contribute to work to reduce health inequalities in Shropshire. Our response to the "Commissioning for Prevention" guidance and the development of our Better Care fund workstreams, also set out in the section above demonstrate our focus on prevention and reducing health inequalities. Our priority areas consider the findings of the National Audit Office's report (2010), the identification of the 5 most significant health problems identified in the "Commissioning for Prevention" guidance (ischaemic heart disease, lower back pain, stroke, lung cancer and Chronic Obstructive Pulmonary Disorder) and overlay our local intelligence via the JSNA, Commissioning for Value packs and social care data to dictate our areas of focus as

Public Health colleagues in Shropshire identified some of the key areas for prevention in the county to including fragility fractures, obesity, smoking and cardiac rehab and has been used to inform our Better Care Fund plan. The work of the Better Care Fund also supports building community resilience and promoting self care. Further details of this can be fund in both the Improving Health and A modern Model of Integrated Care sections.

Public Health Shropshire has formed an in house provider unity called 'Help2Change' to assist with the delivery of prevention services and the CCG is working closely with them to support this work. The Health & Wellbeing Board has adopted 2015 as it year of physical activity and as part of this focus the CCG is working with partners lead by Public Health, to develop an "Inactivity Strategy" across Shropshire

Smoking Cessation
Although in Shropshire smoking prevalence is significantly lower than the national average, smoking in pregnancy is significantly higher making this a priority area in terms of reducing health inequalities. The CCG are currently working in partnership with Public Health, other local authority partners and providers to reduce smoking in pregnancy and this will continue into 2015/16.

NHS Health Check
The NHS Health Check will enable the identification of patients with certain conditions, e.g. hypertension, diabetes, and patients with certain lifestyle risk factors that could lead to them developing some conditions, e.g. smoking, consuming unsafe levels of alcohol. This will be vital in identifying the populations that would most benefit from the 5 recommended interventions.

Updated position from PH for 2nd draft

Prescribing
The 5 interventions recommended are:

- Increased prescribing of drugs to control blood pressure;

Hypertension is a major preventable cause of morbidity and mortality. Hypertension is usually symptomless - screening and accurate diagnosis is therefore vital. Lowering blood pressure (BP) in patients with hypertension decreases the risk of stroke, coronary events, heart failure and renal impairment. Improved identification, diagnosis and treatment of hypertension could improve outcomes; reduce hospital admissions and costs to the NHS. The Primary Care Support team and GP practices auditing treatment of patients taking blood pressure lowering medication.

National indicators associated with this area of prescribing – also a component of the Prescribing Quality and Optimisation Scheme (PQOS)

In 2014/15 there has been an increase in the volume (number of items) of prescriptions to control blood pressure by almost 19,000. Practices are advised to follow NICE and local guidance. Prescribing data is provided to practices on a monthly basis.

- Increased prescribing of drugs to reduce cholesterol;

Based on NICE guidance, for most people, 40 mg simvastatin remains a first-choice treatment for the primary and secondary prevention of cardiovascular disease. Exceptions to this include patients with acute coronary syndrome (ACS), familial hypercholesterolemia, or for patients with type 2 diabetes where total cholesterol (TC) >4 mmol and low-density-lipoprotein cholesterol (LDL-C) >2 mmol, to whom a

higher intensity statin* treatment should be offered. Consideration may also be given to the use of a higher intensity statin in patients with established cardiovascular disease, if TC >4 mmol and also LDL-C >2 mmol.

National indicators associated with this area of prescribing – also a component of the Prescribing Quality and Optimisation Scheme (PQOS)
Regular prescribing data provided to practices.

In 2015/16 there as been an increase in the volume (number of items) of prescriptions to reduce cholesterol by 24,000. Practices are advised to follow NICE and local guidance. Prescribing data is provided to practices on a monthly basis.

- Increased anticoagulant therapy in atrial fibrillation;

Locally, consideration has been given to the evidence for the newer oral anticoagulants (NOACs) for stroke prevention in atrial fibrillation (AF). Guidance was issued to prescribers to ensure appropriate prescribing. Primary care clinicians are more conscious of 'time-in-therapeutic INR range' for patients receiving warfarin and so proactively managing patients. Current review of Local enhanced scheme for the therapeutic drug monitoring of patients on warfarin being undertaken.

In 2014/15 there has been an increase in the volume (number of items) of prescriptions for atrial fibrillation by 8,217. Local guidance based on NICE guidance has been made available to practices. Tools (PRIMIS) are run by the Primary Care Support team and practices to identify patients at risk of stroke – patients are then prescribed anticoagulant drugs.

- Improved blood sugar control in diabetes

Poor glucose control cannot be supported in patients with type 2 diabetes as it is associated with a higher risk of mortality and micro vascular complications. However, controlling blood glucose control is just one aspect of diabetes management. With regard to lowering cardiovascular risk, blood pressure control and lipid lowering are both more effective than controlling blood glucose. Lifestyle factors including smoking cessation, diet and physical activity may also have a significant impact on disease progression and outcomes. Because of the complexity associated with managing diabetes, therapy should be tailored to the individual needs and circumstances of each patient. Several studies have demonstrated that intensive glycaemic control in type 2 diabetes provides only limited benefits and is associated with an increased risk of adverse events.

National indicators associated with this area of prescribing – also a component of the Prescribing Quality and Optimisation Scheme (PQOS)

In 2014/15 there has been an increase in the volume (number of items) of prescriptions to improve the control of blood sugar in diabetes by 22,222. Local guidance based on NICE guidance has been made available to practices. Tools (PRIMIS) are run by the Primary Care Support team and practices to identify patients with diabetes – patients are then prescribed appropriate drugs to improve sugar control in patients with diabetes.

The work set out above will continue into 2015/16

Equality& Diversity

The CCG has in place:

Equality and Diversity Strategy
Patient and Public Engagement Committee
Equality Delivery Steering Group

We have implemented the original Equality Delivery System through:

- Undertaking a baseline assessment against the Equality Delivery System outcomes, about assessing peoples' needs, delivering care, employment systems and leadership
- Involving our community interest groups in the review of the shadow CCG baseline self-assessment against the eighteen outcomes in order to triangulate the community groups' experiences and perceptions of service

We identified four areas for development alongside our communities of protected characteristics which we would implement over a 4 year cycle. We have implemented one of the objectives through the production of a staff awareness film – 'Hats off to Humanity'

We plan to undertake a similar process as before with EDS2, involving our community interest groups in the review of the CCG baseline self-assessment against the EDS2 outcomes in order to triangulate the community groups' experiences and perceptions of service.

In partnership with the community interest group we will identify the areas for development being mindful of the outputs from the original EDS activity.

We will work with Health watch / Equality forums to create conduits for scrutiny by external bodies of the implementation of the Equality Act 2010 within the CCG.

- *Identified the key local stakeholders to the EDS2 framework of activity*
- *Identifying and assembling evidence for analysing equality performance – identifying any gaps and how they can be filled, working with commissioning programme leads*
- *Agreed roles with partner organisations*
- *Currently analysing performance based on evidence and experiences, working with PPECC representatives*
- *Agree grades*
- *Review and refresh equality objectives and develop short-term action plans of activity*

• *Integrate equality working into 'business as usual' operations* • *Publish grades, objectives and actions plans* • *Maintain processes and systems already established to ensure compliance with 14Z2 duty as to public involvement and consultation /26* • *Participate in the development and delivery of an overarching health and social care economy Engagement and Communications Strategy that supports the delivery of the public involvement, engagement and consultation component of the Better Care Fund.* • *Implement refreshed SCCG Communications and Engagement Strategy* NHS Race Equality Standard: The CCG's senior leadership team and workforce in general is representative of the population it serves. Workforce monitoring is a key undertaking of the organisation and the Governing Body is sighted on the data.	

Parity of Esteem

Shropshire CCG has been taking forward work on parity of esteem on the basis of the following principles: Equal access to the most effective and safest care and treatment Equal efforts to improve the quality of care The allocation of time, effort and resources on a basis commensurate with need Equal status within healthcare education and practice Equally high aspirations for service users and • Equal status in the measurement of health outcomes In 2015/16 the CCG will continue to build on the foundations put in place in 2014/15 and in particular will focus on the following areas of work: - Improving Access to Psychological Therapies – The CCG will continue to work closely with South Staffordshire & Shropshire NHS Foundation Trust (SSSFT) to achieve the access (15% and recovery (50%) targets in 2015/16 - Improving diagnosis and support for people with dementia – Work will continue to implement the joint action plan developed with Shropshire Council. This will include a continuation of the memory service commissioned from SSSFT the Directed Enhanced Service including screening at risk groups for memory problems and continued support for the Shropshire Patient Self Help Programme - The CCG will also look at ways that it can better utilise local networks to build on the work around the resilient communities, dementia friends and compassionate communities work to extend it to mental health - Work will continue around the Rapid Assessment Interface and Discharge (RAID) work supporting patients in an acute setting who in addition to their physical health problems also have a mental illness - There will be continued participation in the learning and implementation of actions arising from the Confidential Inquiry into	• The resources you are allocating to mental health to achieve parity of esteem • Identification and support for young people with mental health problems • Plans to reduce the 20 year gap in life expectancy for people with severe mental illness • The planned level of real terms increase in spending on mental health services

Premature Deaths of People with Learning Disabilities (CIPOLD) and participation in the Learning Disabilities Self Assessment Framework and the learning associated with it.

- In relation to crisis service provision we will conclude a review of provision and begin implementation of recommendations from this review with our partners
- We will continue to commission and support our service for helping people with a mental illness into employment

The NHS England document ' Achieving Better Access to Mental Health Services by 2020' highlights the following "all age" items which the CCG will be factoring into plans and service developments for 2015/16:

- 75% of people referred to the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral, and 95% will be treated within 18 weeks of referral.
- More than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral.

Identification and support for young people with mental health problems:-

During 2015/16 Shropshire CCG will develop and implement recommendations to improve access and reduce waiting times for Tier 3 CAMHS services in line with new national standards for mental health services waiting times. Shropshire CCG will focus on measures to deliver parity of esteem as well as ensuring good transition planning and effective delivery of the mental health crisis care concordat. This includes seeking to reduce the number of children and young people who self harm.

Shropshire CCG will work with Shropshire Council to increase choice in mental health services, ensuring service users are aware of their rights and offered choice in mental health services and are able to make well-informed, meaningful choices at appropriate points along the pathway.

Shropshire CCG will agree a Service Development and Improvement Plans (SDIPs) with the provider of mental health services for children and young people to ensure there are adequate and effective liaison psychiatry services in acute settings.

A revised service specification for Tier 3 CAMHS is in place to ensure that the service meets the needs and delivers positive outcomes for children and young people who require a Tier 3 mental health service. Close links have been established with Shropshire Council who is leading on the delivery of a Tier 2 Targeted Adolescent Mental Health Service (TaMHS).

Plans to reduce the 20 year gap in life expectancy for people with severe mental illness:-

On the 20th January, 2014 the Department of Health launched *"Closing the Gap; Priorities for essential change in mental health."* It sets out 25 areas in which action is required over the next *couple of years* to improve the mental health of those affected by mental illness. For instance

"Closing the Gap" states that 42% of all tobacco smoked is by people with mental illness. This and other socio-economic and psycho-

social factors greatly affect the health outcomes of those with mental illness.

The CCG has worked with the provider Trust to improve supports to those with mental illness. All service users in receipt of care under CPA are offered annual physical health checks which are incorporated into care planning. The service has adopted a smoking cessation policy which has seen the mental health provider work collaboratively with the local smoking cessation service. The latter provides information targeting mental health service users and has a link worker with the Redwoods and also employs a registered mental health nurse. The provider Trust also offers other healthy lifestyle initiatives such as walking groups and advice upon diet and exercise.

In addition to this, there is a clear focus upon delivering four key priority areas. These include:

1. *Delivering improvement in access to psychological therapies.* The CCG has developed a specific action plan with the SSSFT to ensure achievement of the given targets for 14/15. A working group meets monthly to review progress and ensure delivery. In addition to this, the CCG is reviewing its GP counselling provision to ensure this service is compliant with IAPT principles and that this activity can be counted from next year.
2. *Improving diagnosis and support for people with dementia.* This is a key priority for the CCG. A dementia strategy and associated action plan has been produced in partnership with the Local Authority and is being actively implemented.
3. *Improving awareness and focus on the duties within the mental health capacity act.* There are several work areas underway that contribute towards this. This includes a specifically commissioned service that provides assessment and support for patients who have mental illness alongside physical health problems.
4. *Crisis service provision.* The CCG is currently working with providers and other stakeholders to undertake a review of mental health services. This will be cross referenced with "Closing the Gap" owing to the commonality of purpose.

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Further to this the CCG anticipates taking forward the following actions in 2015/16:

- Delivery of the Increasing Access of Psychological Therapies (IAPT) target for access and recovery
- To implement learning Disability self assessment framework recommendations
- To carry out an evaluation of the Modernisation of Mental Health Services recommendations including development of a clinical model by the provider to reduce length of stay in line with targets and work to accelerate the improvements in the usage of out of area beds
- To continue to support work associated with the Mental health Crisis Care Concordat including enhancing the capacity of the section 136 process to reduce the use of police cells
- Explore alternative models for crisis and respite care to enhance Mental health Crisis support
- CCG's to work with GP's and providers to ensure patients are offered choice in mental health services and are able to make well informed meaningful choices at appropriate points along the pathway

Response required regarding MH investment

Patient Services - New Approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care

Patients In Control Initiative

The financial challenges facing the NHS today demand a radical shift in thinking and new commissioning culture – powered by patient-centred solutions which maximise return on investment, improve the patient experience and generate better outcomes.

Based on local planning work carried out during 2014/15 Shropshire CCG made a commitment to delivering a focused Patient In Control initiative. The condition we are focussing on in Shropshire is Crohns Disease. Two workshops have been held locally with service users to understand how they feel we can better empower them to manage their conditions. Alongside this we are planning a leadership development day

As part of 'Patients in Control' programme sponsored by NHS England we are offering a series of leadership development workshops for CCGs and Area Teams to:

- Support the drive for improved outcomes and better care experiences for patients and their carers through prevention and local co-design
- Support the drive for better value for money, maximum return on investment, reduced demand on urgent care and the better management of chronic conditions and post-acute care
- Assure compliance with the NHS Mandate, Health & Social Care Act, NHS Constitution and NHS England reporting duties
- Support the successful commissioning of new approaches to self-care, for example through personal care plans, access to information, emotional / peer support, social prescribing and personal health budgets
- Support the effective implementation of integrated personalised commissioning, Better Care Fund, co-commissioning and multi-disciplinary strategies based on co-design with patients, carers and the voluntary and community sector.

The workshop will:

- Establish a clear understanding of the 'Patients in Control' agenda and policy context.
- Develop practical 'know-how' and expertise in person centred care through scenario based action learning, good practice, case studies and 'lessons learned'.
- Identify areas where local co-design/co-production can contribute to the development of new commissioning practice.
- Establish CCG action plans to implement the 'Patients in Control' agenda
- Facilitate leadership commitment to implementing this critical initiative.

The workshop will be supported by a team of experienced facilitators who will be working in partnership with patient leads. This team has experience in strategy implementation, NHS commissioning and operations as well as clinical knowledge and expertise.

- How will you commission services so that patients and citizens have the opportunity to take control
- How will you put real time patient and citizen voice at the heart of decision making
- How will you include authentic citizen participation in the design of your plans
- How will you promote transparency in local health services

Work associated with the Patient in Control initiative will continue into 2015/16.

Young Health Champions

A further example of Shropshire CCG commitment to putting our citizens at the heart of what we do is our Young Health Champions project, which we will continue to build on in 2015/16. This project, set up by Shropshire Clinical Commissioning Group and funded entirely through the Big Lottery was a way of supporting younger people to have a greater understanding of health issues and how they can take responsibility for their own health and wellbeing.

There is currently a network of 130 health champions aged 11-25 throughout the County.

Recent achievements include:

- Designing a space for teenagers in the purpose built children's unit at Princess Royal Hospital in Telford
- Becoming dementia friends and supporting activities to educate their communities about the illness
- Creating opportunities for different generations to come together for emotional support through an up-cycling project.

Personal Health Budgets

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.

The CCG will lead on the work locally in relation to further developing integrated personal budget arrangements for children and young people with an Education, Health and Care Plan. Shropshire CCG will also work closely with the Local Authority to refine joint commissioning arrangements in relation to this area of work

The CCG will build on the implementation of Personal Health Budgets for children and young people with an Education, Health and Care Plan and those in receipt of Continuing Health Care and work with regional partners to respond to the national directive to roll out PHB to those with Long term conditions. We will continue to work closely with the council to jointly use resources to respond to personalisation and link to personal budgets

Add statement around Integrated Personalised Commissioning for 2nd draft

Communication & Engagement

Shropshire CCG currently has a Communication and Engagement Strategy in place which runs from 2014 to 2017. Members of the

Patient and Public Engagement and Communications Committee (PPECC) have been instrumental in developing and refining this document.

The strategy builds on the framework contained in the Department of Health guidance paper, *The Communicating Organisation* (December 2009), follow guidance in the National Health Service England paper, *Transforming participation in health and care – the NHS belongs to us all* (September 2013), and champions the values, rights and responsibilities enshrined in the NHS Constitution.

The strategy will remain responsive to the changing context within the NHS and it will also reflect our commitment to promoting equality of opportunity, eliminating discrimination and recognising and valuing diversity.

Our strategic communications and engagement objectives:

- To support the wider CCG in delivering its corporate vision and objectives
- To embed successful communication and engagement with stakeholders to ensure a culture of co-production
- To promote the health and wellbeing of all Shropshire people
- To build and protect the reputation of the CCG
- To promote equality of opportunity, eliminate discrimination and recognise and valuing diversity

In order to make sure we achieve our strategic objectives the CCG will develop an annual tactical action plan, which will outline specific areas of work and progress made to achieving the areas of work. The Patient and Public Engagement and Communications Committee (which is a sub-committee of the Board) will review the progress at its bi-monthly meetings.

<u>Engagement</u>

Engagement is a key cornerstone of the NHS changes is the principle *no decisions about me without me*, (*Liberating the NHS* – Government response – December 2012). We are committed to continuous and meaningful engagement.

Patients will get more choice and control, backed by more and better quality information. Services will be co-designed by patients and as a result will be more responsive to patients and their needs, rather than patients having to fit around services.

We have a duty to ensure that our engagement activity (just like our communications activity) is inclusive and does not disadvantage anyone in our communities. We work hard to ensure that people who do not have advice, or may not have equal access to information or opportunities to engage, are not disadvantaged.

Our engagement will be accessible and appropriate for a range of audiences. We recognise that there can never be a 'one size fits all' approach. We will deploy a range of diverse approaches, including digital and social media approaches alongside the more traditional

approaches of focus groups, meetings and forums.

We will continue to support and encourage community leaders to be communications champions and develop our work with them to ensure that people from different backgrounds and faiths, with different languages and different engagement needs have access to information and can get involved.

We will use the Commissioning Engagement Cycle to guide our engagement work and to make sure that co-production is at the heart of what we do.

External Communication we will use and develop

- **Website:** An effective website that people can easily access information about the CCG.
- **GP practices:** Regular campaign and survey materials will be sent to GP practices to engage patients.
- **Press and media relations** : Good local relationships and a regular presence in the local media will promote the role of the CCG and help connect the organisation with local people
- **Provider and partner communications:** Information will be shared with partner organisations for dissemination to their staff and service users as appropriate.
- **Advertising:** This will be used where there are clear objectives and where evidence shows the media has effective reach with the right people in a cost-effective way.
- **Community interest and patient groups:** These provide opportunities to engage with existing, well-formed groups.
- **Social media:** Twitter, in particular, provides an instant, proactive as well as reactive channel appropriate for a wide range of messages and is a useful way of connecting and interacting with a wide range of audiences
- **Annual Report**: Yearly summary of key developments, engagement activity, statutory content including the financial report, produced in an easy to read format.
- **Monthly board meetings**: The CCG's board meetings are open to the public and ways of raising questions at a Board meeting will be promoted on the CCG website and as part of Board papers.

Internal Communication we will use and develop

GP membership and practice communications:

- **E-bulletins:** Members receive regular bulletins and email messages and are invited to attend meetings such as the annual general meeting, Mandate launch and programme workshops.
- **Locality meetings**
- **Practice manager meetings/forums**
- **Intranet (Shropshare):** This is a separate website from the CCG's public site and is being configured for GP member use.

CCG staff:

- **Staff meetings:** Bi-monthly all-staff meetings
- **Staff newsletter:** Fortnightly electronic staff newsletter to all staff
- **Messages to all staff:** Email 'newsflash' messages to all staff should be reserved for need-to-know messages.
- **Intranet (Shropshare):** This is a separate website from the CCG's public site.

In addition to this our key principles are as follows:

- We will use a range of methods including newsletters, surveys, social media, workshops and focus groups to communicate and engage in an approach that can be measured.
- Proactive communication and engagement of patient experience and insight will inform and develop the shape of communications and engagement activities.
- There will be an annual audit of engagement and engagement activity to ascertain the success of these methods in terms of co-production of health services in Shropshire.
- We will continuously seek feedback and evaluate and improve by listening
- Our tone of voice will be clear, professional, accessible, honest, respectful and easy to understand.
- We will avoid unfair stereotypes and acknowledge the different needs of individuals and communities.
- Our staff will be developed to be excellent communicators and create effective, credible mechanisms inside and outside of the organisation.
- Our communications will be cost effective, using new technology (where appropriate) and working with partners to communicate with one voice.
- Our engagement will be accessible and communications will be easily obtainable and available in other languages, symbols or formats, if required.

The CCG will continue to develop its participation and partnership work based on the following principles:

Continual and open dialogue between commissioners, local leaders, community members and other stakeholders fosters a culture of transparency and trust.

Commissioning decisions are better supported when people are involved in identifying problems and designing solutions that work.

Alongside the continued implementation of our Communication & Engagement Strategy we will also continue to use the Engagement Toolkit - 'TRANSFORMING CARE'PARTICIPATION IN HEALTH AND CARE as good practice guidance to underpin our work and take an active part in the 'NHS England Involvement Project'. Patient Participation Groups will continue to remain active alongside the Shropshire Patients Group.

Areas of work which have already commenced where there has been significant engagement and involvement of communities which will continue into 2015/16 are:

- NHS Future Fit Programme
- Review of Walk in Centre
- Review of 'End of Life Care'
- Review of 'Dementia' strategy and plan
- Mental Health Service review
- Development of 'Young Health Champions'
- Better Care Fund

Partnership Working will continue to be a priority for the CCG and we will build on the "Building Health Partnership" work already commenced, linking where appropriate to the FutureFit programme as well as delivering on the 'Patients in Control initiative and continuing to develop our successful 'Young health Champions' work.

In addition we will

- Continue to work with the Health and Wellbeing Board to develop and overarching Communication and Engagement Strategy in 2015/16
- Work with the VCSA around developing a grant framework
- Work with our partners to develop and implement the workstreams associated with Better Care Fund

The Health & Wellbeing Board Communications & Engagement strategy focuses upon building upon The Compact[1] and upon the joint streams of work across the health and social care system of Shropshire. Individual health and social care organisations across the county will have their own strategies and plans that feed into and support this overarching strategy. All organisations linked to this strategy are committed to seamless and effective communications and engagement for everyone who uses health and social care services in Shropshire.

The purpose of this strategy is to create transparency, consistency, to join up working and to avoid duplication in communications and engagement work.
This agreement will increase knowledge and understanding of health and care across Shropshire, helping the people of Shropshire to be better informed and involved in decisions around their care and, as a result, to have better access to services. This will help health and social care organisations to achieve their individual priorities and aspirations around health and wellbeing.

[1] For more information on The Compact in Shropshire, please see: vcsvoice.org/the-compact/

Health and social care partners want to ensure that, where possible, communication and engagement is co-produced across the health and social care economy alongside other partners and the people of Shropshire.

All organisations signed up to this strategy are committed to the following principles and will:

- Adopt good practice and operate in a transparent, targeted, objective and timely fashion with the spirit of openness and candour
- Work together; sharing information and making use of skills across networks
- Ensure accessibility and equality needs are respected and accommodated at all times
- Take an approach that fosters continuous engagement and reflects two way dialogue with our local people
- Facilitate positive relationships with our employees and empower staff to be communications and engagement ambassadors

Information sharing

All of the organisations that have signed up to this strategy agree to share findings and information learned from engagement and communications activities, such as consultations, in order to improve the experience that local people have of health and social care services. This will also reduce the risk of duplication of work and ensure that active conversations with communities are shared across the health and social care system. This agreement is not about sharing personal information.

Platforms such as the Joint Strategic Needs Assessment (JSNA) will be utilised in the sharing of information common across the health and social care landscape in Shropshire.

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Approaches

We will use the most relevant and targeted methods to ensure that we communicate and engage effectively with the people of Shropshire. We will use a combination of tools such as demographic profiling, grass roots knowledge and experience, and engagement with stakeholders to ascertain how best to communicate and engage with relevant individuals, groups and communities.

A combination of approaches will be deployed to ensure that every contact with the people of Shropshire counts. When devising specific communications and engagement plans we will incorporate all channels that are deemed most effective to target people. Our communications and engagement will be outcome-focussed and there is an efficient feedback loop to demonstrate that we are listening and acting upon feedback.

We will use a range of channels, for example; websites, newsletters, press releases, social media, surveys, face-to-face events, focus groups, community conversations and staff as advocates. Also by using our networks to strengthen the channels that we use and ensure that the mechanisms utilised reflect the best method of communication and engagement for that group.

We consider there is an importance in capturing the views and experiences of the people of Shropshire, and this detail will inform the update of the JSNA and be used in the development of services. By using a targeted, relevant and outcome-focussed approach we will aim to achieve good communications and engagement with people and by definition we will develop a network of trusted communicators.

Feedback loop and making a difference

For all activities there will be a feedback mechanism to share the messages that have been generated as a result of any

communications and engagement. We are committed to sharing any outcomes where there are changes as a result of engagement and communications. We understand that good communications and engagement is a cyclical process and we believe that this will underpin achieving a healthy Shropshire.	

Wider Primary Care at Scale

Our understanding of the potential of Primary Care to deliver our ambition

In recognition of the central role of primary care in delivering our ambition, the CCG has applied for full delegated responsibility for Primary Care in 2015-16 and is awaiting confirmation of approval of this. As part of the submission the CCG has engaged with its membership, created the Terms of Reference for a Primary Care Commissioning Board, updated its constitution, attended workshops on the process for transfer of the responsibilities and is meeting with the Area Team on a regular basis to understand the detail of the funding allocation. The CCG is considering the Primary Care allocation as part of the financial and operational plan for 2015-16. The Shropshire Primary Care Strategy is in the process of being refreshed in line with these additional responsibilities.
Specific actions to be taken forward include:

- Establishing a Primary Care Commissioning Board.
- Refreshing the Primary Care Strategy to incorporate Full Delegated responsibility
- Reviewing the Primary Care support structure and aligning it to incorporate revised responsibilities/constitution

We view primary care as playing a central role in the delivery of pro-active care, increasing community capacity and offering 24/7 care. To this end, we are committed to the continued support and development of the Care Homes Advanced Scheme and we are prototyping partnership care (between specialists and generalists to support ore patients in the community) through locality based projects in diabetes, heart failure and osteoarthritis.

We are committed to a progressive vision of primary care at scale in urban and rural settings, whilst, at the same time, aiming to enhance the values of list-based family general practice as a key to providing continuity of care and nurturing relationships, particularly in the management of people with long term conditions. As part of the FutureFit reconfiguration programme to reconfigure hospital based services in the context of a whole system plan, FutureFit2 has convened GPs from across the county and other community stakeholders to define in more detail the integrated models of care which will care for more people in the community, keep more people independent and reduce hospital admissions and lengths of stay. This design will be completed and modelled by the end of 2015.

General practices in Shropshire/T&W have recently established a GP Federation as a vehicle for enhanced collaboration between practices as providers. This has the potential to support primary care to operate at a greater scale to improve access and continuity of care, both in relation to core GMS services and beyond. The CCG has supported a bid by the Federation to the Challenge Fund to develop primary care services both across hours of the day, days of the week and total services delivered, (as part of a whole system workforce plan under FutureFit), including the development of novel roles, rotating posts and placements and enhanced training

- Your understanding of the potential contribution of primary care to the delivery of your ambition
- Working with partners and the public to develop an integrated approach to primary and community services with joint commissioning as appropriate
- How you will enable primary care to operate at greater scale to improve access and continuity of care and to enable your urgent and emergency care network to function effectively

opportunities, and to provide IT solutions which allow patients better access and information through their practices and pave the way for integrated care records across the whole health and social economy. Through FutureFit2, the CCG is also supporting the Federation to develop a collective vision for primary care in collaboration with all 44 GP practices in Shropshire (and the 22 in Telford & Wrekin).

Working with partners and the public to develop an integrated approach to primary and community services, with joint commissioning as appropriate.

The CCG is facilitating the engagement and mobilisation of local communities around GP practices and enabling the development of community resilience by continuing to support the development and roll out of the compassionate communities project, the practice community and care co-ordinators, the young health champions through the Better Care Fund and Dementia friendly communities through the HWBB..

Through FutureFit, FutureFit2 and by supporting local development opportunities, the CCG is enabling the engagement and collaboration of all stakeholders at locality level to provide '24/7 local care', a combined community offer which will include General Practices, OOH GP services, MIUs, community hospitals, community teams, voluntary sector, 3rd sector and care homes. This will incorporate the concept and planning of the 'team around the practice'. The CCG is also supporting immediate local opportunities for integration, for example by supporting 2 practices in the North of the county are to develop plans to merge and co-locate with a community hospital. The Integrated Care Service is now being rolled out across the county and provides both admission avoidance and facilitated discharge services. Further to this an expression of interest has been submitted to pilot a multispecialty community provider new model of care.

In addition to supporting practices and partnering with Public Health in the delivery of secondary prevention, the CCG is also working through the HWBB to develop a whole economy prevention strategy which addresses the wider determinants of health, delivered through local partnerships and community action.

How will we enable Primary Care to operate at greater scale to improve access and continuity of care and enable our urgent care network to function effectively?

Both FutureFit and national guidelines describe a tiered and networked model of urgent care, with urgent care centres (UCCs) providing walk in services and networked to an Emergency Centre. Two urban urgent care centres are currently being prototyped by integrating A&E and primary care services at the front door of both acute hospitals. The CCG is also committed to prototyping 2 rural urgent care centres which, although providing a consistent and networked offer, will test local opportunities for collaboration and seek to address the particular needs of rural communities.

The CCG is prototyping full consultant triage of all GP requests for admission, which has already improved and re-established working relationships between these two professional groups, and will form part of an integrated ambulatory care service which will combine primary and secondary care workforces and operate in close co-operation with the prototype urgent care centres at both acute hospitals.

A live GP dashboard is currently being tested in 7 practices; it shows practice specific information about admitted patients and provides a platform for initial communication with primary care to flag patients where primary care advice and collaboration might be helpful in facilitating the discharge of patients with complex problems.

Continuity of care across time and care settings will be enhanced through a combination of pro-active care and case management for at risk patients, moving from a referral based model to a partnership based model of care which enables clinicians to manage more patients in the community with timely specialist support when required, and the progression towards an integrated care record available in all care settings and all points of patient contact. The learning from Care Home Advanced Scheme will be applied to at risk patients in other care settings and, assuming the CCG is successful in its application for devolved responsibility for commissioning primary care, the national admission avoidance enhanced service will be reviewed and may be modified locally. Similarly, the learning from the partnership care locality prototypes in diabetes and heart failure which have been running over this winter will be used as a basis for rolling out the next phase of partnership care, with the potential for applying new commissioning models to support whole system pathways of care. A system wide IT forum is now well established and is tasked with developing an integrated care record. Summary care records are now available in the A&E and ambulatory care departments of the acute trust across both sites. Emis is installed in the urgent care centres.

Further statement to be included regarding access

A review has been undertaken of our performance in relation to the GP survey. Our performance has to date been above average and we have therefore submitted as part of our performance measures a trajectory for a modest improvement in 2015/16. However it is our intention before the final submission of our plan to undertake further detailed analysis of the spread of performance across our GP practices and to identify those where performance can be improved and develop action plans to address this.

A Modern Model of Integrated Care

Better Care Fund

We envisage a system where, through working together, we have created a pattern of services that offer excellence in meeting the distinctive and particular needs of the rural and urban populations of Shropshire. We propose to tackle the challenges we face responsibly, creatively and with a passion for what matters most.

Development of work around Long Term Conditions sits at the heart of our Better care Fund Plan, which has been developed around 4 key strategic themes:

- **Prevention** - Empowering people to make better lifestyle and health choices for their own and their families health and wellbeing, preventing the prevalence of ill health and the need for intervention

- **Early Intervention (Case Management)** - The identification of 'at risk' groups of people and the approach to support those people through a process of joint assessment, allocation of a 'key-worker' joint care planning and active case management

- What you are doing to ensure people with multiple long terms conditions and clinical risk factors are offered a fully integrated experience of support and care

- **Supporting People in Crisis -** In the event that an individual finds themselves in crisis, rapid, focused intervention with a view to helping a person remain in their own home or return there as quickly as possible.

- **Supporting People to Live Independently for Longer -** Reducing dependence on paid support and enabling independence. Maximising the use of community resources and natural support to develop community resilience.

Each of the 'Strategic Themes' has a number of 'Transformation Schemes' which should contribute to the delivery of the 'Theme Objective'. The 11 Transformation Schemes are:

Strategic Theme - Prevention

- Integrated Falls Prevention

Strategic Theme - Early Intervention (Case Management)

- Proactive Care Programme
- Community & Care Coordinators
- Care Home Advance Scheme
- Team Around the Practice

Strategic Theme - Supporting People in Crisis

- Integrated Community Services
- Mental Health Crisis Care

Strategic Theme - Supporting People to Live Independently for Longer

- Resilient Communities
- Dementia Strategy
- Integrated Carers Support
- End of Life Coordination

The following gives a summary of the anticipated changes in the configuration of services over the next 5 years. Details of the particular schemes cited can be found in Annex 1 of this document

Prevention

Prevention services will be configured to empower people to make better lifestyle and health choices for their own and their families health and wellbeing, preventing the prevalence of ill health and the need for intervention

The impact of falls and the increasing number of people living with dementia has been identified as a significant challenge within our economy the following schemes will assist in the delivery of the outcomes of this strategic theme:

- The **Integrated Falls Prevention** model will reform existing falls and fracture pathways, increasing the number of falls

assessments, increase the number of people receiving falls risk reduction interventions and deliver a reduction against our baseline of falls related admissions

Early Intervention (Case Management)

This strategic theme will focus on the transformation of Primary Care services to deliver the identification of 'at risk' groups of people and the approach to support those people through a process of joint assessment, allocation of a 'key-worker' joint care planning and active case management

All of our GP practices have, or will have by 2015, direct or indirect support from the following schemes to assist in the delivery of this strategic theme:

- **Proactive Care Programme** requires practices to identify patients who are at high risk of unplanned admission and manage them appropriately with the aid of risk stratification tools, a case management register, personalised care plans and improved same day telephone access. In addition, the practice also provides timely telephone access to relevant providers to support decisions relating to hospital transfers or admissions in order to reduce avoidable hospital admissions or accident and emergency (A&E) attendances
- **Community and Care Co-ordinators** will be available in all GP practices in Shropshire. Providing a focal point within each community based within primary care this service will build on community resources and networks to support people living independently for longer, ensure individuals receive the correct level of care rather than placing patients in care settings that are of a higher dependency than their needs require and have direct impact on reducing hospital admissions
- **Care Home Advanced Scheme (CHAS)** – covering all care homes with personalised care plans (individually agreed and developed with the patient and their relatives alongside the GP) to support ongoing care provision within the care home, admission avoidance and improved clinical and social outcomes for the resident
- **Team around the practice project** – through the utilisation of local resources and partners (general practice, local pharmacies, voluntary groups, community groups, community services, mental health, out of hours and social services) a model of "rural primary care at scale" will be produced enabling the integration of all care provision locally and avoiding unnecessary admissions.

Supporting People in Crisis

In the event that an individual finds themselves in crisis, rapid, focused intervention with a view to helping a person remain in their own home or return there as quickly as possible. The following schemes will assist in the delivery of this strategic theme:

- **Integrated Community Service** – integrated community and social services team focusing on admission avoidance, early discharge, maintaining care at home and avoiding re-admission through reablement and enablement.
- **Mental Health Crisis Care Services -** To support people who are experiencing mental health crisis's so that they can access support as soon as possible when they are in crisis with the anticipation that it will either prevent admission or lead to early discharge whilst reducing the impact on the crisis on their long term mental health.

Supporting People to Live Independently for Longer

- Local carer support charities have joined forces to deliver an **Integrated Carer Support** service to support vulnerable carers

with respite care. This will increase service capacity by delivering support to an additional 200 local carers

- The **Dementia Strategy** aimed at integrating memory services into GP practices. This will improve access to the memory service and embed the service within the Practices allowing more timely diagnosis and provision of support closer to home. This initiative will ensure early intervention and crisis prevention.
- Investing in and developing **Resilient Communities** – including the roll-out of the established Compassionate Communities project already operating in key localities across the county with the aim of developing a sustainable community based approach that supports families and people to have the best chances in life, to live independently, and to have active, prosperous and healthy lives.

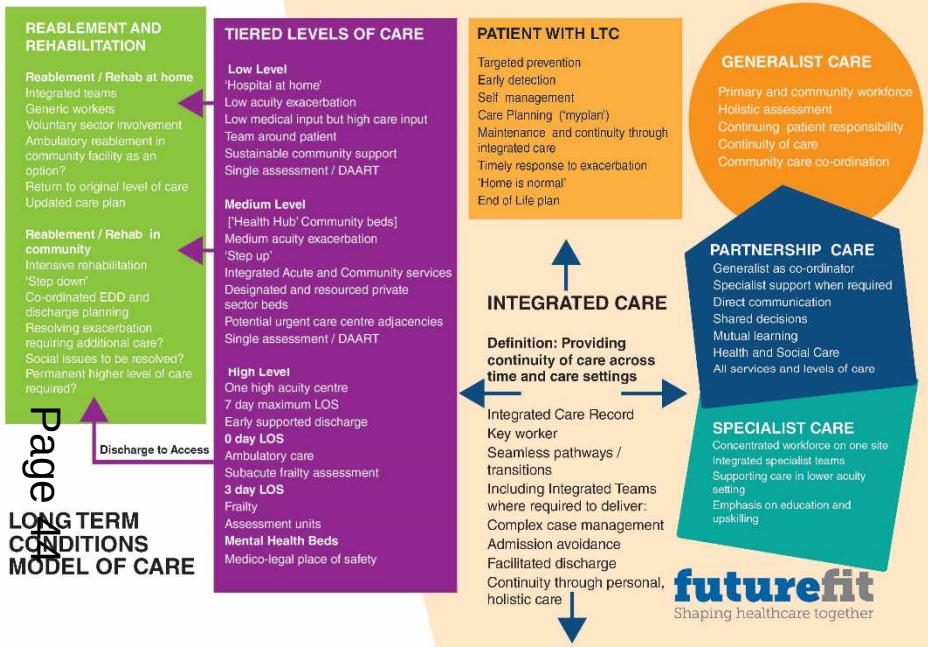
Within the BCF plan we have set out our plans with Shropshire Council to ensure the use of the NHS number as the primary identifier. In addition both Shropshire CCG and Shropshire Council are currently participating in the Health & Social care data sharing pilot from which we anticipate data to be available to support and inform our collective commissioning decisions within 2015/16

Further details are contained within the BCF plan which can be found at: ADD LINK

Future Fit

Long Term Conditions (LTC) is one of three core elements of the service model for health care delivery which is being developed by the Future Fit clinical design. Collaborative working and service integration are central to the high level model of care.

The key overarching aims in relation to LTC are to shift resources to strengthen self-care and prevention, to ensure that the patient remains at the centre of their care, to work with a multidisciplinary focus with the GP at the centre, ensuring effective case management of patients. In addition work will also be undertaken to reduce time spent in hospital by people with LTC. Further schemes will focus on Pulmonary Rehabilitation, respiratory services, development of diabetes services and the role of telehealth



Aside from the partnership approach set out in the BCF Plan and the long term vision set out via Future Fit, the CCG has identified a number of key issues it will be focusing on to specifically address the area of LTC in 2015/16

<u>Diabetes Scheme – ensure patients constitutional rights to 18 weeks RTT are achieved</u>
Implement three tiered model of care, to enable improved quality in primary care, a reduction in referrals and unplanned admissions in relation to diabetes care. The scheme will further improve patient's self care knowledge. Anticipated reductions in new patient and

follow up activity

Heart Failure - ensure patients constitutional rights to 18 weeks RTT are achieved
Implement three tiered model of care, to enable improved quality in primary care, a reduction in referrals and unplanned admissions in relation to heart failure care. Anticipated activity reductions in new referrals, follow ups, and admissions

Low Vision - ensure patients constitutional rights to 18 weeks RTT are achieved
To develop a low vision pathway, moving activity from secondary care to primary care. This work is part of the longer term plan for Ophthalmology

Continuation of eye care schemes for full year effect – implemented in 2014 – all implemented to ensure patients constitutional rights to 18 weeks RTT are achieved
Review of schemes implemented to date:
Post Op Cataract (follow up appointments)
Cataract Referral Refinement (new appointments and conversion to surgery from new appointments)
OHT monitoring (follow up only)
Children's Ophthalmology appointments (new and follow up)

Review of AMD pathway – review of pathway for patients with Macular Degeneration and implement any required changes amd review new treatments for inclusion in pathways

Develop community eye care service to ensure patients constitutional rights to 18 weeks are achieved
Tender process to ensure extra delivery of ophthalmology services in the community (based on learning from the Proof of Concept Service Dec 13-June 2015). Anticipated commencement date of new service will be October 2015, with an extension provided to the current Proof of Concept to ensure continued delivery of ophthalmology services.

Consideration to future commissioning of AQP Audiology Service
Options appraisal to be undertaken to determine future delivery of AQP contract for Audiology
Notification of termination of contract issued prior to 30 September 2014 with an indication that we will review within the next 12 months the future delivery of the service

Pulmonary Rehabilitation – ensure patients constitutional rights to 18 weeks are achieved
Review of current delivery of PR courses in the community. Further development where identified to ensure adequate capacity to support the service going forward. This will continue to increase patient's knowledge and management of their condition to avoid deterioration and recognise early signs of exacerbation

The CCG will build on the implementation of Personal Health Budgets (PHB) for children and young people with an Education, Health and Care Plan and those in receipt of Continuing Health Care and work with regional partners to respond to the national directive to roll

out PHB to those with Long Term Conditions. We will continue to work closely with the council to jointly use resources to respond to personalisation and link to personal budgets	

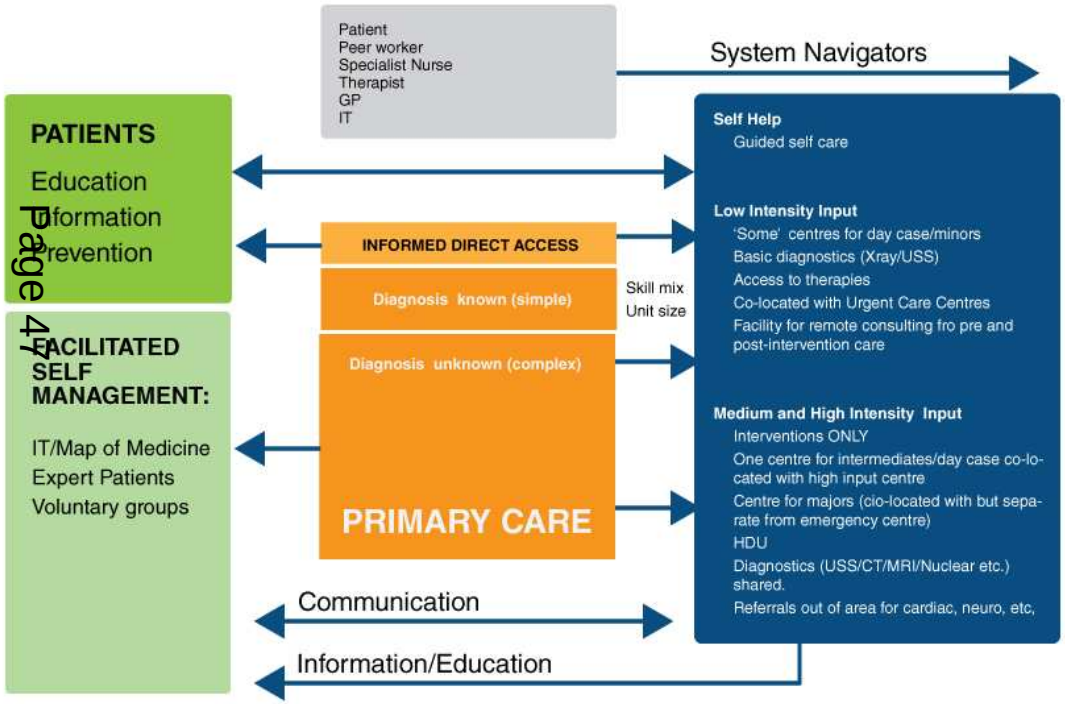
Access to the highest quality urgent and emergency care

In response to Operational Resilience and Capacity Planning for 2014/15 guidance (gateway reference 01632**)** a joint Resilience and Operational plan was developed with Telford & Wrekin CCG. The plan covers both non elective and elective care and describes how the whole system will work collectively to deliver against the constitutional targets of 18 weeks and 95%. This plan identified our current position, the continuing risks and how the CCGs as system leaders would work in partnership with wider system partners to plan for known variations in demand in Q3 and Q4. It also addresses how we would as a system respond to changes in capacity through surge planning and commits through the System Resilience Group (SRG) to provide assurance of delivery and ownership of actions. This planning and structure will form the basis of work going forward into 2015/16 and beyond. At the time of preparing this first draft of the refreshed operational plan, analysis of demand, resilience and capacity over the winter period of 2014/15 to inform forward planning into 2015/16 is well under way but not yet complete. However the application of this analysis and learning will be a key factor in refining future plans. Specifically the CCG will focus on the following actions relating to urgent care: • National urgent care clinical standards in the Phase 1 report including from Professor Keogh and seven day working requirements will continue to be reflected in contracts with providers in 2015/16 - Work will be undertaken to define the service specification for co-located primary care services in A&E using the evaluation of the prototype created by transfer of the Walk-in Service in December 2014. This will look at the expansion of the current model prototype phase 2 for admission avoidance with links to ambulatory care and DAART - The CCG will participate in Regional NHS111 procurement exercise, having regard to its integration with the wider urgent care system in particular GP out of hours services. - Revisions to the ambulatory emergency care pathways will be agreed and implemented using the output of the Local health Economy's participation in the September 2014 cohort of the Ambulatory Care Network, - Complete work to define the service specification and associated pathways for Discharge to Assess model using the evaluation of the 'proof of concept' model introduced in Winter 2014 optimising the use of available capacity, redistribution of resources to match new patient pathway and maximising all patients opportunities for rehabilitation and reablement - Undertake phase 3 Roll Out of the Integrated Community Service to expand the scope of North and South Localities to include admission avoidance	• How your strategic plan is in line with the vision set out in the Urgent & Emergency care review Phase 1 report • How will you be ready to determine the footprint of your urgent and emergency care network during 2014/15 working with key partners and informed by a detailed understanding for your area of: ○ Patient flows ○ The number and location of emergency and urgent care facilities ○ The services they provide and ○ The most pressing needs of you population • How you will be ready in 2015/16 to begin the process of designation for all facilities within your network

A Step Change in the productivity of elective care

Following our successful work in sustainably delivering the 18wk RTT targets, the local health economy Planned Care Working Group is shifting its focus to work with our two main acute providers SaTH and RJAH to deliver the necessary elective care efficiency improvements required in the short term (3-5yrs) until the longer term vison for elective care is delivered through our Future Fit programme. The short term plans are entirely aligned with the long term vison for elective care as summarised in the model of care outlined below;-

Elective Care Model



- How have you considered your model of elective care for your local providers to achieve 20% productivity improvement within 5 years so that existing activity levels can be delivered with better outcomes and 20% less resource

The key methodologies being used by the group are:-

- Expand the use of advice and guidance
- Optimise the use of our Referral Assessment Service to ensure all patients follow the correct pathways
- To design more efficient pathways that maximise the use of direct to test to avoid unnecessary consultant appointment
- Encourage providers use more one stop shop clinical to reduce the number of follow ups prior to any decision to treat
- Encourage providers to use assistive technology/proformas to reduce the need for face to face pre-op where clinically appropriate
- Work with our provider to continually review patient outcomes and effectiveness of treatment and use the findings to update our procedures of limited clinical value policy
- Encourage providers to implement enhanced recovery programmes where possible
- Encourage provider to optimise their theatre capacity
- Challenge our providers to be in the upper quartile for rate of OP with procedures and rate of day case to minimise inpatient stays
- Maximise the use of telephone follow up and nurse, practitioner led follow up as appropriate
- Reduce the number of long term follow ups for joint replacement opting for patients accessing x-ray via their GP after 10yrs

Specifically in 2015/16 the CCG will focus on the following actions relating to elective care:

- Monitoring and further encouragement of use of TeleDermatology with InHealth where patients will be booked into appointments in GP practice hubs for photographs of skin complaints to be analysed by consultant dermatologists and results reported back to GPs with management advice or treatment options.

- Continue to review Dermatology services and implement new pathways as required to increase capacity and improve access to services for patients.

- Finalise service specification following evaluation of proof of concept pilots and go out to tender for community Ophthalmology and Pain management services.

- Together with CSU carry out audits of Procedures of Low Clinical Value using RAS data to bring about a reduction in inappropriate outpatient referrals.

- To identify and deliver high quality evidence based interdisciplinary treatments for chronic pain in a community setting, meeting the needs of people living with chronic pain, primary care providers and commissioners.

- To review Lower Urinary Tract Service (LUTS) provision

- Review of Irritable Bowel Disease (IBD) pathway to look at reducing referrals in outpatients, introduction of test and/or assessment and advice prior to referral.

- Review direct access Barium Enema/Swallow
- Review current Percutaneous Endoscopic Gastronomy (PEG) pathways.
- Review of cardiology pathways to look at reducing referrals in outpatient and further streamlining of patients.
- Ensure cardiology service delivery in line with commissioner expectations. Ensure effective integration, communication and joint working between the acute, primary care and community teams. Ensure a clear pathway is in place for patients accessing the service, providing well-coordinated, appropriate care for patients.
- To review renal service delivery and identify any pathway changes required to ensure care can be delivered as close to home as possible. This will include review of pathways to reduce referrals into secondary care and reduce the onset of dialysis where possible
- To review Ear Nose & Throat (ENT) pathways of care to look at reducing referrals in out patients and clarity of referrals to APCS.

To review the Rheumatology service in Shropshire in order to provide a service consistent with British Society of Rheumatology recommendations.

Following whole system review of Musculoskeletal care, continue to look at pathway redesign to deliver a QIPP saving and maximise care of patients in the community, where appropriate. Ensure service delivery is in line with commissioner expectations and ensure effective integration, communication and joint working between the acute, primary care and community teams. Ensure a clear pathway is in place for patients accessing the service, providing well-coordinated, appropriate care for patients and realising improvements in waiting times.

- Review of Physiotherapy services in Shropshire in line with current evidence. Ensure service delivery is in line with commissioner expectations, including improving and standardising access. Look to implement self-referral to Physiotherapy for MSK conditions.
- Support for Shropshire CCG GP practices during the change to e-RS. Support for GP practices ensuring all routine and urgent referrals from Primary care to secondary care go via the RAS. Engagement with the few GP practices that currently do not use CaB who will be encouraged and supported to use e-RS. Support provider roll out, use of e-RS for 2WW referrals. Improve quality of access to referrals for all stakeholders.
- Providers to review data/audit referrals and follow up activity. Look at removing some follow up to primary care setting and

telephone follow up where appropriate. Scope the possibility/introduction of assistive technologies along pathways – remote consultation.

- To monitor the application of Oxford scoring so it occurs in primary care – supported by RAS. Utilisation of APCS services/Physiotherapy services to negate surgical referral. Application of PLCV criteria by RAS before referral onward.

- Use of Advice and Guidance – encouragement of use of A&G, and use of A&G monitored with regular reports from Provider expected on conversion rates to outpatient appointment or diagnostic test appointment. RAS data.

- Commissioning intentions for 13-14 has seen the role out of directly commissioned tests for MRI Lumbar Spine and CT/MRI Head for Headache pathway. For 14-15 we have implemented MSK – MRI whole Spine, Hip and Knee. Next steps to look at access and protocols for X-ray (foot and ankle, weight bearing etc), Ultrasound, CT, further MRI, X-Ray

- Carry out audits of Consultant to Consultant referrals to determine compliance against policy and implement any corrective measures/amendments required to the policy.

- Consider the use of assistive technologies/proformas to reduce the need for patients to travel to hospital for pre-op.

- Review the pathway for patients presenting with allergy following notification from SCHT that they can no longer deliver the service and following changes to guidance about allergy testing. Determine the need for in-county provision of allergy testing

Specialised Services in Centres of Excellence

The planning guidance published by NHS England identified a twin challenge of an overarching ambition to reduce the number of hospitals providing specialised services, but at the same time the challenge of maintaining convenient access. Whilst over 65% of the current resource in the West Midlands is already focused on six hospitals (See Financial Plan), to move to only three or four providers would be a significant challenge and require a fundamental reconfiguration of the West Midlands Health Economy. As a prelude to this strategic work, the BSBC AT will be actively considering how existing service may be able to work in a more formalised integrated pathway of care and will engage with those Providers that are leading nationally on the work to identify "Provider Chains"

In addition to this NHS England is proposing introducing co-commissioning of Specialised Services with CCGs in lieu of a potential transfer of responsibilities of some of these functions back to CCGs in the future. The CCG has had a high level discussion with B&BC AT to tease out these issues. Two functions are confirmed as transferring back to CCGs in 2015-16:

- Children's Specialist Wheelchairs

- How your strategic plans address whether your providers are seeing and treating a sufficiently high enough volume of patients to meet specified clinical standards, in line with the need to concentrate services in 15-30 centres of excellence, linked to Academic Health Science Networks
- How your plans are

• Outpatients A piece of work is being undertaken through the West Midlands Finance technical group to identify the current costs and resources attached to these services to ensure a smooth transition back to CCGs. CCGs and the Birmingham Area Team, which is responsible for the Commissioning of Specialised Services in the West Midlands, have created a collaborative group which meets regularly to address issues around patient pathways and provider quality and performance. There will be joint opportunities for maximising research and teaching opportunities to encourage innovation and change and the collaborative commissioning forum could also be used to address centres of excellence and maximising the opportunities of working with research and teaching and this will be built into the CCGs strategic plan. In addition to the Centres of excellence and the research and teaching opportunities, the other local priorities identified by the Specialised services team on which the CCG will need to continue to work on collaboratively are: • Seven day working • Access to high quality urgent and emergency care • Safeguarding (post Winterbourne) • High Cost drugs management Particularly for the coming year there will be a focus on how the AT works together with NHS England to review and achieve better value for money and improved quality is a key priority. Specialised services will be developing a robust QIPP challenge of its own and the CCG will need to work with the Area Team to understand the QIPP agenda on the local health economy. Shropshire CCG will ensure there is: • Sufficient resource within the CCG to pick up the responsibilities in relation to co-commissioning • Work with the B&BC AT to develop how co-commissioning will work. • Identification of opportunities for joint planning and development of care across the whole patient pathway within local plans. Supporting the need for change within an agreed case for change. • Close contract management arrangements with specialised commissioners for providers. • Support for the development of the local service priorities and/or reconfigurations currently being considered by the Area Team plan, which include: CAHMS Tier 4, Cancer services, Cardiology, Paediatric Intensive Care and High Dependency services and neuro-rehabilitation services.	ensuring that specialised services in your area are connecting actively to and maximising the opportunities of working with research and teaching

Convenient Access for Everyone

Shropshire CCG has worked hard over the past two years with its main providers to establish detailed demand and capacity plans for planned care to ensure there is sufficient capacity available for patients. We have reduced the number of appointment slot issues on Choose & Book and have also reduced the time patients have to wait for an appointment following an ASI. We will ensure that by the end of 15/16 we have minimised the ASIs for medicine as we have achieve d for surgery in 14/15.

In reviewing our local demand and capacity plans for 15/16 we have identified a challenge in respiratory capacity and have agreed that Shropshire and T&W CCGS will do a joint review of our local respiratory services to maximise/expand as necessary our strong community service and minimise the pressure on acute services.
Our other areas of focus are:-

- review pathways in ENT to optimise capacity and ensure community access where appropriate
- further to the review of paediatric community services, implement the key recommendations to improve timely access to services
- continue to drive down waiting times for Tier 3 CAMHS services with the further development of COMPASS (our single referral point) and improve support for parents/carers
- mental health crisis care – ensuring local provision is in line with the MH crisis care concordat
- complete the formal evaluation of RAID and agree final service specification for ongoing delivery
- evaluate the mental health crisis 24 7 call line currently being piloted with a view to sustainable implementation
- Develop a local Trier 3 Obesity service , currently only available at Heartlands and Walsall
- Formal tender for termination of pregnancy services including increased provision within the county
- continue to transform the local urgent care system to support the sustainable delivery of the 95% waiting time standard which includes:
    - further development of the relationship between the recently co-located walk in service with the acute Emergency Department
    - Continued implementation of the Integrated Community Service across the County
    - Evaluate in Q1 and plan to implement Discharge to Assess model

Early cancer diagnosis / improve referral rates

- implement the new NICE 'urgent suspected cancer referral' guidance when it is published in May. This is expected to involve implementing new pre-referral access to test from general practice, education for GPs, revised referral proformas and working with secondary care to revise all cancer pathways
- Implement the new Macmillan cancer decision support tool when it is integrated into our GP systems
- Monitor screening programme uptake and work with public health colleagues where specific practices or areas are flagged as problems to increase uptake

- How you will deliver good access to the full range of services, including general practice and community services, especially mental health services in a way which is timely, convenient and specifically tailored to minority groups
- Plans to improve early diagnosis for cancer and to track one-year cancer survival rates

Tracking 1 year survival rates

- Use tailored data produced by the National Cancer Intelligence Unit showing breakdowns of survival by specific cancers to identify areas of concern, comparing to rates of similar CCGs and nationally where this implies late patient presentation and/or limited understanding of symptoms, work with public health colleagues to design interventions to increase public awareness

For general practice please see section "Wider Primary Care at Scale" section
Need to add statement about Primary Care

Meeting the NHS Constitutional Standards

Through our local health economy Planned Care Working Group we have reviewed all demand and capacity models by speciality to ensure we have sufficient capacity and commissioned activity to recover the backlog built up as a result of Winter pressures by the end of Q1 and to sustainably deliver the 18wk targets for all specialities thereafter.
In reviewing our local demand and capacity plans for 15/16 we have identified a challenge in respiratory capacity and have agreed that Shropshire and T&W CCGS will do a joint review of our local respiratory services to maximise/expand as necessary our strong community service and minimise the pressure on acute services thereby securing 18wks RTT.
The Planned care working group is undertaking a review of the contingency planning used in 14/15 to see what additional capacity needs to be secured for 15/16 given the pressures experienced this winter and the resulting increase in admitted backlog.

All Cancer targets are now being delivered and a fortnightly local health economy cancer forum will be continued focusing on sustainability and this reports monthly to the Planned Care Working Group. This may be reduced to monthly as and when the workload of the group has reduced accordingly. We have also estimated the impact of the new NICE guidelines expected in May to ensure continued delivery.

The System Resilience Group has developed to oversee both planned and urgent care and maintains a strong grip on quality, patient safety and AO level risks associated with both programme areas. An A&E Programme Management Office has been implemented for the delivery of the 4h target and the Urgent Care Working Group oversees the medium to long term projects underpinning urgent care e.g. the further development of all admission avoidance programmes, ambulatory care, the Urgent Care Centres and the roll out and sustainability of Discharge to Assess.

Achieve standards at regional level and improve at local level within local resources for Ambulance targets – this is to be achieved via a detailed remedial action plan included in the contract with WMAS for 15/16 as agreed through the coordinating commissioner. To progress local improvement, a monthly locality meeting is in place with WMAS, Shropshire and T&W CCGs and SATH. This looks at local ambulance performance by CCG, handover times at the local acute trust and ensure optimal use of local alternatives to ambulance conveyance to hospital via local Care Coordination Centre.

- That your plans include commissioning sufficient services to deliver the NHS Constitution rights and pledges for patients on access to treatment as set out in Annex B and how they will be maintained during busy periods
- How you will prepare for and implement the new mental health access standards

With regards to the preparation for and implementation of the new mental health access targets :- 1. Liaison psychiatry - RAID, the CCG is awaiting external evaluation report due March/April. Performance data show that the service is currently meeting access targets; monthly meetings between provider and commissioners will continue to ensure performance is maintained. With consideration to evaluation findings, we intend to undertake a review of RAID and CAMHS with view to develop an all age acute liaison service. 2. IAPT - work with provider to agree and put in place the necessary service development and improvement plans to deliver targets. This will be monitored through the SDIP in the contract for 15/16.. 3. EIP - agree with provider plans for implementation of access standards and implement and monitor through the SDIP in the contract for 15/16 MH section to be further expanded for second draft due to recent change in MH commissioner Commissioner Guidance for MH standards is still awaited and will be referenced once available	
Response to Francis, Berwick and Winterbourne View	
Quality and Safety is one of the key considerations for SCCG in the commissioning of services and is at the heart of our organisation. Our Q&S strategy supports the implementation of development of the 5 Key Domains and 3 key indicators in the NHS Outcomes Framework, Quality, Innovation, Productivity and Prevention (QIPP) and quality assurance of services. SCCG board acknowledges the impact of high-level failures in the NHS on patients, carers, and the public such as those that happened at Mid Staffordshire NHS Trust 2005-2009 and Winterbourne View Hospital 2010 and the dangers of placing financial priorities above quality priorities. The recommendations and lessons learned from the reviews and inquiries and the more recent Berwick Report 2013 have been incorporated in the everyday business of the CCG and underpin the systems and process and scrutiny we apply to both internally and externally with our providers. This includes demonstrable shared planning and decision-making between clinicians and commissioners and recognition of the ensuring patients are engaged and an essential part of both the commissioning and quality and assurance process. The principle of Duty of Candour is embedded within the CCG and recognised and demonstrated across our providers. However we will continue to ensure that the learning and transparency remains a fundamental principle that is acted upon throughout all healthcare organisations that we interact with. **Transforming Care Concordat** The CCG Board is commitment to its duty of ensuring the implementation of recommendations from Winterbourne View and embraces the principles and requirements of the Concordat and the deliver of the milestones. At the time of this report the CCG is compliant with the milestone for 1st June 2014 there is a robust system and process in place for reviewing individuals who may require a placement closer to home under the guidance.	How your plans will reflect the key findings of the Francis, Berwick and Winterbourne View Reports – including how your plans will make demonstrable progress in reducing the number of inpatients for people with a learning disability and improve the availability of community services for people with a learning disability

A local Transforming Care plenary group is in place with partner membership of both local CCGs and councils. The group will focus on plans to reduce the number of inpatients for people with a learning disability and improve the availability of community services. Three sub-groups have been established that report into the main group. The remit of these groups are: 1.Winterbourne Review 2. Confidential Inquiry into Premature Deaths of People with a Learning Disability (CIPOLD, 2013) 3. Joint Health and Social Care Self-Assessment 4. to reduce the number of inpatients for people with a learning disability and improve the availability of community services for people with learning disabilities (ALD).

In March 2014 the CCG Board following a Patient Voice/Story/experience of out of area placement. The Director of Nursing and Quality announced publicly a statement of intention to make explicit our commitment to the people of Shropshire who we commission services on behalf in ensuring robust systems and processes are put in place and maintained to assure the quality and safety of all out of area placements. The CCG will:

- Insist on a clear rationale for why an out of area placement is the most suitable option for any individual in receipt of NHS funded care and were possible for what time period.
- Establish a single point of contact within the CCG for parents and carers in the knowledge that the individual will be listened to and if necessary steps will be taken to initiate the must appropriate method to investigate any concerns raised.
- Require an agreed time frame to be put in place for the review and assessment visits of the placement, to assure the quality and safety of the placement. As well as ensuring it remains the most appropriate placement to meet the individual's needs.
- Establish a process that requires all out of area placements to be signed off at the highest level within the organisation by the Chief Clinical Officer and Director of Nursing, Quality Patient Safety and Experience.

Were it is deemed that a particular placement is no longer the most appropriate placement to meet an individuals need, that steps are taken immediately to identify a suitable placement within or as close as possible to Shropshire.

Maintain an up to date register of all individuals in out of area placements will be maintained by the CCG and will include both the dates and outcomes of placement visit reviews.

- Ensure appropriate members of the CCGs quality and safety team including safeguarding leads scrutinize information from placement visits and if indicated take necessary action.
- Take a summary report from the Quality and Safety team to be provided to the CCG Quality, Performance and Review Committee a sub-committee on the board on a regular basis.

The CCG will continue to work closely with both social care and provider colleagues during 2015/6 . Ongoing monitoring and identification of local care needs and care support services will take place to assure the needs of the local children and adults with challenging behaviour our met. During 2015/6 the CCG will produce weekly data per individual case coming on and off database register.

Implementation of recommendations and required changes to current systems and process began as part of the authorisation process for the CCG and will be continue to be developed further. Implementation of the recommendations is ongoing with all relevant providers during 2015/6 the CCG will monitor the implementation of the changes in system and processes that have taken place during 2014/5 to ensure these are working effectively

During 2014/15 the CCG refined their systems and processes and expect the same of our providers going forward to ensure the patient is always put first. We plan to build on both our CCG and wider partnership listening and engagement programme. To ensure both we and our providers listen to the learning and act on findings of **Hard Truths** embedding However we will continue to ensure that the learning and transparency remains a fundamental principle that is acted upon throughout all healthcare organisations that we interact with.embedding the harm. The CCG will continue to develop robust and transparent systems and processes that are informed by the requirements of the Concordat, working with the local authority regarding the services needed to meet the needs of local children and adults with challenging behaviour. In 2015/6 the CCG will progress the work to ensure the transparency of systems and processes meet the requirements of the Concordat The Winterbourne View Concordat charged NHS commissioners with achieving a substantial reduction in reliance on inpatient care for people with learning disabilities or autism. The CCG will work jointly with specialised commissioning and local authorities to make demonstrable progress in improving the system of care and reducing reliance on inpatient care for this group: ensuring that nobody becomes an inpatient inappropriately and those who are currently inpatients are supported back into the community. Progress since the Concordat has been insufficient. There is a moral as well as practical imperative for us to do better during 2015/16 Progress will be monitored through the measures set following November 2014 (*Winterbourne View – Time for Change*), NHS England.	
Patient Safety	
The CCG has a dedicated quality, safety and patient experience team that works in close collaboration both internally with commissioning, clinical colleagues and Patient representatives and externally with a variety of partner organisations including the neighbouring CCG, NHSHE Area Team, CSU, social care, regulatory bodies and secondary care, primary care providers. A variety of quality assurance mechanisms and data sources are used by the CCG across the range of commissioned services to ensure appropriate quality monitoring, assurance and improvement. These include • Robust systems and reporting including SI reporting/ NHS 2 NHS concerns and clinical panel review meetings with feedback to providers, triangulation against complaints, compliments, safeguarding referrals and real time information from patients safety and quality visits to providers. These provide a degree of understanding and level of assurance as to the safety and quality of services at 'a point in time' as well as the opportunity to share learning from improvement. Quarterly triangulation of SI's per provider will be undertake to identify any potential harm. In 2015/6 all provider NHS contracts will have robust local quality requirements to ensure all harms are reported and mechanisms for learning for improvement will be shard and audited through the SI scrutiny panel meeting as well as the CQRM's . • Public health and other data sources to inform and monitor innovation in primary care to address key health indicators. • Information obtained in primary care (e.g. health checks and other data) to inform commissioning across care pathways • Delivery against Key performance Indicators within the Quality Schedule, CQUIN schemes, report, workforce metrics including	• How you will address the need to understand and measure the harm that can occur in healthcare services, to support the development of capacity and capability in patient safety improvement • How you will increase the reporting of harm to patients, particularly in primary care and focused on learning and improvement

sickness absence, vacancies and agency usage, themed reviews, patient and staff surveys and FFT results and informed service improvements. • Quality and patient safety assurance visits will be planned to clinical areas where concern is raised in relation to capacity and demand. The findings will be presented to the Clinical quality review board meetings . Evidence of validated early warning signs through triangulation of information from shared information across key partnership organisations and health care regulators. The CCG actively participates and values the shared learning and intelligence from a variety of collaborations including the Quality Surveillance Group lead by NHSE colleagues. The CCG recognises the importance of providing a leadership role to promote and to build on the work of the already established multi-agency and patient/ carer involvement in the Local health Economy harm free care board. Throughout 2015/16 we will continue to refine and develop systems and processes so that they can capture and respond more rapidly to potential early warning flags in the wider health and social care systems. Further developing the skills and expertise across the CCG to interrogate and act on data to improve transparency and to provide the opportunity for flagging and sharing good patient safety initiatives and services, as well as alerting commissioners and the patient/ public and provider to services that requires improvement. Active engagement with the local NHSE collaborative and across clinical networks is being actively pursued to feed the learning from patient safety incidents and highlight areas of risk to identify improvements for safer patient care and outcomes. The CCG is committed to taking a lead across the LHE to improve utilisation of results from elements of the National Safety Thermometer across all relevant services to reduce patient harm and improve services. This will include greater use of and meaningful comparison of data across CCG boundaries. The CCG will continue to support the development of a system wide professional and public communications campaign for harm free care including the defining and agreeing quality outcomes and trajectories with providers to reduce harm e.g. pressure ulcers, falls, and healthcare acquired infections including: Fully implement the Clostridium difficile reduction plan and interventions to improve patient safety, outcomes and experience. During 2015/6 the CCG will also take an active part in their local Patient Safety Collaborative and encourage all providers to join the 'Sign up to Safety' campaign, aligning safety improvement plans with their local Patient Safety Collaborative activity where appropriate. **Expected Outcomes for 2015/16 -** 90% of commissioning service specifications will include specific quality indicators that are agreed in partnership with patient/public groups NHS England has identified tackling sepsis and acute kidney injury as two specific clinical priorities for improving patient outcomes for 2015/16. The CCG will undertake an analysis during 2015/6 of the evidence and the unmet potential for improved outcomes in relation to sepsis and acute kidney injury. This will inform a five year timeframe for improving care in the areas which would have the biggest potential impact in reducing premature mortality. This work will form the basis of new sepsis and acute kidney injury national indicators	• Your plans for tackling sepsis and acute kidney injury • How you will improve antibiotic prescribing in primary and secondary care

for the 2015/16 commissioning for quality and innovation (CQUIN) incentive framework Resistance to antibiotics is spreading, and now constitutes a major threat to the delivery of safe and effective healthcare. AMR and antibiotic prescribing are inextricably linked; overuse and incorrect use of antibiotics are major drivers of resistance. In 2015/16 the CCG together with providers will develop plans to improve antibiotic prescribing in primary and secondary care. The CCG will gain assurance that secondary care providers validate their antibiotic prescribing data following the Public Health England (PHE) validation protocol. This will form the basis of the new national quality premium measure for CCGs in 2015/16. We will improve antibiotic prescribing in secondary care by including in the Quality Schedule for Medicines 2015/16 part of the contract with our acute provider as well as other provider trusts the need for adherence to the microbiology formulary and reporting from the antimicrobial committee into the Acute provider's Drugs &Therapeutics committee. For primary care the Medicines Management Clinical Quality and Safety team will, as part of their work with practices to reduce hospital admissions related to medicines (HARMs), monitor the prescribing of antibiotics and other medicines which when used together put patients at an increased risk of Cdifficile.	
Patient Experience	
The CCG is committed to ensuring that patients, carers and their families receive an experience that meets and exceeds their expectations of services. The CCG will continue to ensure wide engagement of patients and patient voice to be powerful and present through all levels of the organisation service users. Continuing to ensure that CCG Boards listen and learn from the voices and experience of patients and carers and that improving the patient experience continues to be viewed as a top priority and that it features highly on all our provider and partner organisations agendas. These will include refining systems and processes to ensure putting the patient first –listening to and learning from the **Hard Truths** - embedding the duty of candour across multi agencies and provider as part of the commissioning of services- embedding the statutory duty to tell patients about harm. Ensuring and both providers and commissioners continue to embed staff engagement in responding to and learning from complaints across the Local Health Economy. The CCG will during 2015/6 take an inactive part in our local patient safety collaborative. The CCG will assess the quality of care experienced by undertaking patient stories and learning from the feedback via the "patient voice. These experiences will be shared at a variety of ways such as the CQRM's QPR and CCG board. Also in 2015/6 the CCG will use CQC's inspection reports and ratings as they roll these out during the year, to assure themselves of the quality of are in our area. We will learn from where care is good or outstanding , where care requites improvement or is inadequate. Cre**ate a culture of continuous quality improvement, openness, transparency and candour across the healthcare system;** Every member of the CCG Governing Body owns the quality agenda and every member of staff understands their role and contribution	• How you will set measureable ambitions to reduce poor experience of inpatient care and poor experience in general practice • How you will assess the quality of care experienced by vulnerable groups of patients and how and where experiences will be improved for those patients • How you will

to deliver quality**.** The CCG has implemented and embedded integrated systems and processes to triangulate feedback from FFT, Complaints and soft intelligence and incidents, will enable an additional evidence base to support the underpinning of service improvements and a mechanism to potentially celebrate and sustain good practice, patients satisfaction and experience. The CCG will establish feedback from complaints and seek assurance from providers of improvements via the monthly CQRM and report progress to the QPR board. The CCG continues work **to build on good practice whilst identifying mediocre or poor practice where it exists and provide support or take appropriate action to improve quality, patient safety and experience whilst striving for excellence in all commissioned services by**; • Challenge areas of poor performance and mediocrity at CQR meetings and in inspections or safeguarding visits • Taking immediate appropriate action if any aspect of patient safety is threatened Being prepared to work with providers to effect service improvement utilising the expertise and experience of clinicians and the experiences of patients, their families and the public The Patient Experience Plan will support the CCG Quality Strategy and outline our intention and processes and systems for: Realising the CCGs commitment to engage, empower and support patients in matters relating to their own experiences of healthcare. Creating a culture throughout the healthcare system that promotes quality events and initiatives that support positive improvements in patient experience. In 2015/16 we will continue to the invest in use tools and learning that support professionals, patients and the public to support a shift in both mind-set and behaviour towards those which value personalisation and customer services. e.g. 'Sit and See' programme. In 2015/16 we will also continue to stimulate and Lead on the development of a customer service culture across both the commissioning and local provider landscape which views the patient/carers as customers and one that strives to continuously exceed customer. Stimulate and Lead on the development of a customer service culture across both the commissioning and local provider landscape which views the patient/carers as customers and one which strives to continuously exceed customer expectations. The CCG will continue to work to improve the information to which people have access. The CCG will seek assurance during 2015/6 that providers through the NHS Standard Contract show demonstrable progress towards achieving fully interoperable digital health records from 2018. The CCG will progress plans for 2015/6 for patients to have online access to their GP records, giving patients more direct control. The CCG will continue to engage widely and fully with their local communities and patients, including with their local Healthwatch and include clear goals on expanding personal health budgets within their published local Joint Health and Wellbeing Strategy. The CCG is committed to providing patients choice in how they receive care, in line with their legal rights set out in the NHS Constitution	demonstrate improvements from FFT complaints and other feedback • How you will ensure that all the NHS Constitution patient rights and commitments given to patients are met • How you will ensure you meet the recommendations of the Caldicott Review that are relevant to the patient experience

and the statutory duties of NHS England and CCGs to promote choice. The CCG will work with providers together and with patient groups to understand current delivery, and make significant further strides to honour patients' entitlements to choose. The CCG's particular priority for choice for 2015/6 will be mental health and to this end the CCG will work with GPs and providers to ensure that patients are aware of their rights and are offered choice in mental health services and are able to make well-informed,meaningful choices at appropriate points along the pathway The CCG in 2015/16 will continue focus on actions to improve the way that we engage with communities and citizens, including with local Healthwatch, involving them in decisions about the future of health and care services. The CCG will focus on how to meet their statutory duties on public and patient involvement in their commissioning decisions. In support of this we will continue to further develop the NHS Citizen approach (www.nhscitizen.org.uk). The CCG will seek assurance of these actions though the monthly CQRM's We will also continue to consult the voluntary and community sector at local or national level for more strategic advice.	
Compassion in Practice	
The CCG will continue to ensure that there is alignment and delivery of each of the components in providers plans for the implementation of 6Cs 'Compassion in practice'. Our commitment to embedding the 6C in all health care organisations particularly commissioning is detailed in our 2013-16 Quality and Patient Safety and aligns with our organisations strategic Vision and values. Monitoring and active engagement will take place through the actions set out in this section: **Compassion in practice** We will continue to support our initiative of 'Compassionate Communities' and pay attention to the delivery in specific aspects of care including: continued support and promotion of the concept of both Dementia and Dignity Champions across health, social care and the wider community. During a recent event held in collaboration with our neighbouring CCG and care homes we achieve great success in increasing the number of champions to provide compassionate support as well as care. **Communication** Continuing to foster a local health economy approach and commitment to improve standards of care, share intelligence to identify, reduce and eliminate poor and mediocre practice and improve patient safety and outcomes across the 5 Domains. This will be supported on shared Key Performance Indicators for nurses across sectors. Investing time in assisted technology to improve communication with and experience for patients and share innovative ways of sharing positives in practice, knowledge and skills. Widening clinical knowledge and embedding and promoting the power of the Patient Voice.	• How your plans will ensure that local provider plans are delivering against the six action areas of the Compassion in Practice implementation plans • How the 6Cs are being rolled out across all staff

Competence **E**vidence of valued based recruitment by both providers and commissioners for specific roles e.g. Healthcare assistants and Registered nurses across the local health economy. Seeking assurance regarding the competency to practice of nurses in sectors and compliance with specific competency frameworks access to learning and development opportunities, peer support and clinical supervision. Integrated local workforce planning and consideration of development of nurse and allied professional roles to provide sustainable solutions to assist resolve the difficulties with medical consultants in specialised areas including emergency medicine whilst providing a sustainable solution with the necessary expertise and skills. Recruitment of nurses to agreed staffing skill-mix levels in clinical areas based on the recommended methodology and tools. **Care** Commitment to seek out, act to prevent and improve poor quality, unsafe care Local Health Economy commitment to ensure the delivery of safe quality patient care, and to reduce and eliminate preventable harms supported by the NHS Safety thermometer and patient experience data in preventable Pressure sores, falls, CAUTis, improving nutrition and hydration. **Courage** Developing systems to support staff to speak out against poor, unsafe and uncaring practice without fear of repercussions. **Commitment** To support energising for excellence to deliver the highest quality, safest care and experience possible for patients and their families. Demonstration of local leadership by the CCG to moving the agenda forward and embed the 6cs throughout the local health and social care footprint e.g. ensure local health economy showcasing and learning events. During 2015-16 evidence of progress and sustainability of delivery will continue through the following; Quality contract monitoring including Themed reviews, provider ward to board metrics, delivery of CQUINs response to complaints and patients and staff surveys. Integrated patient and staff learning events including local, regional and national shared learning and improvement events. Quality and safety visits with triangulation of information across multiagency. Evidence of valued based recruitment by both providers and commissioners for specific roles e.g. Healthcare assistants and Registered nurses. Monitoring and active engagement will continue to evolve through 2015-16 to deliver actions and initiatives that will embed and improve care, safety and patient experience in these six key action areas.	

Staff satisfaction	
In addition to traditional staff survey and workforce measurements for example sickness, staff appraisal, leavers, vacancies. The CCG is scoping alternative innovative ways of seeking staff feedback, to identify any improvements that can be made and how this may impact on patient satisfaction. These include recognising and celebration of those leadership styles and behaviours that are consistent with delivering the NHS and Social Care vision and supporting a wider understanding leadership can be demonstrated at all levels of an organisation. The CCG in collaboration with providers and other partner organisations will continue to work throughout 2015-17 to introduce joint programmes and event that encourage and support staff and to share and celebrate positive experiences and success in delivering safe, effective quality care and outcomes for patients and their families carers. Initial programmes for consideration include ways to seek staff views, including rolling out the FFT, action learning sets, peer review and the STAR system to test the level of satisfaction of staff with local health care organisations Staff as initial supporters and advocates of patients and service users and supporting them to **Speak up when it is the right thing to do for** patients…. The CCG will take action to improve the physical and mental health and wellbeing of their staff by supporting to staff to help them keep to a healthy weight, supporting active travel schemes and ensuring NICE guidance on promoting healthy workplaces is implemented. Further detail is set out in the Improving Health section	• An in-depth understanding of the factors affecting staff satisfaction in the local health economy and how staff satisfaction locally benchmarks against others • How your plans will ensure measureable improvements in staff experience in order to improve patient experience
Seven Day Services	
For Shropshire CCG the Seven Day Service Clinical Standards ("the Clinical Standards") are mostly related to the acute emergency services provided by Shrewsbury and Telford Hospitals NHS Trust (SaTH). The CCG remains committed to working with our secondary care providers to ensure the delivery of all Seven Day Service Clinical Standards by 2016/17. We are confident that the work currently underway to develop these services will enable our providers to deliver the Seven Day Clinical these Standards. These plans include: • Implementation of the SDIP of the national clinical standards in relation to twice daily ward rounds for critical care, Urgent and emergency care by March 2016. • Implementation of the SDIP of the national clinical standards in relation to daily ward rounds for AMU and SAU by March 2016. • Working with the provider to identify 5 of the 10 clinical standards for 7 day services to be implemented by March 2016. These will be included in the local quality requirements section of the NHS contract and monitored through the monthly CQRM's. • Progress the development of the diagnostic national clinical standard to include interventional therapy and endoscopy, for implementation by 2017. • Progress the development of the support services national clinical standard in terms of community and mental health services for implementation by 2017. • Continue to work to progress all 10 national clinical standards by 2017. The most significant challenges, which can be grouped into three broad strands, are faced by Shropshire's main acute provider,	• How you will make significant further progress in 2015/16 to implement at least 5 of the 10 clinical standards for seven day working

Shrewsbury and Telford Hospitals NHS Trust: - Organisational capacity - Clinical capacity - Financial capacity One of the key influences on the ability of providers to meet seven day service requirements will be the ongoing FutureFit work stream and in particular the decisions around the positioning of services. The FutureFit programme will be the main forum in which discussions about seven day services will take place and actions are agreed. During 2015/6 a whole system event is proposed for both health and social care to identify and map the workforce footprint across the health economy. This will identify the baseline, gaps and the workforce requirements to deliver 7 day services for the local population. Continue to explore the options to reshape our workforce, looking at advanced roles across the whole economy and working closing with agencies such as the local universities. 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 remains improving access to services. **Out of Hospital Urgent and Emergency Care Services** Plans which address the need to provide consistently high quality urgent and emergency care services outside of hospital services are set out on the next column: The CCG will be working in quarter 1 2015/16 with all providers to ensure they have robust Service Development and Improvement Plans that address the priorities for seven day working. In so doing we acknowledge that for some providers full compliance with the 10 clinical standards will not be achievable in the first year. The plans will be stretching but realistic and achievable.	
Safeguarding	
Shropshire CCG's position in relation to Safeguarding is largely unchanged from 2014/15 in terms of the principles and overarching work streams. Work around safeguarding is undertaken on a long terms footprint and a number of the sentiments set out in our previous plan are reiterated here for the purpose. A mandate arrangement for Safeguarding Adults, Children and Young People is in place across both local CCGs (hosted by SCCG) this allows the ability ensure that expert knowledge and resource is available consistently and further support the shared and robust triangulation of intelligence of any safeguarding issues across providers. It also assists with a greater opportunity to dissemination of learning and implementation of safer services for patients and those who are vulnerable. The organisational framework within the corporate safeguarding policy reflects the recommendations of the NHS Commissioning accountability and assurance framework as well as statutory guidance and legislation including concordat requirements Robust lines of corporate and individual responsibility and accountability will continue from front-line to CCG Board. Increased awareness of commissioners and providers through appropriate levels of training and education continue to underpin the	• How your plans will meet the requirements of the accountability and assurance framework for protecting vulnerable people • The support for quality improvement in application of the Mental Capacity Act • How you will measure the requirements set

safeguarding agenda within the CCG. Evaluation and learning from all reviews will be formally feedback to both CCG and local safeguarding boards. Awareness of the responsibility and accountability will be evaluated at all stages of the commissioner plans over a 2 year -5 year period. This will also take into consideration national and local learning, patient/ care experience and any changes in legislation. All commissioner plans and provider contracts meet the required training, reporting standards and are monitored robustly through the quality contracting processes and continued engagement in both the Children and Adult safeguarding Boards. The organisational framework within the corporate safeguarding policy reflects the recommendations of the *NHS Commissioning Accountability and Assurance Framework* (2013) as well as statutory guidance and legislation for both children and adults including concordat requirements. Robust lines of corporate and individual responsibility and accountability will continue from front-line to CCG Board. Appropriate training is provided via LSAB and LCSB (or in accordance with agreed standards) so all staff from provider and commissioner organisations have appropriate knowledge and skills which reflect their role to enable effective application and monitoring of safeguarding activity, inclusive of MCA/DoLS and Prevent Review the current mandate for hosted arrangements and structures for (SCCG hosted) Safeguarding was completed by July 2014. As a result of this the existing memorandum was dissolved and Shropshire and telford & Wrekin CCG's have now taken up their own distinct safeguarding lead posts. A robust review and audit process will be established over the next 6 months to test effectiveness. An annual review responsibilities and opportunities for closer working with local multi agency and specifically local authority will Undertake further work to embed and identify specific requirement related to both safeguarding and **Mental capacity responsibilities** for organisations and workforce. Continue to ensure that commissioner plans meet the increased focus on knowledge and understanding required to support adults and children at risk. Commissioner plans and provider contracts meet the required training, reporting standards and will continue to be monitored robustly through the quality contracting processes and continued engagement in both the Children and Adult safeguarding Boards. Awareness of the PREVENT initiative has been raised with local providers and their embedding of the systems and processes to ensure delivery will be monitored via both CQRs and the Local Health Economy Safeguarding boards. Board activities (TBC):	out in your plans in order to meet the standards in the prevent agenda

Disseminate learning from SCRs/DHRs. Annual reviews/Audit of provider services will be coordinated via the Boards. Continued sign up to agreed West Midlands Safeguarding Adults Procedures. Participate in MCA/DoLS implementation sub group. Attend Prevent Steering group and Chanel Panel To update CCG safeguarding policy as required to demonstrate compliance with new legislation, guidance and CCG lines of accountability. This is especially relevant to implementation of The Care Act 2014 and changes to MCA/DoLS legislation/case law To ensure that staff can apply theory to practice in relation to MCA and DoLS by quality assuring the training delivered with Telford and Wrekin CCG To ensure that CCG staff have undertaken training in accordance with role by Audit/collation of stats Identify in policy responsibility and appropriate levels of training	

Research & Innovation

The CCG has an individual at board level with responsibility for all issues relating to – "a commitment to promoting research and the use of research evidence". The CCG has a process in place for receiving valid excess treatment cost claims – approved by the Governing Body Board. The CCG is involved in the CLRN The organisation has processes in place for ensuring evaluation of the majority of the services it commissions. • local stakeholders and primary care research experts to ascertain how research is promoted within the CCG and support the development of a locally owned Research and Innovations Strategy. • The CCG includes participation in NHS research in Provider contracts in 50-80% of new service contracts. • Ensure staff have access to appropriate training regarding accessing, interpreting and using evidence. • Establish several links with HEIs and occasionally involve members of the research community in service redesign and decision making • The CCG considers supporting the costs associated with study initiation on a case by case basis. • The total numbers of patients recruited by member providers (e.g. GP practices) into research projects has increased between	• How your plans fulfil your statutory responsibilities to support research • How you will use Academic Health Science Networks to promote research • How you will adopt innovative approaches using the delivery agenda set out in *Innovation Health and Wealth: accelerating adoption and diffusion*

6-14% from the previous year (April to March). • Between 50 and 70% of member GP practices have completed accreditation as RCGP research ready The organisation has processes for accessing, interpreting and applying research evidence appraisals to inform some aspects of service redesign, commissioning policy and decision	*in the NHS*

Financial Resilience

Business Rules The financial plan for Shropshire CCG meets the business rules required by the "Everyone Counts" planning guidance as follows: • 1% surplus • 0.5% contingency in 0.5% non-recurrent expenditure **QIPP plans** The CCG's QIPP target amounts to 2.6% of the CCGs Programme budget (£9.3m). The target reflects the requirement to re-direct funding into the Better Care Fund. The QIPP programme is drawn together from the following sources: • Benchmarking information which illustrated that the CCG is an outlier for Orthopaedic expenditure and Cancers and Tumours. Both of these areas are addressed within the QIPP programme • Full year effect of successful schemes implemented during 14-15 including admissions avoidance schemes (e.g. integrated community service, Care home extended service, Discharge to assess, relocation of WIC) and planned care schemes (e.g. tele-dermatology, community based urology service, advice and guidance, community pain pathway) • Reviewing Procedures of limited clinical value and consultant to consultant referrals to ensure the CCG is maximising the opportunities they provide. • Further known opportunities to reduce Prescribing expenditure • New schemes identified as a result of 5 year strategy development (Dementia, urgent care, LTC, Better Care Fund) The QIPP Programme Target is split roughly 61/39 between existing/implemented schemes and new schemes in development. In addition to current known schemes, beyond 15-16 the CCG has a rolling programme of further strategic work streams developing further improved pathways (e.g. LTC) and urgent care redesign (e.g. Future Fit) with an emphasis on prevention, patient education and self-management (e.g. Better Care Fund) which will have reached implementation stage by and beyond April 2016. **Better Care Fund** The CCG and Local Authority are moving ahead with plans for transformational change to support better care for patients in 15-16. The impact of this on the acute providers differs between SATH and RJAH. This is due to the CCG being an outlier in terms of Orthopaedic activity and plans to correct this. For SATH the impact on activity is forecast to be approximately 1.3% of the overall commissioned activity (or the equivalent of demographic growth i.e. commissioned activity levels for 15-16 are planned to be at the same level as 14-15). This equates to approximately 309 avoided emergency admissions. For RJAH there will be a planned cut in activity between 14-15 and 15-16 of approximately 4.5% of inpatients and day cases. This will bring the CCG back into line with other commissioners and represents a £1m reduction in orthopaedics spend. **Linking of Service, Financial and activity plans** The commissioning intentions of the CCG for 15-16 fall out of the CCGs strategies for Urgent Care, Long Term Conditions, Medicines Management, Planned Care and the Health and Wellbeing Board Strategy. Each intention includes information on which provider contract it affects and whether it is a service review, a service development, an activity change and/or a QIPP scheme. This ensures	• Meeting the business rules on financial plans including surplus, contingency and non-recurrent expenditure • Clear and credible plans that meet the efficiency challenge and are evidence based, including reference to benchmarks • The clear link between service plans, financial and activity plans

that service, financial and activity plans are linked. In addition to the commissioning intentions the CCG has a Procurement strategy which outlines how the CCG will ensure value for money in its commissioned spend. The baseline activity that has been used to roll forward the provider contracts is costed to ensure it is affordable within the financial envelope available. The baseline activity is based on M7 14-15 actual activity extrapolated to year end and adjusted to ensure that seasonal adjustments and part year service changes are fully taken into account. The contracts for 2014-15 for the 2 acute providers also reflect recent equilibrium modelling to ensure the CCG is commissioning the right level of activity to account for patient's constitutional rights. The CCG has a Quality Impact Assessment programme/ process for all provider Cost Improvement Programmes and for assurance of proposed service developments or newly commissioned services and provider service reconfigurations . The Clinical Advisory Panel is part of the assurance process and final sign of is by the Director of Nursing and Quality, Vice CCG Clinical Chair and CFO. The CCG QIA process and policy is currently being reviewed and will be incorporated in the QIA process for 14/15 and 14-16 QIPP plans.	

Appendix A Shropshire CCG 2015/16 Operational Plan on a Page

Vision and Principles

We envisage a system where, through working together we have created a pattern of services that offer excellence in meeting the distinctive and particular needs of the rural and urban populations of Shropshire

Principles: Home is normal. The level of care should match the level of need and unnecessary escalation of care should be avoided. A commitment to 7 day working as part of an integrated local health Economy approach. Recognition that a commitment to quality and safety is paramount for clinicians. The need to get the system right for the next 10-20 years.

Outcomes

Delivery across the five domains and seven outcome measures
To be completed for draft 2 of the Operational Plan

Improving health

- Implementation of work streams associated with the local response to 'Commissioning for Prevention' and the Prevention and Early Intervention themes of the Better Care Fund Plan
- Development of a range of programmes to improve the health & wellbeing of CCG staff
- Active participation in the Health &Wellbeing Board's year of Physical activity

Reducing Health Inequalities

- Continues work on implementation of work streams associated with the 5 most cost effective high impact interventions in the NAO report
- Continue to implement key areas of development alongside the communities of protected characteristics

Parity of Esteem

- Reduce waiting times for Tier 3 CAMHS services
- Delivery of the IAPT targets for access (15%) and recovery (50%)
- Support the continued work of the MH Crisis Care Concordat
- Work to ensure the delivery of mental health access targets

Quality

Response to Francis, Berwick and Winterbourne View

- Delivery of the Transforming Care Concordat milestones
- Focus on out of county placements
- Act on the findings of Hard Truths

Patient safety

- 90% of commissioned services include quality indicators agreed in partnership with patient/ public groups
- Undertake analysis of the potential for improved outcomes in relation to sepsis and acute kidney injury
- Develop plans to improve antibiotic prescribing in primary & secondary care

Patient experience

- Stimulate and lead on the development of a customer service culture across the commissioning and provider landscape
- Incorporate into the 2015/16 contracting process that providers are demonstrating progress towards fully interoperable digital health records
- Progress plans for patients to have online access to their GP records

Compassion in practice

- Continued alignment in each of the provider plans of delivery of each of the components of the 6C's 'Compassion in Practice'
- Supporting the development of value based recruitment by both providers and commissioners

Staff satisfaction

- Implementation of NICE guidelines on promoting healthy workplaces
- Scoping alternative and innovative ways to seek staff feedback whilst continuing to promote and utilise traditional methods

Seven day services

- Working with secondary care providers throughout 2015/16 to deliver all of the Seven day Service Clinical standards by 2016/17
- Participate in a whole system event to identify and map the workforce footprint across the LHE to support future plans

Safeguarding

- Update the CCG Safeguarding policy to demonstrate compliance with new legislation and CCG lines of accountability
- Annual reviews / audit of provider services to be co-ordinated via the Boards

Access

Convenient access for everyone

- Continue to sustainably deliver the 18wk RTT
- Review pathways in ENT to optimise capacity
- Further to the review of paediatric community services, implement the key recommendations to improve timely access to services
- Continue to transform the local urgent care system to support the sustainable delivery of the 95% waiting time standard which includes:
  - further development of the relationship between the recently co-located walk in service with the acute Emergency Department
  - Continued implementation of the Integrated Community Service across the County
  - Prototyping of the Discharge to Assess model

Meeting the NHS Constitution standards

- Maintaining RTT targets
- Maintaining cancer standards
- Use of System Resilience Group and Urgent Care Working Group to sustainably deliver A&E waiting times target
- Achieve standards at regional level and improve at local level withinavailable resources for Ambulance targets

Innovation

Research and innovation

- Utilising research evidence appraisals to inform service redesign, commissioning policy and decisions

Delivering value

Financial resilience; delivering VFM for taxpayers and patients and procurement

- Robust QIPP planning
- Delivery of BCF outcomes and financial plan
- Linking service, financial and activity plans

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Health and Wellbeing Board
27th March, 2015

PHARMACEUTICAL NEEDS ASSESSMENT CONSULTATION

Emma Sandbach
Email: Emma.sandbach@shropshire.gov.uk Tel: 01743 253967 Fax:

1. Summary

1.1. The Shropshire Health and Wellbeing Board are undertaking a formal consultation on the draft Pharmaceutical Needs Assessment (PNA). The Pharmaceutical Needs Assessment (PNA) is a statutory requirement of Local Authority Health and Wellbeing Boards. The PNA will run from 13 February 2015 until the 15th April 2015 in order to comply with the statutory consultation guidelines. The PNA is a statement of the local need for pharmaceutical services and supports the commissioning of pharmacy services based on local priorities. It is used by NHS England to decide whether there is a need for new pharmacies in the area.

1.2. The consultation provides an opportunity to shape the future of pharmacy services in Shropshire. It is important that pharmacies provide high quality services for people in Shropshire, and therefore the views of pharmacists, patients and customers are important.

1.3. The draft PNA report can be accessed at the following link: http://www.shropshireccg.nhs.uk/pharmacists#PNAC

1.4. The PNA draws on data from different sources including demographics, socio-economic, geographic, pharmacy activity and prevalence data. Two consultations also took place one with the community pharmacies to identify what they provided, opening hours, etc. and one developed in partnership with Shropshire Healthwatch which was asking for the views of patients and the public about local pharmacy services.

1.5. All Health and Wellbeing Boards have to make neighbouring Local Authorities and Health Boards in Wales aware of the PNA Consultation in order to comment on services that may dispense to Shropshire patients. To date we have been sent links to the consultation documents for Herefordshire and Telford and Wrekin. There are two pharmacies in Telford & Wrekin and two in Hereford that dispense to Shropshire patients. Therefore, it is important to note that local services commissioned in Hereford and Telford may be different to those commissioned in Shropshire, meaning people would potentially have access to different services that are not available in Shropshire.

1.6. The following lists are some of the findings around access and gaps from the PNA:

- As at 31st December there are 53 community pharmacies in Shropshire, located throughout the county in towns, market towns and larger villages.
- The pharmacies are close to GP practices providing choice and convenience for patients.
- Most pharmacies opening times generally mirror those of the GP practices, however most pharmacies also open for at least some of the day on a Saturday. There are 7 pharmacies open on a Sunday.
- Due to the rural nature of Shropshire, many localities are supported by GP practices that dispense to their patients (18). Dispensary opening hours reflect the opening times of the practice. Dispensing doctors offer services to help fulfil the pharmaceutical needs of the patients in these areas.
- There appears to be good access to most services commissioned by Public Health in Shropshire, such as emergency hormonal contraception and smoking cessation services.

Gaps in pharmaceutical provision

- The distribution of pharmacies per head-of-population is lower than the national average. However there seem to be some parts of the county where there is over provision.
- Patient feedback and evidence from community pharmacy questionnaire demonstrates opening hours at weekends and later in the evening are not suitable in some parts of the county.
- There appear to be gaps in provision from 4pm on a Sunday or Bank Holiday until late into the evening.
- Patient access to pharmaceutical services out of hours and at weekends means that many are directed to Shropdoc the out of hours provider for prescribing repeat medicines.
- There appears to be poor coverage across the county for needle exchange services. There is only one pharmacy in Shrewsbury providing needle exchange and none in Market Drayton.
- There are only 100-hour pharmacies in Shrewsbury and Oswestry with no provision elsewhere in the county.
- Some advanced services AUR and SAC are only provided by a small number of pharmacies.
- There is a lack of awareness with some patients to the extent of advice that community pharmacies can provide on the services that they provide.

2. Recommendations

2.1 To note the contents of the PNA and to provide and feedback on the consultation.

REPORT

3. Risk Assessment and Opportunities Appraisal

3.1 The PNA is supposed to be published by 1st April 2015. As the consultation process has to be 60 days this deadline will not be met. NHS England has been contacted to identify how any applications for new pharmacies would be processed until the PNA is formally published. The NHS England response was that current regulations would be adhered to and they would continue to refer to the existing PNA until the formal publication date.

4. Financial Implications

N/A

5. Background

The Shropshire Pharmaceutical Needs Assessment (PNA) draft for consultation is live on the CCG Website at http://www.shropshireccg.nhs.uk/pharmacists#PNAC

6. Additional Information

N/A

7. Conclusions

N/A

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) See above for the link to the draft Shropshire PNA
Cabinet Member (Portfolio Holder) Cllr Karen Calder
Local Member
Appendices

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Health and Wellbeing Board
27th March 2015

HEALTH AND WELLBEING BOARD COMMUNICATION AND ENGAGEMENT STRATEGY AND ACTION PLAN

Responsible Officer
Email: jane.randall-smith@healthwatchshropshire.co.uk Tel: Fax:

1. Summary

1.1 In October 2014 the HWBB approved the establishment of a Communication and Engagement Task and Finish Group to develop an overarching health and wellbeing communication and engagement strategy and action plan for Shropshire. The aim was not to replace any individual organisation's plans and strategies but has developed overarching principles for health and wellbeing communication and engagement across Shropshire, with specific actions identified to improve communication and engagement across Shropshire.

1.2 It was recognised that many health and care organisations in Shropshire engage with the population to design services, understand need and service user experience, and provide information to the public. It was agreed that it would be worth exploring how we could do more together to reduce duplication and increase consistency of messaging. It was also felt this strategy was needed in order to develop a collective approach and commitment to working with the population to design services, and to ensure that where ever possible health and care organisations could support one another, share information and best practice.

1.3 The task and finish group includes members from Healthwatch (chair), the CCG, CSU, Shropshire Council Communications and Public Health, and the VCSA.

1.4 In December the T& F group invited key stakeholders from partner organisations to participate in a communication and engagement workshop. The workshop included an informative presentation regarding Best Practice and Law in Consultation by Nick Duffin of the Consultation Institute. Each organisation also brought with them their key considerations for communication and engagement and the group worked collectively to develop local principles.

1.5 Attached in Appendices 1 and 2 are the Draft Communications and Engagement Strategy and Action Plan that have been developed on the basis of the workshop and further meeting sessions. This Strategy and Action Plan are currently being consulted on more broadly as a first step to increasing awareness of the HWBB and its communication and engagement strategy, and to ensure that the strategy and action plan are not missing any key elements.

1.6 The development of this strategy has coincided with the Shropshire Health and Wellbeing Peer Challenge, and has been developed in the context of large scale transformation programmes (including Future Fit and Better Care Fund). As such the Communication and Engagement task

and finish group has recognised that we will be entering a time when how we communicate and engage about these changes will be vitally important for the population and for the success of new programmes and developments.

1.7 As well recent meetings of the Health and Wellbeing Board have emphasised a significant role for communication and engagement with regard to supporting the urgent care system in Shropshire. Also communication and media campaigns have been highlighted as a requirement to support cross partnership working with the Safer Stronger Partnership Board.

1.8 Further, the T&F group has considered the use of the branding Shropshire Together as part of its task for the development of joint communication and engagement. The group has considered the input from the Board (which can be found in Appendix 3) and the subsequent direction of development of the HWBB (as summarised in the recent Peer Challenge report), and recommends that the Board continue to build the brand of Shropshire Together as a platform where joint health and wellbeing messages can be shared and disseminated.

2. Recommendations

1.1 The Health and Wellbeing Communication and Engagement T&F group recommend that the Board:

1. Provide initial comment and input to the draft Communication and Engagement Strategy and Action Plan (further opportunity to provide input has been provided through the online questionnaire);
2. Endorse the development of a permanent communication and engagement subgroup with a role to **a:** develop communication and engagement programmes in line with the key programme development in Shropshire, and **b:** make recommendations to the Health and Wellbeing Board as required and **c:** share, where appropriate, information and ideas for collaboration, joint working and input to the JSNA; and
3. Continue to use and build recognition of the branding of Shropshire Together as the platform for delivering and supporting messages and engagement across the Shropshire Health economy.

REPORT

3. Risk Assessment and Opportunities Appraisal

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

3.1 The HWBB priorities work to reduce health inequalities. The HWB Communication and Engagement Plan sets out principles around communicating and engaging with all people including children and young people and those with protected characteristics.

4. Financial Implications

4.1 There are no direct financial considerations as part of this report. However, the development of the strategy and action plan and ongoing delivery and support of both will include officer and financial resource.

5. Background

5.1 HWBB paper outlining requirement for a HWB Comms and Engagement Task and Finish Group can be found here.

6. Additional Information

N/a

7. Conclusions

7.1 Please see summary and recommendations.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) **Karen Calder, Portfolio Holder - Health**
Local Member
Appendices 1. Draft Health & Wellbeing Board Communications and Engagement Strategy 2. Draft Health and Wellbeing Communication and Engagement Action Plan 3. Shropshire Together and the Health and Wellbeing Board 'SWOT' Analysis Summary

Draft Health & Wellbeing Board Communications and Engagement Strategy

Background

Shropshire is a vibrant and diverse county with varied and unique health and social care needs. In particular, Shropshire's rurality and demographic structure bring specific challenges with regard to communication and engagement. Although largely a fairly affluent county, Shropshire has areas of deprivation which combined with rural sparsity create issues for access to services.
As an example, we recognise that making information available online cannot be our only method of communication with the public as many of our residents have inadequate internet access. Similarly, Shropshire has an ageing population with a high proportion of individuals aged over 50 years old. This brings challenges around the requirements for provision of social care and ensuring that individuals are not socially or geographically isolated.

In Shropshire, strategic health and care decisions are made by the Health and Wellbeing Board which has membership from the Local Authority, the Clinical Commissioning Group, Healthwatch, the VCSA and NHS Local Area Team. The Health and Wellbeing Board acts to ensure that key leaders from the health and care system work together to improve the health and wellbeing of Shropshire residents. Health and Wellbeing Board members collaborate to understand their local community's needs, agree priorities and work together to plan how best to deliver services.

Introduction

Health and social care have recognised that we all work with patients, carers and service users to gather feedback and design services. Through this strategy, we can work more collaboratively in our communication and engagement by sharing information, skills and best practice. Shropshire's health and care services are committed to the provision of a responsive local health and social care system that reflects the population we serve.

All organisations linked to this strategy are committed to seamless and effective communications and engagement for everyone who uses health and social care services in Shropshire. This strategy focuses on building upon good practice principles and values highlighted in the Shropshire Compact[1] and the joint streams of work across the health and social care system of Shropshire. Individual health and social care organisations across the county will have their own communication and engagement strategies and plans that feed into and support this overarching strategy.

Purpose

The purpose of this strategy is to create transparency, consistency, to join up working and to avoid duplication in communications and engagement work. It intends to support the Health and Wellbeing Board in the delivery of its strategy.

This agreement will increase knowledge and understanding of health and care across Shropshire, helping the people of Shropshire to be better informed and involved in decisions around their care and, as a result, have better access to services. This will help health and social care organisations to achieve their individual priorities and aspirations around health and wellbeing.

Health and social care partners want to ensure that, where possible, communication and engagement is co-produced across the health and social care economy alongside other partners and the people of Shropshire.

All partners aim to make most effective use of all networks across health and social care systems.

[1] For more information on The Compact in Shropshire, please see: yourvoice.org/the-compact/

Principles

All organisations signed up to this strategy are committed to the following principles and will:

- Adopt good practice and operate in a transparent, targeted, objective and timely fashion with the spirit of openness and candour
- Work together; sharing information and making use of skills across networks
- Ensure accessibility and equality needs are respected and accommodated at all times; this includes children and young people, vulnerable people and those with protected characteristics
- Take an approach that fosters continuous engagement and reflects two way dialogue with our local people
- Facilitate positive relationships with our employees and empower staff to be communications and engagement ambassadors
- Support health and care providers achieve priorities through good communication and engagement
- Provide the public with simple and clear information to enable better access to the right service

Information sharing

All of the organisations that have signed up to this strategy agree to share findings and information learned from engagement and communications activities, such as consultations and wider communications campaigns, in order to improve the experience that local people have of health and social care services. This will also reduce the risk of duplication of work and ensure that active conversations with communities are shared across the health and social care system. This strategy is not about sharing personal information or commercial in confidence data.

Platforms such as the Joint Strategic Needs Assessment (JSNA) will be utilised in the sharing of information common across the health and social care landscape in Shropshire.

Approaches

We will use the most relevant and targeted methods to ensure that we communicate and engage effectively with the people of Shropshire. We will use a combination of tools such as demographic profiling, grass roots knowledge and experience, and engagement with stakeholders to ascertain how best to communicate and engage with relevant individuals, groups and communities.

A combination of approaches will be deployed to ensure that every contact with the people of Shropshire counts. When devising specific communications and engagement plans we will incorporate all channels that are deemed most effective to target people. Our communications and engagement will be outcome-focussed and there is an efficient feedback loop to demonstrate that we are listening and acting upon feedback.

We will use a range of channels, for example; websites, newsletters, press releases, social media, surveys, face-to-face events, focus groups, community conversations and staff as advocates. Also by using our networks to strengthen the channels that we use and ensure that the mechanisms utilised reflect the best method of communication and engagement for that group.

We consider there is an importance in capturing the views and experiences of the people of Shropshire, and this detail will inform the update of the JSNA and be used in the development of services. By using a targeted, relevant and outcome-focussed approach we will aim to achieve good communications and engagement with people and by definition we will develop a network of trusted communicators.

Feedback loop and making a difference

For all activities there will be a feedback mechanism to share the messages that have been generated as a result of any communications and engagement. We are committed to sharing any outcomes where there are changes as a result of engagement and communications. We understand that good communications and engagement is a cyclical process and we believe that this will underpin achieving a healthy Shropshire.

This strategy will be reviewed in the first 6 months, and will be reviewed annually thereafter.

Our Partners:

Shropshire Clinical Commissioning Group (CCG) the local NHS organisation responsible for commissioning local healthcare for the people of Shropshire. This includes commissioning services like acute and community planned hospital care, rehabilitation care, urgent and emergency care, community health services and mental health and learning disability services.

Healthwatch Shropshire is the independent consumer champion for health and social care in Shropshire. Healthwatch Shropshire seeks the views of patients, carers, service users and the wider public about how their health and social care services are run. Healthwatch has the right to visit places providing publicly funded health and social care services (such as hospitals, GP practices and residential homes). It makes reports and recommendations, publicises its findings, and it uses its statutory powers to influence change.

Shropshire Council provides a range of services to Shropshire residents including the delivery of health and social care services. This incorporates children's services, social care placements and support, safeguarding of vulnerable children and adults, information, advice and guidance, public health support around healthy lifestyles and services from the leisure and outdoor recreation teams.

Midland and Lancashire Commissioning Support Unit (CSU) provides specialist support to Shropshire CCG, particularly around back office functions. In Shropshire, the CSU is helping to support the CCG with its communication and engagement, including the NHS Future Fit programme.

South Staffordshire and Shropshire Healthcare NHS Foundation Trust provide adult and older people's mental health services and learning disability health services. They work in partnership to promote the independence, rehabilitation, social inclusion and recovery of people with a mental illness.

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.

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.

Shropshire Community Health NHS Trust provides community health services to people in their own homes, local clinics, health centres, GP surgeries and other locations across Shropshire, Telford & Wrekin and some surrounding areas. These services include Minor Injury Units, community nursing, health visiting, school nursing, podiatry, physiotherapy, occupational therapy, and support to patients with diabetes, respiratory conditions and other long-term health problems.

GP Practices - There are 44 GP practices in Shropshire and local practices have formed a GP Federation. The single Walk in Centre is currently located on the Royal Shrewsbury Hospital site.

Shropshire Doctors Co-operative Ltd (Shropdoc) provides urgent medical services for patients when their own surgery is closed and whose needs cannot safely wait until the surgery is next open. ShropDoc provides out of hour's primary care services to 600,000 patients in Shropshire, Telford and Wrekin and Powys.

West Midlands Ambulance Service (NHS Foundation Trust) - The Trust serves a population of 5.36 million people covering an area of more than 5,000 square miles made up of Shropshire, Herefordshire, Worcestershire, Staffordshire, Warwickshire, Coventry, Birmingham and Black Country conurbation.

NHS England is an executive, non-departmental, public body of the Department of Health. NHS England oversees the budget, planning, delivery and day-to-day operation of the commissioning side of the NHS in England as set out in the Health and Social Care Act 2012.

Shropshire Local Pharmaceutical Committee – The Shropshire Local Pharmaceutical Committee is the representative statutory body for all Community Pharmacy contractors in the county of Shropshire.

People 2 People is a not-for-profit independent social work practice working with Shropshire Council to provide adult social care support to older people and those with disabilities. The aim of People2People is to offer a different way of supporting individuals to keep their independence for as long as possible.

Shropshire Partners in Care (SPIC) represents independent providers of care to the adults of Shropshire and Telford & Wrekin. Its purpose is to support the development of a high quality social care sector in the areas of Shropshire and Telford & Wrekin. They provide information, support training and signposting to relevant services to everyone that contacts the office.

The Voluntary and Community Sector Assembly (VCSA) works to facilitate partnership between the voluntary and community sector and public sector, ensuring that the VCS are represented on groups led by the CCG, Shropshire Council and other partners. Members of the Voluntary and Community Sector Assembly include many VCS organisations who deliver health and social care services in Shropshire.

Help2Change provides a single point of access to a suite of services to help individuals improve their health. Services are aimed at keeping individuals well, improving their wellbeing and preventing illness. Information and advice is also available via the Healthy Shropshire website.

IP&E provides public services on the Council's behalf, enabling the Council to reinvest profits from any trading back into services. Their aim is to deliver better outcomes for the public by designing services around customer need and maximising public profit.

Draft Health and Wellbeing Communication and Engagement Action Plan

PRIORITY	ACTION	Further detail	WHO?	DATE	REVIEW
1	**Approval from Health and Wellbeing Board**	Including sign up to the strategy from partners. Link with development of the Health and Wellbeing strategy.	Health and Wellbeing Board members	April/May 2015	Review strategy - 6 months, then yearly
2	**Supporting access through information, advice and guidance**	Engaging the population and delivering information to ensure that the public are aware where they can go for services, etc. For example, disseminating information about urgent care services (appropriate use, locations, opening times) and communicating the message around any changes to services. Development of the Shropshire Together website will support this; communicating the work and available services from across the health economy.	All Communication and Engagement leads	Continuous	
3	**Raise profile of the Health and Wellbeing Board**	Through the operational tools detailed below and including the Shropshire Together website as a platform. A Health and Wellbeing Conference in Autumn 2015 will focus upon health inequalities. The outcomes of the event will be used to inform planning for the Health and Wellbeing Board (HWBB).	Communication and Engagement leads from: Shropshire Council/IP&E, Healthwatch, CCG, CSU, VCSA, Shropshire Together	Continuous Autumn 2015	
4	**Development of mechanisms to support joint working through:** **A. Strategic decision making**	A. Development of an operational group to make recommendations to the HWBB. Clear project management approach for carrying out the work from the HWBB and local campaigns. Networking and working together. Developing protocols for deciding upon and delivering campaigns. This will include supporting the communication and engagement of key programmes such as NHS Future Fit and Better Care Fund.	A. Communication and Engagement leads from: Shropshire Council/IP&E, Healthwatch, CCG, CSU, VCSA, Shropshire Together	May/June 2015 onwards	

	B. Operational tools **C. Sharing information**	B. Tools such as; a shared social marketing and communications resource platform, single consultation portal, news story feed through to the HWBB website, local network for working together (communication and engagement leads), agreed media protocol (including across social media), shared photo library, a regular health column in newspapers, shared evaluation tools to monitor effectiveness of communication and engagement. C. Individual organisations sharing information about individual campaigns, events or updates via an effective forum or platform. These actions will lead to joint working and promotion of health and wellbeing across the health economy through initiatives such as a shared health and wellbeing stand at the Shrewsbury Flower Show (Aug 2015) and early development of the media campaign highlighting access to urgent care in Shropshire. This also includes development of the Shropshire Together website with input from across the Shropshire health economy.	B. Shropshire Council/IP&E, Healthwatch, CCG, CSU, VCSA, Shropshire Together, providers incl. SSSFT, SPIC, Shrop Comm, SaTH, RJAH, etc. C. ALL		
5	**Develop tools for evaluation**	To generate an understanding of the most effective methods of communication and engagement and to ensure that we achieve the outcomes we set.	Operational Group (see 4A)	June 2015	
6	**Determine the best way to engage those who are not routinely engaged**	Linking with the locality Joint Strategic Needs Assessment to understand better the population, making a targeted approach to ensure inclusion and consideration is given. This includes considering how best to engage with children and young people, vulnerable persons and those with protected characteristics.	Operational Group (see 4A)	Continuous	
7	**Investigate 'twinning' with another Local Authority**	To learn from each other's successes and difficulties with communications and engagement.	Operational Group (see 4A)		

Shropshire Together and the Health and Wellbeing Board 'SWOT' Analysis Summary

Introduction

Over the summer, various members of the Health and Wellbeing Board were asked for their comments around the topics of Shropshire Together, the Stakeholder Alliance, Health and Wellbeing Board communications and the JSNA. Comments have been compiled into a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis with main themes identified. Recommendations for development are supplied.

ST = Shropshire Together, SA = Stakeholder Alliance, HWBB = Health and Wellbeing Board

HWBB members consulted:
Karen Calder, Ann Hartley, Jane Randall-Smith, Karen Bradshaw, Paul Tulley, Rod Thomson, Bill Gowans, Helen Herritty, Lee Chapman, Stephen Chandler, George Candler, Caron Morton, Jackie Jeffreys, Mark Donovan.

Shropshire Together

Strengths	Weaknesses
• ST has a role in making information understandable. • ST has a role in providing the public with a general message that we are working together and info about our flagship pieces of work. • ST was good at telling people what the HWBB is/does. • The idea of the 'hot seat' was good and well-received.	• ST's objectives were not clear. Views were collected and shared without clarification for what they would be used. • Might be better to put resource into promoting the HWBB. • The same people/organisations involved in ST are already involved in other groups; better to use existing forums. • Difficult to distinguish difference between ST and SA.
Opportunities	**Threats**
• Role in promoting the work of the HWBB and making people feel they can approach the Board. • Provide a place where all info is pulled together with ST then promoted. • Explain to people how Shropshire works. • Co-ordinating updates from other agencies and supporting organisations without skills to transmit their messages. • More proactive about telling Shropshire what we do.	• Need to improve communications and consult each other before beginning projects to ensure there is no duplication. • Need to ensure we are connecting at a 'real' level as well as at an high, strategic level. • Once the HWBB has its own branding, ST will 'fall away'. • Recreating what is already there; brings little value.

Board members had differing views on the previous and potential effectiveness of Shropshire Together in its current form. In large, the majority felt that Shropshire Together brought benefit; it provided continued engagement, facilitated partnership working and helped to share information across organisations during a time of upheaval and organisational change. However, there was a feeling that the health and wellbeing landscape has now developed and that there are other organisations now fulfilling certain aspects of Shropshire Together's previous role.

It was felt that there is still a need to ensure that duplication of work across agencies is minimised. There is potential for something similar to Shropshire Together to take a role in co-ordinating that which is already in place amongst organisations and for providing support to organisations that do not have suitable networks for information sharing and engagement. It was suggested that Shropshire Together could do this as a virtual agency. This topic is further discussed under 'Website'.

Stakeholder Alliance

Strengths	Weaknesses
• Sharing platform is important. • Opportunities for people to see what is going on/how to give feedback. • Online presence is good – we're required to have info available online by the Care Bill. • Useful method of finding out what people think/a place where people can ask questions. • When we share info with the public they are more satisfied.	• Not maximised to its full potential – collaborative space for work. • Not open (log-in). • Terminology 'stakeholder'. • Existing, established forums for stakeholders. All organisations have public-facing elements. • Felt like a HWBB space, not for taking other things. • SA Communications have become less professionally relevant over time. • Needs to be strategy at the heart of SA. • One size fits all. • Behaviour needs to be managed so that individuals get involved without prompt.
Opportunities	**Threats**
• Needs to be live and functional – invite response but also to respond back to people. • Harness power of social media. • Closed area for board members. • Need to make involvement obvious, 'have your say'. • Online concerns need to be given same weight as comments made in person. • Real-time feedback is important.	• Shropshire's digital exclusion – we need both. • Need to ensure not duplicating work of Healthwatch. • Would need to be bottom-up, do people want it? Needs-based assessment. • Unintended consequence; 300 different voices • Need to be sure what for what the feedback is being used. • The HWBB has a stakeholder alliance. • Do the people on the list want to be involved?

In general, board members felt that an online sharing and collaborative space was useful, but that the Stakeholder Alliance had been underutilised and not used as was intended. They felt that it was important to keep the facility, but that any engagement and feedback should only be requested if there is a clear purpose for doing so, and that information received should be treated with the same substance as comments made in person. However, it was emphasised that any engagement should consider how it can connect with Future Fit.

Some made comments asserting that there needs to be a clear request from stakeholders to have the Stakeholder Alliance, however, all saw the benefit of sharing information. It was clear that there needs to be other methods for those without internet to participate.

Website

Strengths	Weaknesses
• Things work best when people self-select or find the info for themselves. Important to give people the opportunity to browse.	• Cannot be the only medium. • Not meeting expectation.
Opportunities	**Threats**
• Create a Shropshire Link/Gateway/'What is it like to live in Shropshire?'/Welcome to Shropshire. • Could highlight different themes each month: road safety etc. Topical. • Provide engagement and two-way dialogue. • Option to sign up to alerts but also make info clear and accessible.	• Other organisations have their newsletters, what does this add? • What is the difference between the SA and ST website?

Few members mentioned the current Shropshire Together website directly, but those who did felt that it was more a space for the HWBB. Several individuals made suggestions for how the website could be better used by broadening the types of information or messages that it covers and including a wider range of partners. It was felt that the website needs to be kept more up-to-date and to include topical messages or discussion, for example theming the information around events such as fire safety around Bonfire Night etc.

Three board members mentioned how the website could be revamped to act as a 'Welcome to Shropshire' type gateway, telling residents how they can access the services they need and broadening the health and wellbeing aspects of the website.

Health and Wellbeing Board Communications

Strengths	Weaknesses
• Comms have improved because of the BCF. • A few individuals felt that the comms was appropriate, partly because of the CCG and its PPGs. • Communicate message that we are working together, across agencies (ST did this well).	• Awareness of HWBB is low. • HWBB needs to be more 'user-friendly'. • Residents need to understand how Shropshire works. • Info needs to be able to be understood by professionals and public. • Need clarification of the HWBB's role. • Any info needs to be simple and clear – current info is too wordy. Current info is neither light enough nor formal enough. Provide summary reports of documents. • Need to be proactive in telling people what we do, not waiting to be asked.
Opportunities	**Threats**
• Raise HWBB's profile. • Can learn from other areas such as S. Yorkshire. • Healthwatch could act as the mechanism for everyone to feed into the HWBB. • HWBB could come under the banner of ST? • Public should be able to find out what are the health concerns for Shropshire. • People will want to get involved at particular times, over particular issues. • Difference between what we communicate regularly/on particular occasions. • An onus upon HWBB to share info and ensure it filters through organisations. • Ask organisations how they want to receive information. • Designing needs individuals getting together. Finishing/finesse can be done remotely. • Promote the fact that the HWBB gives the public access to a representative from NHS England. • Need a dedicated, shared resource for comms for all members of the HWBB. • Could test the comms with a PPG.	• Need to ask members of the SA what they are getting out of their membership/the information? • People are not aware of the wider context of how the HWBB affects the public. People do not know what it does. • HWBB is not given the same status as other Council committees. • Many people are happy to let bodies 'get on with things'. • Cannot just communicate plans they are already being developed, but equally can't give a blank sheet. • Need to communicate when something is finished (how to use etc.) not just asking for comment on a finished product. • Any info needs to be of interest and needs to provoke discussion. • Need to think – who are we engaging? Why? What are we going to do with the information? • Public might not need to understand the HWBB's processes and functions – others might want to know.

There was debate over whether or not the HWBB has its own brand. While some board members considered the HWBB to have a strong brand (and should be working to become an entity in its own right), others felt that the HWBB was not sure of its own role, and that as a result it does not have a brand, nor can it be promoted. Some board members felt that the HWBB could have a more statutory function if ST was completing the communications/information sharing, allowing it to develop its role.

Most respondents agreed that there is a distinction between the type of information, as well as the degree of communication, that the public and professionals require. Any information needs to be clear and simple. There should be the general type of information that we communicate on a semi-regular basis and then the more in-depth information, indicating how the public can get involved, with the other issues.

There was a strong feeling that before any engagement that encourages response or consultation is published, there needs to be a clear and precise reasoning for the discussion and a well-defined plan for what the HWBB will do with information that is gathered. Healthwatch was seen as a key partner for sharing information with the public.

Strengths	Weaknesses
• Very good at drilling down to simple messages (but sometimes we need to see the detail) • Should be online. • Does not need to be updated annually (our demographics don't change). • Executive summary with direction for further information. • Everything should reference the JSNA as evidence (but not use it as a strategy). • The data is made to feel 'live' which helps to show its value.	• Under-utilised across the Council and by partners. • Sometimes more detail is needed. • Hoped it would be a 'live' online space where info is regularly updated by PH and other agencies. • Not obvious how and when it is being updated. • Needs to be more user-friendly. • Raw data sets are not useful for people who do not have the understanding. • Difficult to know how you influence it. Want more qualitative, lived experiences (subjective and objective).
Opportunities	**Threats**
• More people need to know what it is and why it is there – it should inform what we do. • Want to be told about changes to the JSNA. • Two formats: high level figures with enough insight for most and a more detailed version for those who need more info. • Include strategic needs as well as assets. • Join the JSNA with our local commissioning needs. • Make available on Share Point. • Needs to be something that the public can shape – everyone to feed into it (esp. VCSA). • Consultation on a draft.	• Some staff would go directly to the Health Intelligence team rather than using the JSNA.

The majority of board members felt that the JSNA was under-used across the Council and by other partners. They felt that it had a lot to offer but that it needed more promotion, as a result it was not embedded in decision making.

Suggestions were made to have the JSNA in two forms; one being fairly high-level which would include enough information for most needs, and a second that included more in-depth, supporting information including more complex data for those who are able to utilise this information. The executive summary was highlighted as useful, particularly as it is suitable for use by non-professionals.

There was also a feeling that partners and the public should be more involved in its creation. Individuals wanted to know when it was going to be updated, and how they could have an influence on its content.

Several board members mentioned by-passing using the JSNA to go directly to the Health Intelligence team to get the data that they need. This may be creating unnecessary work for the Health Intelligence team if this data is already available via the JSNA.

Consultation Portal

Strengths	Weaknesses
• Saves the public having to look across organisations. • Potential effective use of resources.	• 40% of CAB's clients do not have internet access
Opportunities	**Threats**
• Would want to show who is behind the consultation. • Information would need to back to the consultation host (i.e. SaTH, CCG etc.).	• Not clear who is running the consultation.

Most respondents felt that Shropshire Council's consultation portal could be used successfully and effectively by other organisations, with the premise that it would be clearly indicated to which organisation the consultation belonged and that the data should be returned directly to the organisation.

Health and Wellbeing Board Other

Strengths	Weaknesses
• Strong Chair with comprehensive knowledge/understanding and good leadership.	• HWBB needs powers mandated to it.
Opportunities	**Threats**
•	• Needs a whole-system plan. • Issue of continuity with members.

Recommendations

Communications and engagement:

1. To develop a health and wellbeing communication and engagement plan that encompasses all areas of health and wellbeing and incorporates all health and social care partners. We recommend that a working group could resolve the detail of how this would work in practice and return to the Board with a proposal for action.

   This plan would be able to use the current tools such as the website, Stakeholder Alliance, the Health and Wellbeing newsletter and include appropriate links to the JSNA and Shropshire Council consultation portal.

2. Keep the branding of 'Shropshire Together' as a strap line for the Health and Wellbeing Board and work with a Health and Wellbeing comms and engagement task and finish group to consider using the available tools (the engagement, website, Stakeholder Alliance) under the title of 'Health and Wellbeing'

Agenda Item 13

Shropshire Council | NHS Shropshire Clinical Commissioning Group | Shropshire together

Health and Wellbeing Board
Friday 27th March 2015

CHILDREN'S TRUST REPORT TO THE HEALTH AND WELLBEING BOARD

Responsible Officer **Karen Bradshaw**

Email: karen.bradshaw@shropshire.gov.uk Tel: 01743 254201

1. Summary

The Children's Trust report provides regular assurance to the Health and Wellbeing Board on the work of the Trust and highlights areas for closer consideration by the H&WBB.

2. Recommendations

The H&WBB is recommended to:

a) Note the information and actions in the report
b) consider endorsing and promoting partner agencies to provide and / or promote opportunities for those young people identified as NEET, including those children looked after by the Local Authority.
c) consider Health Inequalities for Looked After Children and Care Leavers as an item for the agenda of the H&WBB

REPORT

3. Risk Assessment and Opportunities Appraisal

The Children's Trust through its associated health and wellbeing outcomes support the reduction of inequalities across Shropshire

4. Financial Implications

No financial decisions are explicitly required with this report, there may be associated resource implications to be considered for some actions.

5. Background

The Children's Trust have met twice since the last report to the Health and Wellbeing Board and the matters considered at the meetings included below:

a) Special Education Needs & Disability (SEND) Reform
The Children's Trust report to the H&WBB in November 2014 provided a summary on the SEND Reform and the Local Offer. One of the main changes the report advised is the replacement of educational statements and learning disability assessments with Education, Health and Care Plans (EHCP). The Children's Trust recognised, the significant challenge being

faced by the Local Authority as it looks to convert the 2000 Statements of SEN (which represents 4.1% of the school population) into EHCP. To update the H&WBB the process of conversion began in November 2014 and to date:

- 192 transfer review meetings have been held in schools.
- 140 of those have now been considered
- 94 will be converted to an Education Heath and Care Plan (EHPC).
- 63 Year 11 Statements will cease at the end of the academic year as the young person's SEN can be met at college without the need for a EHCP.
- 30 Plans have been finalised so far and of those 22 have been completed within the 14 week timescale. (73%). The 8 cases that did not meet timescales were where the team could not finalise as advice/approval was awaited from other agencies.

The Children's Trust will continue to monitor progress across the school population and in addition has also sought further information on progress with regard to those young people with SEND in custody. A sub group is in place to progress implementation plans, however the release of national legislation is awaited and there may be implications that will have to be taken into consideration. The Disabled Children & Young People 0-25 Strategic Board raised concerns that the Designated Medical Officer joint post between Shropshire and Telford & Wrekin CCG was not yet in place. This concern will be raised in a report to the Children's Trust.

b) Child & Adolescent Mental Health Service (CAMHS)

In considering the CAMH Service the Children's Trust has been reassured to see that governance and reporting mechanisms have been strengthened and that the Clinical Commissioning Group (CCG) Commissioners meet monthly with Shropshire Community Health Trust (Shropcom) to monitor delivery and to track areas that have been highlighted for improvement. However, the Children's Trust stressed that further work is required on the 'step up and step down' of services. The Trust has requested feedback on the work currently being undertaken re resource allocation at Tier 3 CAMHS and further information on the operational delivery of Tier 2 based with Compass.

The Children's Trust recognise that further work is needed to effectively plan strategic activity across the CAMHS tiers and were reassured to see that a multi agency 'Children and Young People Emotional Health and Wellbeing Strategic Group' was being set up to look at how this might best be done. The CCG and Shropshire Council are providing a joint update on mental health to each meeting of the Children's Trust.

c) Perinatal Mental Health

The Children's Trust have been advised that NHS England are undertaking a review and gap analysis of perinatal and post partum mental health services in the Shropshire area. As the landscape around the provision of services in this area changes to see the Local Authority taking on the commissioning role around Health Visitors and the Family Nurse Partnership the Children's Trust will maintain interest in developments.

d) Not in Education Employment or Training (NEETS)

The numbers of NEET in Shropshire may be relatively small in comparison to statistical neighbours, however the Children's Trust recognise that it includes some of the County's most vulnerable young people. The vulnerability of some young people is increased by the fact they are placed in Shropshire by other Local Authorities and this is something that the Children's Trust would highlight to the Health and Wellbeing Board when they look more closely at the number of young people placed in the County and the implications that has on the provision of services.

The Children's Trust has asked partner agencies to look at their own commissioning practices and to identify areas where they might offer apprenticeships or work placements as part of their corporate responsibilities. The Children's Trust would ask the Health and Wellbeing Board to consider endorsing and promoting this practice.

Action - Health and Wellbeing Board consider endorsing and promoting partner agencies to provide and / or promote opportunities for those young people identified as NEET, including those children looked after by the Local Authority.

e) Corporate Strategy for Looked After Children

The strategy has been reviewed and can be viewed at http://staff.shropshire.gov.uk/media/342727/Shropshire-Corporate-Parenting-2014-np.pdf

Being a good Corporate Parent means supporting the needs of looked after children whilst listening to their views and wishes and supporting them to make the most of their lives. When a child comes into the care of the Council the role of the Corporate Parent means that child is the collective responsibility of the Council, elected members, employees and partner agencies. The Children's Trust would ask those sat around the table for the meeting of this Health and Wellbeing Board to consider:

- How well understood is Corporate Parenting in your organisation?
- Are the requirements of Corporate parenting considered when developing new ways of working and commissioning?
- What contribution can your organisations offer to help provide opportunities to our looked after children and care leavers?
- Are health inequalities evident in Shropshire for those children and young people who are looked after or are care leavers?

Action – Request to the Health and Wellbeing Board from the Children's Trust to consider Health Inequalities for Looked After Children and Care Leavers.

f) Under 18 conception data

The Children's Trust were reassured to see that the number of under-18 conceptions in Shropshire has fallen within the past year. Annual statistics released by the Office of National Statistics (ONS) indicate that there are 19.1 births per 1000 females aged 15-17 in Shropshire compared to a figure of 24.3 for England and Wales. This represents a reduction of 43.8% from the baseline figure set in 1998 compared gives Shropshire the lowest conception rate within the West Midlands region as well as evidencing that local approaches to reduce teenage pregnancy rates are having an impact.

The number of under 16 conceptions in Shropshire has also decreased to 3.7 per 1000 between 2011 and 2013 compared with 4.5 per 1000 between 2010-12. This is 60 conceptions between 2011-12 of which 63.3% led to an abortion. The under 16 conception rate for England and Wales is 5.5 per 1000 in 2011-13.

g) Area Forums

Plans are underway to arrange the Area Forums focussed on community resilience and how Early Help and the Troubled Families Programme work in local communities as well as raising awareness around child sexual exploitation. The forums will pose the questions:

- How resilient is your community?
- How well do you know it?

The dates for the spring Forums are the mornings of 27th & 28th April and 1st May 2015.

h) Triangulation meeting

The chairmen of the Health & Wellbeing Board, the Children's Trust and the Shropshire Safeguarding Children Board met to look at how we can work together to ensure the priorities of each Board improve the lives of vulnerable children and families. Through discussion it was agreed by those present that it would be helpful if the Chairmen of the Shropshire Adult Safeguarding Board and the Safer Stronger Communities Partnership were invited to join the group

i) Looking ahead

In order to promote transparency the Children's Trust has produced a work programme that outlines reports scheduled for future meetings. This provides an opportunity for the Health and Wellbeing Board to be informed of future agenda items for the Children's Trust.

6. Additional Information

Children's Trust Work Programme attached as Appendix A

7. Conclusions

The Children's Trust continues to raise challenges across partner agencies.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) Cllr Karen Calder – Health Cllr Ann Hartley – Children's
Local Member
Appendices Appendix A Children's Trust Work Programme

APPENDIX A - Children's Trust – Work Programme 2015 / 2016

All children and young people will be happy, healthy, safe and reach their full potential, supported by their families, friends and the wider community

Meetings	**Wed 18 March 2015** **Wenlock Room** **2:00pm – 4:00pm**	**Wed 1 July 2015** **Council Chamber** **2:00pm – 4:00pm**	**Wed 7 October 2015** **Council Chamber** **2:00pm – 4:00pm**	**Wed 13 January 2016** **Wenlock Room** **2:00pm – 4:00pm**

	Agenda Item	Purpose of report	Owner
Wednesday 18 March 2015 **Joint Strategic Needs Assessment (JSNA) will be included in discussion of each agenda item**	Regular feedback item	Feeding back items from the Health & Wellbeing Board, Headteacher's Forum, Safeguarding Children Board	Chair Karen Bradshaw
	Joint regular report on Mental Health including CAMHS	Progress on work ongoing with the development of a Children & Young People Emotional Health and Wellbeing Strategic Group to effectively plan strategic activity across the CAMHS tiers.	Jo Robins Shropshire Council Julie Davies CCG
	Discussion paper on self harm	Action 9 b: Self-Harm Strategy	Joint report Jo Robins and Fiona Ellis
	Substance Misuse Joint Working Protocol Review	Action 4: evaluate the impact of the joint working protocol	Jayne Randall
	Children's Trust Delivery Plan 2014/15	Progress on actions and looking forward to 2015/16	ALL
	Regular feed forward item	Summarising items for taking forward to H&W, SSCB, HT Forum	Chair Karen Bradshaw
	Autism Needs Assessment – Progress Report For Information	Action 9a Conduct an Autism Needs Assessment for Shropshire that looks to understand prevalence, service need/ demand, and current provision across all sectors. Interdependencies with actions 1 and 2	Penny Bason / Lorraine Laverton
	Agenda Item	**Purpose of report**	**Owner**
Wed 1 July 2015	Regular feedback item	Feeding back items from the Health & Wellbeing Board and Safeguarding Children Board	Chair Karen Bradshaw
	Joint regular report on Mental Health including CAMHS	Progress on work ongoing with the development of a Children & Young People Emotional Health and Wellbeing Strategic Group to effectively plan strategic activity across the CAMHS tiers.	Julie Davies

Wed 1 July 2015	Domestic Abuse Problem Profile	SSCB Action A048 West Mercia Police to link with Children's Trust and Public Health re Domestic Abuse Problem Profile	TBC
	Parenting Support Strategy	Action 10: Roll out of Solihull Programme	Karen Ladd
	Autism Needs Assessment – Final Report	Action 9a Conduct an Autism Needs Assessment for Shropshire that looks to understand prevalence, service need/ demand, and current provision across all sectors. Interdependencies with actions 1 and 2	Emma Sandbach Fiona Ellis & Marion Versluijs
	Joint Strategic Needs Assessment	Regular feedback and input from the Children's Trust into the JSNA process JSNA will be considered within discussion of each agenda item	Emma Sandbach
	Regular feed forward item	Summarising items for taking forward to H&W and SSCB HT Forum	Chair Karen Bradshaw
	Agenda Item	Purpose of report	Owner
Wed 7 Oct 2015	Regular feedback item	Feeding back items from the Health & Wellbeing Board and Safeguarding Children Board	Chair Karen Bradshaw
	Joint regular report on Mental Health including CAMHS	Progress on work ongoing with the development of a Children & Young People Emotional Health and Wellbeing Strategic Group to effectively plan strategic activity across the CAMHS tiers.	Fiona Ellis
	Family Nurse Partnership – the first operational year	Actions 1 and 12	Ann-Marie Speke, Lindsay MacHardy & Sarah Rock
	Joint Strategic Needs Assessment	Regular feedback and input from the Children's Trust into the JSNA process JSNA will be considered within discussion of each agenda item	Emma Sandbach
	Regular feed forward item	Summarising items for taking forward to H&W and SSCB HT Forum	Chair Karen Bradshaw

CHILDREN'S TRUST AREA FORUMS - 2015			
DATES	TIME & VENUE	TOPIC	OWNER
Monday 27th April 2015	**09:30 – 12:30** **Trinity Centre Meole Brace**	**Early Help** **Troubled Families** **Community Resilience**	**Tina Russell** **Barbara Stafford-Cairns** **Sarah Wilkins**
Tuesday 28th April 2015 -	**09:30 – 12:30** **Ellesmere Town Hall**	**Early Help** **Troubled Families** **Community Resilience**	**Tina Russell** **Barbara Stafford-Cairns** **Sarah Wilkins**
Friday 1st May 2015	**09:30 – 12:30** **Craven Arms Community Centre**	**Early Help** **Troubled Families** **Community Resilience**	**Tina Russell** **Barbara Stafford-Cairns** **Sarah Wilkins**
Monday 2nd November 2015	**09:30 – 12:30** **Council Chambers Shire Hall**	**Early Years**	**TBC**
		NEETS	**TBC**
		Information & Data Sharing Protocols	**TBC**
Tuesday 3rd November 2015	**09:30 – 12:30** **Ellesmere Town Hall**	**Early Years**	**TBC**
		NEETS	**TBC**
		Information & Data Sharing Protocols	**TBC**
Thursday 5th November 2015	**09:30 – 12:30** **Craven Arms Community Centre**	**Early Years**	**TBC**
		NEETS	**TBC**
		Information & Data Sharing Protocols	**TBC**

NB **The work programme is a guide for future reports. However, it is a live document and therefore will change to reflect the requirements of the Children's Trust**

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Health and Wellbeing Board
27th March, 2015

NHS FUTURE FIT SHORTLIST

Responsible Officer Paul Tulley, Chief Operating Officer, Shropshire Clinical Commissioning Group
Email: Paul. Tulley@shropshireccg.nhs.uk Tel: 01743 277500 Fax:

1. Summary

1.1. The attached report sets out the options for acute and community hospital services identified by the NHS Future Fit Programme Board. Each option (apart from the 'Do Minimum') proposes a way of configuring services that is designed to deliver the previously agreed Clinical Models of care.

1.2. These options are now subject to detailed development in advance of a full economic assessment.

2. Recommendations

2.1 The Board is invited to note the report.

REPORT

3. Risk Assessment and Opportunities Appraisal

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

3.1. A formal risk management process is in place for the Programme.

3.2. The Programme has an Integrated Impact Assessment worsktream which is undertaking Equality Analysis and other related assessments, including engagement with groups with protected characteristics.

3.3. Proposals will formally be put to the public in a Consultation which is expected to commence from December 2015. In the meanwhile, a programme of pre-consultation will continue to take place in parallel with the development of options.

4. Financial Implications

4.1 These will be analysed and appraised as part of the economic analysis which is due to be completed in June 2015, in line with the requirements of HM Treasury's *The Green Book*.

5. Background

5.1 The Programme is focused on acute and community hospital services in Shropshire and Telford & Wrekin. It involves all communities who use those services, particularly across Shropshire, Telford & Wrekin and mid Wales. The aim is to develop a clear vision for excellent and sustainable acute and community hospitals - safe, accessible, offering the best clinical outcomes, attracting and developing skilled and experienced staff, providing rapid access to expert clinicians, working closely with community services, focused on those specialist services that can only be provided in hospital.

6. Conclusions

6.1 The Board is invited to note the report.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) Shortlist attached.
Cabinet Member (Portfolio Holder) **Cllr Karen Calder**
Local Member
Appendices Report on shortlisting process – NHS Future Fit

futurefit
Shaping healthcare together

Report on the Shortlisting Process

The purpose of this report is to present the Programme Board's proposed shortlist of options and to summarise the process undertaken by the Evaluation Panel in developing its recommendations to the Board.

Sponsor organisations and other stakeholders are invited to consider these proposals as set out in the table below:

Key Decision Documents	Programme Board	CCGs	Other Sponsors	Joint HOSC	Health & Wellbeing Boards
Selection of Short List	Approve	Approve	Endorse	Consider	Receive

Executive Summary

The Programme Board received recommendations from the Evaluation Panel appointed by its sponsors and other stakeholders.

The Board had an extensive discussion of the Panel's recommendations in the light of all the evidence provided (including a minority report from a patient representative). Following this discussion the Board agreed the following acute services shortlist:

- Emergency Centre (EC) and Diagnostic & Treatment Centre (DTC) on a New site;
- EC on a New site, DTC at Princess Royal Hospital (PRH)
- EC on a New site, DTC at Royal Shrewsbury Hospital (RSH)
- EC at PRH, DTC at RSH
- EC at RSH, DTC at PRH
- Do minimum (existing dual site acute services maintained, provider and commissioner efficiency strategies implemented but no major services change).

The Board also agreed that there should be further debate on the best and safest configuration of obstetric services within these scenarios. This should include reviewing the clinical evidence and workforce models to understand whether obstetrics could operate on a site alongside a DTC, alongside an Emergency Centre or alongside either.

On Urgent Care Centres (UCCs) Programme Board agreed to proceed to work on:

- Prototyping two urban Urgent Care Centres, one in Shrewsbury and the other in Telford; and
- Exploring the most appropriate rural urgent care solutions in partnership with local communities and considering current facilities/services. All existing Minor Injuries Units will be considered as potential sites for Urgent Care Centres.

Next steps include:

- A further round of pre-consultation public engagement which kicks off with two 'pop-up shops', one in Telford Shopping Centre on 20/21 Feb and Shrewsbury Darwin Shopping Centre 27/28 Feb. Events in Powys are also being planned. Many more events will follow and will be publicised via the NHS Future Fit website;
- Detailed development of the shortlisted options (including estates, workforce and finance).

It is expected that the Board will be able to propose a preferred option later in the year. Formal Public Consultation would then commence from December 2015 (subject to the timing of national approvals).

Background

Each sponsor and stakeholder organisation was given the opportunity to nominate a member of the Evaluation Panel. Some changes in membership had to be made through the course of the Panel's meetings. The final panel for the shortlisting process was comprised as follows:

Dr Bill Gowans, Vice Chair	Shropshire Clinical Commissioning Group
Chris Morris, Executive Lead for Nursing and Quality	Telford & Wrekin Clinical Commissioning Group
Victoria Deakins, Lead Therapist for North Powys	Powys Local Health Board
Mr Mark Cheetham, Scheduled Care Group Medical Director	Shrewsbury and Telford Hospital NHS Trust
Dr Emily Peer, Assistant Medical Director & GPSI	Shropshire Community Health NHS Trust
Pete Gillard	Shropshire Patient Group
Christine Choudhary *(unable to attend)*	Telford & Wrekin Health Round Table
Vanessa Barrett, Board Member	Healthwatch Shropshire
Kate Ballinger, Manager	Healthwatch Telford & Wrekin
Kerrie Allward, Better Care Fund Manager	Shropshire Council
Liz Noakes, Assistant Director and Director of Public Health	Telford and Wrekin Council
Mark Docherty, Director of Nursing, Quality & Clinical Commissioning	West Midlands Ambulance Service NHS FT
Dave Watkins, Locality Manager, North Powys	Welsh Ambulance Services NHS Trust
John Grinnell, Director of Finance	Robert Jones & Agnes Hunt Hospital NHS FT
Alison Blofield, Associate Clinical Director/Nurse Consultant *(unable to attend)*	South Staffordshire & Shropshire Healthcare NHS FT
Dr Jessica Sokolov	Local Medical Committee/GP Federation
Ian Winstanley, Chief Executive	Shropshire Doctors' Cooperative Ltd.

NHS England and Montgomeryshire Community Health Council declined to nominate members because of their subsequent assurance and scrutiny functions. The Chairs of the

Joint Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin were in attendance as observers.

The Panel's earlier work had included the development of a wide range of potential scenarios from which the longlist was created following the Panel's recommendation to Board. A number of pre-consultation public engagement events also informed the development and evaluation of options.

The Long List

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

In December 2014, the Board agreed that there should be a differential approach to the identification of shortlists for the consolidated and dispersed elements of the proposed networks of care.

Evaluation Criteria

The Evaluation Panel was also responsible for recommending the criteria against which longlisted options would be evaluated. A number of pre-consultation public engagement events also informed the development and weighting of the criteria.

Four criteria were proposed initially, to which Board added a fifth by separating out workforce considerations from wider quality impacts. The Board delegated to its Core Group the task of confirming the final set of measures to be used by the Programme Team to provide evidence for the Panel. These measures focused on evidence pertinent to the differentiation of acute scenarios rather than to the overall evaluation of programme proposals. That subsequent evaluation will only be possible once shortlisted options have been developed in more detail.

The agreed criteria are set out below with a brief explanation of the nature of the information provided to the Panel. That information was presented in three tiers:

- **Tier 1** - an overall summary of acute options and obstetric variants, criterion by criterion, plus the programme Team's proposed approach to a shortlist for UCCs;
- **Tier 2** - a summary description of each option summarising all the measures available; and
- **Tier 3 –** the underlying sources of information, including
    - The Clinical Design Report
    - Phase 1 Activity and Capacity Modelling
    - Latest Summary of Phase 2 Activity and Capacity Modelling
    - Baseline Impact Assessment Report
    - Reports on Pre-Consultation Engagement Activities
    - Feasibility Study Report
    - Financial Assessment of Feasibility Study (includes additional scenarios from long list)
    - Acute Services Template (setting out the views of acute clinicians of key co-location issues)
    - Summary Affordability Report
    - Commissioner Funding Scenarios
    - Accessibility analysis.

All three tiers were made available to Board to inform its decision-making on shortlisting. They are subsequently being made available to the public, too, (where not already published) to help people to form their own views on shortlisted options as part of ongoing pre-consultation engagement and impact assessment activities.

To enable a high-level view to be taken of equity impact, the information provided highlighted any adverse differential impacts on particular social groups. The Panel had requested that these groups should include Older People (75+), Children (0-5), people with Long Term Illness, people on Low Income and people with no access to a car or van.

The weighting applied to the criteria was determined by the Panel, informed by public views. Members initially submitted their own weighting proposals, the results of which were presented to the Panel when it met. Following discussion, a final set of weightings was

agreed. These are recorded against the criteria below which appear in ranked order.

1. **QUALITY – 29.4%**

   Evidence for this criterion focused on

   - The extent to which each option support the delivery of key programme benefits (which reflect health service need criteria). This was informed by the content of the Clinical Report and by the assessment of acute clinicians. Given that all change options respond to the Clinical Report, which sets out to design quality into the system, only a limited amount of information was available at this stage to support the differentiation of options. When options are fully developed they should be more amenable to a more detailed quality impact analysis.

   - The impact on patients with time-critical conditions for the most serious cases conveyed by the ambulance service. The data provided was based on West Midlands Ambulance Service conveyance times. West Midlands Ambulance response time information was also made available to the Panel. Welsh Ambulance Service data has only recently become available and will be used to inform subsequent evaluation.

2. **ACCESSIBILITY – 26.5%**

   The Clinical Model envisages the development of networks of care covering urgent and emergency care, planned care and long term conditions. At the present time it is not feasible to undertake detailed accessibility analysis on these networks, given the number of potential combinations of acute and community options. The system-wide impact will be assessed as part of the full evaluation later in the year. For the time being, the accessibility of consolidated acute services has to be looked at in isolation. This may unavoidably advantage the 'Do Minimum' option (Option 1) but this is not material at this stage given that this option is a required component of the shortlist in any case. The Programme Team expects that subsequent modelling will demonstrate improved overall accessibility for all other options once local facilities are factored in (UCC, LPC, CU). It is in these dispersed facilities that a significant amount of future activity is expected to take place, as demonstrated in the Phase 2 Activity and Capacity modelling. Whilst it has been possible to include theoretical public transport information for the New site, the provision of public transport would clearly be subject to change should a new site be constructed.

   The travel time analysis provided was based on Phase 2 activity projections for 2018-19. These were derived by taking SaTH activity levels (using a 2012-13 baseline) and applying to these the expected impact of:

   - Provider and commissioner efficiency strategies (as set out in Phase 1 activity and capacity modelling);

   - Demographic change (using projections from the Office for National Statistics);

- The Clinical Design Report (as set out in Phase 2 activity and capacity modelling).

The measures reported cover emergency care (ambulance/car only) and planned care (car plus 3 public transport time windows – weekday morning, weekday evening and weekend morning) plus consultant-led obstetrics. Average travel times and distances reflect the potential impact of change (subject to patient choice) on patients and their carers/visitors, including where they may in future travel to out of area hospitals.

3. WORKFORCE – 25.0%

This criterion (previously a component of the Quality criterion) was informed by the assessment of senior local acute clinicians about the advantages and disadvantages of the changes proposed under each option. Again, only a very high-level assessment is possible at this stage but there were three key factors:

- Options consolidating emergency care on a single site are expected to significantly improve recruitment and retention for EC and acute medicine;
- Options locating DTC and EC on separate sites are expected to be attractive for surgical recruitment as a result of separation of planned care services, resulting in a reduced impact from medical outliers; and
- Options with a greater proportion of new facilities are expected to be more beneficial for recruitment of staff.

4. DELIVERABILITY – 10.3%

Evidence under this criterion drew on the Programme's Feasibility Study work (both the original study and as subsequently expanded to cover all longlisted options).

The information provided included high level estates and financial information indicating the likely scale, duration and cost of the physical work required. It was highlighted that this information was not intended to propose final site configurations since these may evolve significantly during subsequent design phases.

In addition to this estates-based information, the Programme Team also provided a view on the likely acceptability of each option so far as it could reasonably be judged at this stage.

5. AFFORDABILITY – 8.8%

The Programme Board determined in December that no options could conclusively be identified as unaffordable on the basis of the information currently available. The affordability criterion was therefore treated in the same way as other criteria.

The Panel was provided with:

- High-level estimates of acute costs from the expanded feasibility work;

- Estimates of the investment required in Urgent Care Centres;

Although the Panel were clearly not being asked to undertake an economic appraisal (which will form part of the next stage evaluation), it was invited to view options in the light both of wider demands on the resources of the Local Health Economy and of the relative inferiority of any options when benefits are compared with costs. This was in line with guidance in the DH Capital Investment Manual. Four cost categories were reported in the summary documentation:

- **25 Year Capital Costs**

  These costs set out both the initial capital cost of each option and the impact of future lifecycle costs over the following 25 years (in line with national guidance). This reflects the fact that, under the different options, differing proportions of the facilities will be operating in "New", "Refurbished" or "Retained" condition. Given the age of some of the existing estate, total replacement of some retained facilities is required within the 25 year period. Costs are discounted to current levels. They reflect the total cash investment required over the period. No assumption has been made about the source of this capital funding at this stage (e.g. public funds, private finance or a combination of the two).

- **Net Increase in Capital Charges**

  Capital funding resources are expected to come from outside the Local Health Economy but the relevant provider must be able to service the impact of that funding. This is expressed as an annual charge on the resources available to the provider. Net figures are provided in which the annual impact of new funding is offset by any savings from facilities no longer required under a particular option.

- **Total Change in Acute Revenue Costs**

  These are also annual costs borne by providers. In addition to the net increase in capital charges, these figures also reflect estimates of savings in maintenance energy and utility costs and savings in clinical efficiency (arising from a reduction in two-site working).

- **Estimated Overall Cost Change with 4 UCCs**

  These figures take the total change in acute revenue costs, remove the costs associated with urgent care activity which (under the options for change) would not be provided in an EC and add estimated costs for running 4 UCCs. This gives a view, therefore, on the potential net impact on the Local Health Economy of the Programme's proposals.

Urgent Care Centres (UCC)

The Panel was presented with a proposal from the Programme Team about the potential make up of a shortlist for UCCs. This proposal built on clinical design work, patient and public engagement and financial, activity and travel time modelling. A proposal from Bishops Castle Patient Group was also made available.

The proposed approach took account of the need to understand in greater detail how UCCs would work, how they would relate to other components of the Clinical Model and how they would be staffed. The Programme Team had concluded that there was a need to proceed with caution and to adopt a prototyping approach in setting up an initial number of UCCs. This would allow testing of:

- Whether staff with the right skills can be recruited;
- Whether confidence in the model can be built amongst both patients and ambulance services;
- How a variety of patient pathways would be delivered in a networked EC/UCC model;
- How UCCs would link to 24/7 primary care services;
- What services envisaged in health hubs could be provided from UCCs;
- The need for co-location with beds (CUs) and certain planned care services (LPCs); and
- Whether the number and type of patients who would attend UCCs has been accurately estimated.

The Programme Team's recommendation was that four UCCs should be subject to prototyping initially: one each in Shrewsbury and Telford and two more in rural areas to test the quality, deliverability and viability of the models.

The Evaluation Panel accepted the proposed approach, subject to some amendments, although a minority report was submitted by one patient representative.

Both documents were made available to Programme Board which agreed to proceed to work on:

- Prototyping two urban Urgent Care Centres, one in Shrewsbury and the other in Telford; and
- Exploring the most appropriate rural urgent care solutions in partnership with local communities and considering current facilities/services. All existing Minor Injuries Units will be considered as potential sites for Urgent Care Centres.

Emergency Centre (EC) and Diagnosis & Treatment Centre (DTC)

The Evaluation Panel received a presentation of the summary of acute options. It was then able to put detailed questions (covering all tiers of information provided) to a group of expert advisors who had been involved in the accessibility analysis, feasibility study, affordability analysis and pre-consultation public engagement.

At the conclusion of these detailed discussions the Panel was asked to undertake an initial scoring of each option (and obstetric variant). It was agreed that would be done individually and confidentially. Panel members awarded a score for each option/variant against each of the evaluation criteria using a scale of 0-7 (where 7 is a stronger score). Initial scores were collated, totalled then weighted to produce a single overall score for each option/variant. Sensitivity analysis was applied to show the effect of changing the weightings of the evaluation criteria. These initial results were reported to the Panel to inform further discussion on the evidence presented, and to begin to enable the Panel to consider which options would best form part of a balanced recommendation to the Board.

Following discussion, individual panel members were then given the opportunity to alter any of their initial scores if they wished to. The revised results were then presented and discussed. The following table summarises those results.

Rank	Option Description (number)	Score	Difference from best	Gap
1	EC, DTC & Obs on new site (8a)	71.9	0.0%	
2	EC/Obs at new site, DTC at RSH (5a)	69.9	2.7%	2.7%
3	EC/Obs at new site, DTC at PRH (4a)	69.4	3.5%	0.8%
4	EC/Obs at PRH, DTC at RSH (3)	67.2	6.4%	2.9%
5	EC/Obs at RSH, DTC at PRH (2a)	65.9	8.3%	1.9%
6	EC & DTC on new site, Obs at PRH (8b)	63.8	11.2%	2.9%
7	EC, DTC & Obs at PRH (7)	63.2	12.1%	0.9%
8	EC at new site, DTC/Obs at PRH (4b)	61.9	13.9%	1.8%
9	EC, DTC & Obs at RSH (6a)	61.3	14.7%	0.8%
10	EC at new site, DTC at RSH, Obs at PRH (5b)	59.3	17.5%	2.8%
11	EC at RSH, DTC/Obs at PRH (2b)	56.4	21.5%	4.0%
12	EC & DTC at RSH, Obs at PRH (6b)	54.5	24.2%	2.7%
13	Do Minimum (1)	51.2	28.8%	4.6%

The Panel felt that the top five ranked options provided a good balance of feasible options for further development and evaluation alongside the 'Do Minimum' comparator.

Sensitivity analysis demonstrated that levelling the weightings did not significantly change the results, although Option 7 (EC and DTC at PRH) rose from 7th to 2nd because of the impact of increasing the relative affordability weighting on the lowest cost option. Option 8a moved from 1st to 6th. When the weighting for affordability is increased to about 25% (and other criteria maintain relative weightings) the most noticeable impact is the reduced performance of New site options which start to fall out of the top five.

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