Shropshire Council

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

Date: 10 February 2017

Committee:
Health and Adult Social Care Scrutiny Committee

Date: Monday, 20 February 2017
Time: 10.00 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
Head of Legal and Democratic Services (Monitoring Officer)

Members of Health and Adult Social Care Scrutiny Committee

Gerald Dakin (Chairman)	Tracey Huffer
Madge Shineton (Vice Chairman)	Heather Kidd
Peter Adams	Pamela Moseley
John Cadwallader	Peggy Mullock
David Evans	Peter Nutting

Your Committee Officer is:

Amanda Holyoak Committee Officer
Tel: 01743 252718
Email: amanda.holyoak@shropshire.gov.uk

AGENDA

1 Apologies for Absence and Substitutions

2 Declarations of Interest

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 of the Last Meeting

To confirm the minutes of the meeting held on 30 January 2017 as a correct record, TO FOLLOW marked: 3

4 Public Question Time

To receive any public questions or petitions from the public, notice of which has been given in accordance with Procedure Rule 14. Deadline for notification is 5.00 pm on Wednesday 15 February 2017.

5 Member Questions

To receive any questions of which Members of the Council have given notice. Deadline for notification is 5.00 pm on Wednesday 15 February 2017.

6 West Midlands Ambulance Service (Pages 1 - 36)

The Committee has asked West Midlands Ambulance Service to attend the meeting to respond to questions about: the WMAS proposed withdrawal from the 'Physician Referral Unit'; Progress on working with the Fire and Rescue Service; Performance in Shropshire by postcode. Information provided by WMAS for the meeting is attached, marked: 6

Michelle Brotherton, General Manager, West Mercia, Mark Docherty, Director of Clinical Commissioning and Strategic Development/Executive Nurse and Pippa Wall, Head of Strategic Planning, will attend the meeting to answer questions.

7 **Shropshire CCG - Prioritisation and Value for Money Methodology** (Pages 37 - 54)

To receive the Shropshire CCG Prioritisation and Value for Money methodology, attached marked: 7.

Julie Davies, Director of Performance and Delivery and James Aker, Associate Director of Commissioning will attend the meeting to present the report and answer questions.

8 **Work Programme** (Pages 55 - 56)

To consider the proposed work programme for the Committee, attached marked: 8

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West Midlands Ambulance Service NHS
NHS Foundation Trust

Information Pack for Shropshire HOSC
20 February 2017

Mark Docherty	**Executive Director**
Michelle Brotherton	**General Manager**

Trust us to care.

Items we are covering

- Background to the Service
- CQC Rating
- Vision / Strategic Objectives / Strategic Values
- Two Year Operational Plan
- Draft Quality Account Priorities
- Activity, Demand and Performance
- Physician Response Unit
- Collaboration with Fire and Rescue Service
- Ambulance Response Programme
- The Electronic Record

Overview

- Only Ambulance Service to achieve each of the national emergency access targets 2015/16 and best performing of each
- Only Ambulance Trust in Segment One of Single Oversight Framework
- WMASFT remains the top performing service in the Country
- One of four Ambulance Trusts to achieve statutory Financial duties
- No Paramedic vacancies – circa 2,500 nationally
- Lowest sickness absence rate in Country
- Highest paramedic skill mix ratio in Country
- Best fleet in the Country

Firmograhics

- Established in July 2006 merging with Staffordshire in October 2007
- 5.6 million population (Circa 10.5% of the English population)
- Over 5,000 square miles, 80% rural
- Approaching 3000 *999* calls per day
- Over 532,000 emergency journeys annually
- £250 million budget
- Fleet of over 850 vehicles
- 4,500 Staff and 1,000 Volunteers
- 5 x Helicopters
- 1 x Motorcycle

CQC Rating

Overall Outstanding

Read overall summary

Safe	Good ●
Effective	Outstanding ☆
Caring	Outstanding ☆
Responsive	Good ●
Well-led	Good ●

Vision

Delivering the right patient care, in the right place, at the right time, through a skilled and committed workforce, in partnership with local health economies

Strategic Objectives

- Achieve Quality and Excellence
- Accurately assess patient need and direct resources appropriately
- Establish market position as an Emergency Healthcare Provider
- Work in Partnership

Strategic Priorities

- Business as Usual
- New Models of Care
- Business Opportunities
- Prevention

Values

- World Class Service
- Patient Centred
- Dignity and Respect for All
- Skilled Workforce
- Teamwork
- Effective Communication

Two Year Operational Plan - Key Messages

Activity

- Evidence of continued growth at around 4% per year, forecast between 2.6% and 3.1%
- Regular review of operational model to ensure continued focus on efficiency
- Early implementation site for the Ambulance Response Programme (ARP). WMAS taken lead role in developing the way in which calls are categorised with the aim of dispatching the right resource in a timely manner to improve clinical outcomes.
- Regular dialogue with commissioners throughout the region

Quality

- Overview of governance arrangements and the process for assessing implications of changes on quality
- Quality Account Priority areas for Patient Experience, Patient Safety and Clinical Effectiveness

Workforce

- Arrangements for creating and updating the Workforce Plan
- Ambitious recruitment and education programme to support optimum skill mix
- Links with Health Education England to address skill shortages

Draft Quality Account Priorities

Patient Experience

- Educate Trust clinicians and implement the *ReSPECT form in order to improve understanding and treatment of patients with specific careplans such as those people at the end of their life
- Work with partner agencies to provide improved care pathways for patients ie mental health, maternity and end of life (Joint partners patient satisfaction surveys)
- Increase Friends and Family Test feedback in order to identify patient satisfaction.

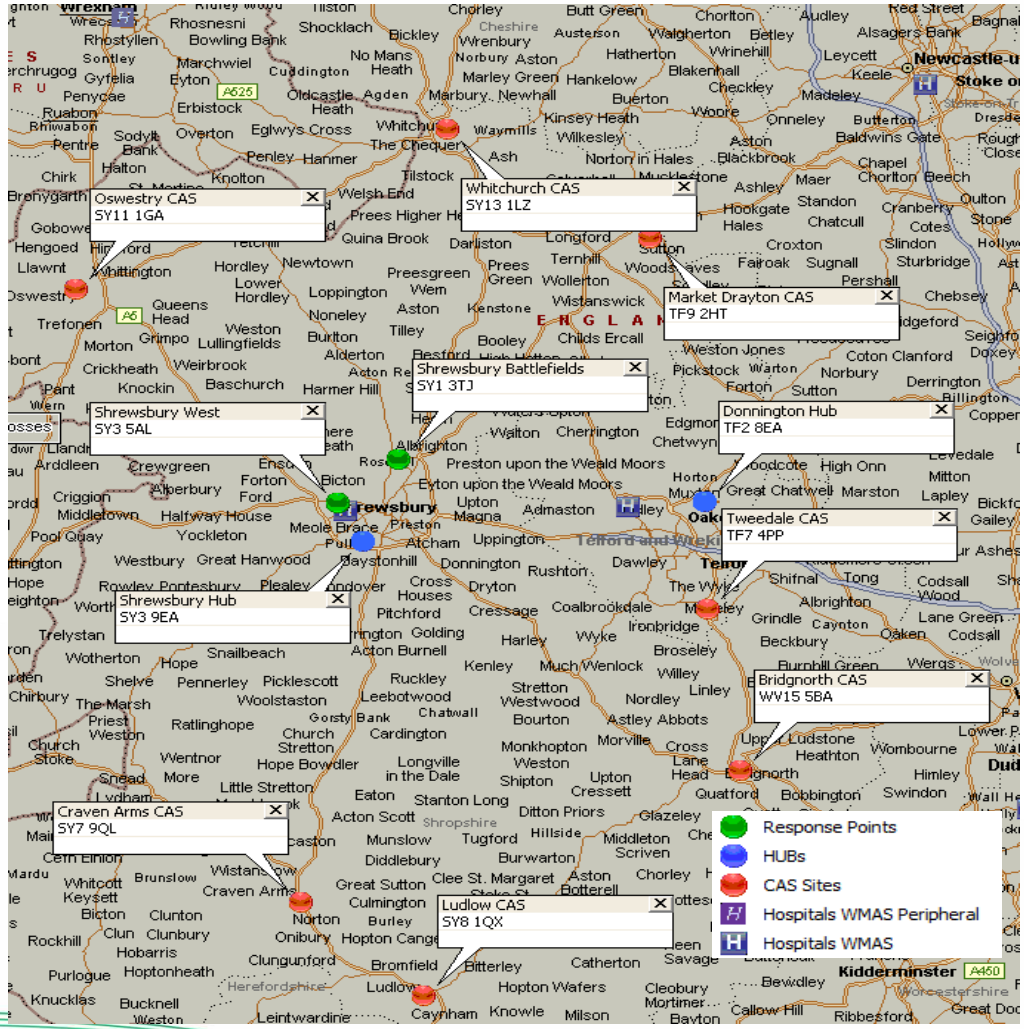
Patient Safety

- Improve timeliness of response based on clinical need
- Reduce the risk of harm that occurs to patients whilst in our care
- Deliver the objectives set within our Sign up to Safety pledge (specific to top 5 risks identified through learning)

Clinical Effectiveness

- Improve the level of care delivered as measured by national Ambulance Quality Indicators
- Use the learning from external regulator reports to improve further
- Work with Higher Education Institutions to provide a skilled workforce able to provide for the changing needs of the community.

Shropshire Response Posts



Hub
Response post
Community Ambulance Station

- 2 x Hubs
- 7 x Community Ambulance Stations
- 2 x Response posts

Community Response Scheme Locations

- Ludlow
- Tweedale
- Bridgnorth
- Oswestry
- Whitchurch
- Market Drayton
- Craven Arms

Response Post Locations

- Shrewsbury Battlefields
- Shrewsbury West

Activity, Demand and Performance

Hospital Handover Performance

April 2016 to January 2017

- Performance

		Average	Longest
Princess Royal	At hospital to handover	22 minutes	2 hours 57 minutes
	At hospital to crew clear	34 minutes	3 hours 1 minute
Royal Shrewsbury	At hospital to handover	33 minutes	3 hours 37 minutes
	At hospital to crew clear	42 minutes	4 hours 31 minutes

- Over hour delays are considered unacceptable
- WMAS meets regularly with hospital colleagues

Hospital Handover Delays

West Midlands Ambulance Service NHS
NHS Foundation Trust

Handover Activity At WMAS Main Hospitals

Handover Breaches

From 01/01/2017 to 31/01/2017

Collated on 01/02/2017 at 10:41:36 - Report ref 101

		Handover Time Duration						
**Conveyed To	Total	*0-15 mins	*15-30 mins	*30-45 mins	*45-60 mins	*45-60 mins %	*Over 1 hr	*Over 1 hr %
Birmingham Childrens	732	578	108	35	6	0.8%	5	0.7%
Russells Hall	3,625	1,843	1,166	373	135	3.7%	108	3.0%
Good Hope	2,746	1,047	1,294	258	87	3.2%	60	2.2%
Heartlands	4,063	1,846	1,836	298	58	1.4%	25	0.6%
Solihull	822	577	223	16	3	0.4%	3	0.4%
New Cross	4,142	2,213	1,468	275	125	3.0%	61	1.5%
City (Birmingham)	2,347	1,535	668	119	20	0.9%	5	0.2%
Sandwell	2,260	1,368	744	112	26	1.2%	10	0.4%
New Queen Elizabeth Hosp	3,932	1,802	1,706	323	82	2.1%	19	0.5%
Walsall Manor	3,045	1,483	1,063	307	101	3.3%	91	3.0%
Hereford County	1,651	708	660	198	51	3.1%	34	2.1%
Princess Royal	1,771	585	642	300	124	7.0%	120	6.8%
Royal Shrewsbury	1,408	310	473	295	142	10.1%	188	13.4%
Alexandra	1,427	683	539	127	52	3.6%	26	1.8%
Worcestershire Royal	2,868	944	1,191	440	164	5.7%	129	4.5%
George Elliot	1,288	502	597	140	30	2.3%	19	1.5%
St Cross	0							
Uni Hospital Cov & War	4,513	1,905	1,677	707	199	4.4%	25	0.6%
Warwick	1,568	1,151	375	38	3	0.2%	1	0.1%
Burton	1,445	1,061	319	49	8	0.6%	8	0.6%
County Hospital (Stafford)	989	939	38	9	2	0.2%	1	0.1%
Royal Stoke Univ Hosp	5,364	3,346	1,481	424	90	1.7%	23	0.4%

WMASFT Annual Activity Growth

Shropshire CCG						
Financial Year	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17 (to Jan 17)
Assigned Incidents	33,172	36,027	37,512	40,151	41,876	36,047
Annual Growth		8.6%	4.1%	7.0%	4.3%	3.5%

Ambulance Clinical and Quality Indicators

- Return of Spontaneous Circulation (ROSC)

	YTD
West Mercia	30.34%
WMAS	31.66%
National Mean	29.51%

- ST Elevation Myocardial Infarction (STEMI)

	YTD
West Mercia	79.35%
WMAS	80.03%
National Mean	79.47%

- Survival to discharge

	YTD
West Mercia	10.49%
WMAS	9.36%
National Mean	8.54%

Ambulance Clinical and Quality Indicators

- Stroke Care Bundle

	YTD
West Mercia	97.96%
WMAS	97.92%
National Mean	97.75%

Physician Response Unit

Background

- The Scheme launched 11/07/2016
- All 6 PRU doctors completed their induction and began working with WMAS
- Week commencing 05/09/2016 PRU were given access to the CAD which enabled them to self select work
- Following reported concerns with the operation of the scheme, the decision was taken to suspend the operating model to allow further discussions to take place

Current Position

- WMAS has offered to run a similar model to that in Worcester in which:
  - Doctors will respond to WMAS calls in their own cars
  - Blue lights will not be used
  - The response model will predominantly be a secondary response
- WMAS is currently awaiting a response to allow this model to be implemented

Collaboration with the Fire & Rescue Service

Current Position

- A meeting took place between WMAS and the Fire and Service in December
- A proposal has been presented to the Fire Service
- Two further meetings are planned in March 2017

The Ambulance Response Programme (ARP)

Ambulance Response Programme

The Ambulance Response Programme (ARP) aims to increase operational efficiency whilst maintaining a clear focus on the clinical need of patients, particularly those with life threatening illness and injury.

NHS England have confirmed that we are not permitted to report any performance at this stage. The evaluation report will be with NHS England for review at the end of February 2017

Phase 2.2 – Categories

Cat 1

- Cat 1 R (Response)
- Cat 1 T (Transport)

Cat 2

- Cat 2 R (Response)
- Cat 2 T(Transport)

Cat 3

- Cat 3 R (Response)
- Cat 3 T(Transport)

Cat 4

- Green T (Transport)
- Green H (Hear and Treat)

Referral

- Category 1:

Immediately life threatening: cardiac arrest and threatened cardiac arrest. Resuscitation often required.

- Category 2:

Emergencies requiring assessment and treatment, +/- transport:

C2T: Assess, treat, transport

C2R: Assess and treat

- Category 3:

Urgent problems requiring treatment to relieve suffering and/or timely transport

C3T: Assess, treat, transport

C3R: Assess and treat

- Category 4:

Non-urgent

C4R: Assess and treat +/- transport

C4H: Non-ambulance response ("hear and treat")

Phase 2.2 – Categories

Cat 1

- Approx 7% of activity
- 75% in 8 minutes target still remains
- 19 minute transport target still remains, though now only includes patients that were transported.
- Includes Cardiac Arrests – as per old Red 1
- Also includes:
  - Fitting Now
  - Under 5s only – specific disposition codes.

Phase 2.2 – Categories

Cat 2

- 45% of activity
- Focus on getting the right response to the patient, not necessarily the fastest.
- Cat 2 R – Assess Treat Transport
- Cat 2 T – Assess Transport

Phase 2.2 – Categories

Cat 3

- 40% of activity

- Focus on getting the right response to the patient, not necessarily the fastest.

- Cat 3 R – Assess Treat Transport
- Cat 3 T – Assess Transport

Phase 2 – Categories

Cat 4

- Around 10% of activity

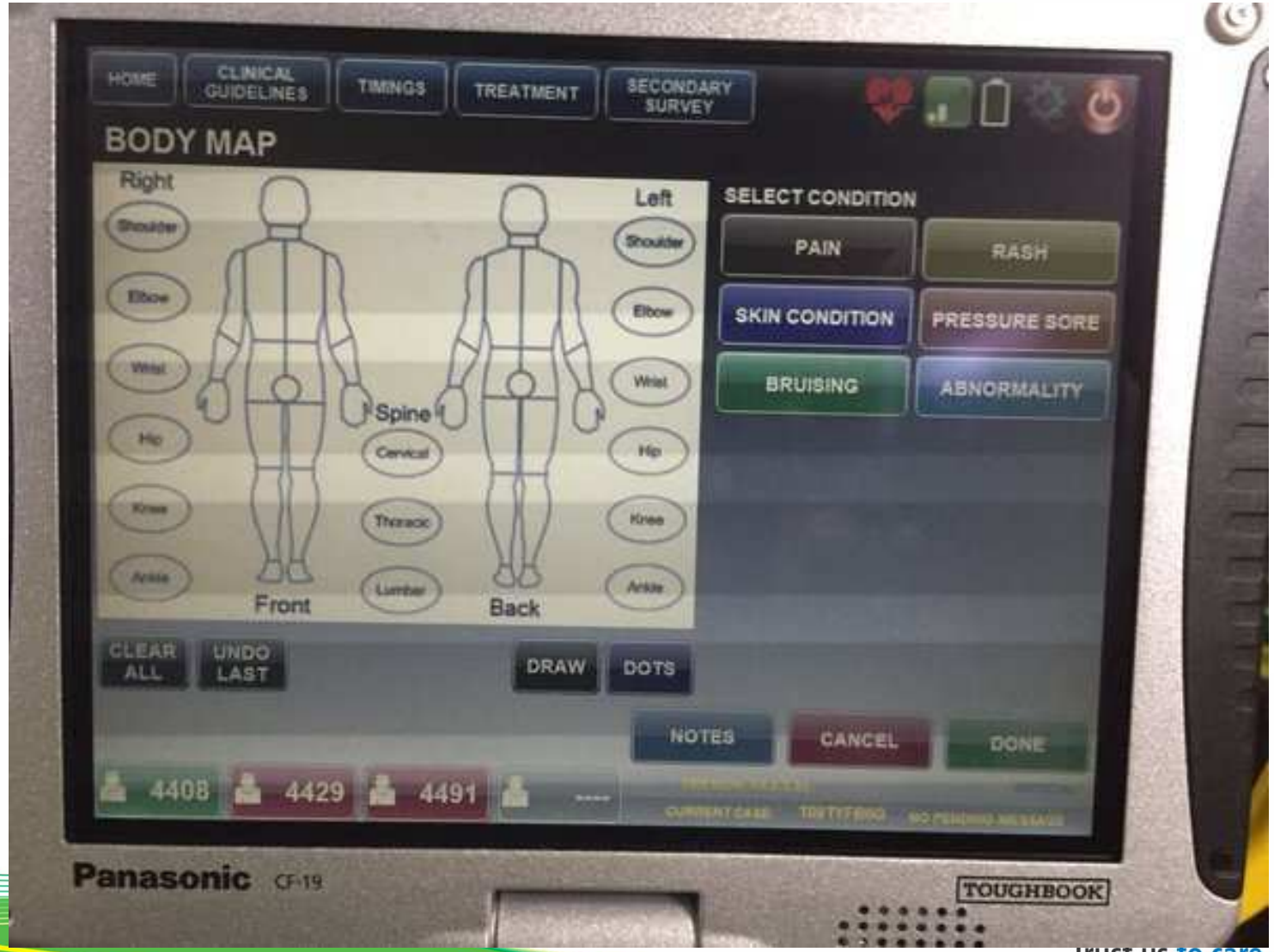
- Cat 4 T - Transport
- Cat 4 H – Hear and Treat

ARP – Measuring the Trial

- The ARP trial, throughout phases 1 and 2.2 is being closely monitored by NHSE.
- Monthly data submissions are supplied from all Trusts.
- Phase 2.2 trial sites are providing daily, weekly and monthly data returns.
- Staff Surveys undertaken
- University of Sheffield are academic partner, and are evaluating the trial
- Evaluation report due out to NHSE at end of Feb 17

Electronic Patient Record

ZOLL
01:06:33
1.0 cm/mV
Lead Fault
Searching
SHOCK
ANALYZE
ENERGY SELECT
CHARGE
2017

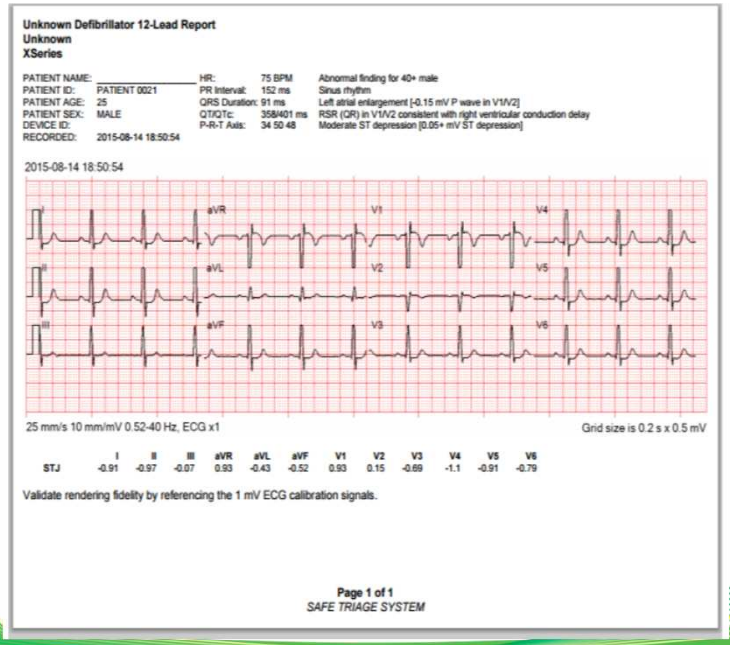

HOME
CLINICAL GUIDELINES
TIMINGS
TREATMENT
SECONDARY SURVEY
BODY MAP
Right
Left
Shoulder
Elbow
Wrist
Hip
Knee
Ankle
Spine
Cervical
Thoracic
Lumbar
Front
Back
SELECT CONDITION
PAIN
RASH
SKIN CONDITION
PRESSURE SORE
BRUISING
ABNORMALITY
CLEAR ALL
UNDO LAST
DRAW
DOTS
NOTES
CANCEL
DONE
4408
4429
4491
Panasonic
CF-19
TOUGHBOOK

Demographics are collected including NHS Number

The Zoll X Series Monitor is linked to the EPR

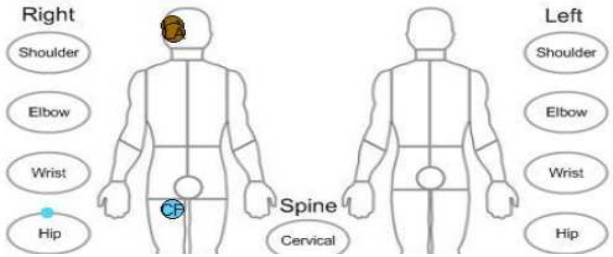
Imagery

Vitals	Latest Value	Captured at
ECGTRACE	not applicable	14 Aug 2015 18:50:54:000



ASSESSMENT: -2016 07:12:11

ASSESSMENT: -2016 07:21:54



Images can be captured on the device, and are automatically uploaded to the system

Once the Destination has been selected then images are available to view

Active Cases (36) Last Served: 12:23:18 **Cases Onsite: 31** **Cases Handed Over: 33**

Alert	Last Updated	Vehicle	Case Name	Gender	Age	Reported Condition	Impression	SafeGuarding	ATMIST	Images	ECG	Case Details	Download Summary	Close Case
	1 Minutes	[redacted]	KQBG	Male	88 years	Illness-?stroke symptoms	STROKE / TIA			✗	✗	GO		
	1 Minutes	[redacted]	KQBG	Female	82 years	Chest Pain Cardiac Upper Back Pb	OTHER: CHEST PAIN			✓	✗	GO		
	7 Minutes	[redacted]	KQBG	Female	85 years	Illness-hip and knee pain				✗	✓	GO		
	11 Minutes	[redacted]	JQBG	Female	12 years	Trauma	DISLOCATION KNEE			✓	✗	GO		
	12 Minutes	[redacted]	KQBG	Female	73 years	Illness-?pe sob	PLEURITIC CHEST PAIN,PULMONARY EMBOLISM			✓	✓	GO		
	23 Minutes	[redacted]	JQBG	Male	84 years	Illness-chest and upper back pain - pacemaker fitted 3/4 wk ago				✓	✓	GO		
	32 Minutes	[redacted]	JQBG	Female	28 years	Fitting	CONVULSION,EPILEPSY			✗	✓	GO		
	44 Minutes	[redacted]	JQBG	Female	87 years	Illness-? fit - now stopped	CONVULSION			✓	✓	GO		
	44 Minutes	[redacted]	JQBG	Female	89 years	Illness-abnormal ecg, bradicardic & dizzy				✓	✓	GO		
	49 Minutes	[redacted]	HQBG	Female	86 years	chest pain dizzy	OTHER: CHEST PAIN			✓	✓	GO		

Developing for the Future

- Development following feedback from Staff to further improve the experience
- Safeguarding Module
- Access to previous WMAS Patient Records
- Barcode entry for WMAS Drugs
- Decision making software
- Directory of Services

NHS
Shropshire
Clinical Commissioning Group

Report to:	Shropshire Council - Health and Adult Social Care Scrutiny Committee - Prioritisation Monday 20th February 2017
Title:	Prioritisation and Value for Money Methodology
Sponsor:	Dr Julie Davies, Director of Performance and Delivery *Shropshire Clinical Commissioning Group*
Author:	Dr Julie Davies, Director of Performance and Delivery *Shropshire Clinical Commissioning Group*
Purpose:	This paper outlines the process by which Shropshire CCG will prioritise healthcare service commissioning.
Recommendation or Action required of the Committee:	This paper is provided for information.

Contents

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Assessment	4
Scoring and recommendations	5
Decision making, project development and project outcome testing	6
Appendices	7

Who Should Read this Document?

- Members of the public in Shropshire
- The CCG's Governing Body
- Sustainability and Transformation Plan stakeholders
- The CCG's membership
- The Health and Wellbeing Board
- Commissioning staff
- Healthcare professionals
- Overview and Scrutiny Committee members

Introduction

Shropshire Clinical Commissioning Group (Shropshire CCG or 'the CGG') commissions healthcare services across the county of Shropshire, with the exception of those residents living in the Telford and Wrekin area. The CCG aims to ensure that services are provided in such a way as to meet the healthcare needs of the resident population fairly, that helps to reduce heath inequalities.

The national Five Year Forward View (NHS England., 2014) summarised the challenges faced by the entire NHS and established the guiding principles and objectives to be considered in order to support sustainable healthcare delivery. Other frameworks, against which this method is aligned includes the NHS constitution, parts of the Human Rights Act and the Equality Acts of 2010; the CCGs values and strategic objectives, particularly the strive for safe, high quality services and better outcomes and achieving value for money e.g. obtaining maximum population benefit from the goods and services commissioned within the available resources.

It is considered likely, in the context of the Sustainability and Transformation Plan, NHS Five Year Forward View that there will need to be step-changes in productivity resulting from major service reconfiguration of health and care services. Commissioners and providers will rapidly, have to make informed, rational choices about the future shape of healthcare interventions and introduce innovative new models of delivery and challenge one another to establish whether the services provided meet local needs and deliver value for money.

The CCG will demonstrate through this method the four key tests for service change, as set out in the Operating Framework for 2010-2011. Firstly, does the initiative have the support of GP Members? Has there been strengthened public and patient engagement? Is there a clear clinical evidence base? Is the scheme consistent with current and prospective patient choice?

Guiding Principles for prioritisation in the Shropshire CCG:

- **Striving to constantly improve quality and safety of care** – Delivering quality and equality for the people of Shropshire are primary guiding principles of the CCG
- **Attaining financial stability** – Seeking value for money to efficiently make improved use of resources and reducing waste and variation
- **Leading the local health economy** – Ensuring local transformation is well-led, transparent, inclusive systematic and robust

What is the Purpose of this Methodology?

This methodology sets out the process by which the Shropshire CCG will prioritise the commissioning of healthcare services, but also in some instances including areas for investment as well as services where funding may be withdrawn as a result of adoption of different care models. This document describes the criteria by which these decisions will be evaluated. As with other Commissioning Groups, a scoring and ranking mechanism will be applied to support objectivity and transparency with our stakeholders.

The key aim of the methodology is to assess the service priorities in Shropshire and identify which and how much of different interventions are commissioned within a finite commissioning budget. Services deemed not to be a clinical priority for the population as part of the assessment process may receive a withdrawal of funding, in order to provide more effective healthcare for the population.

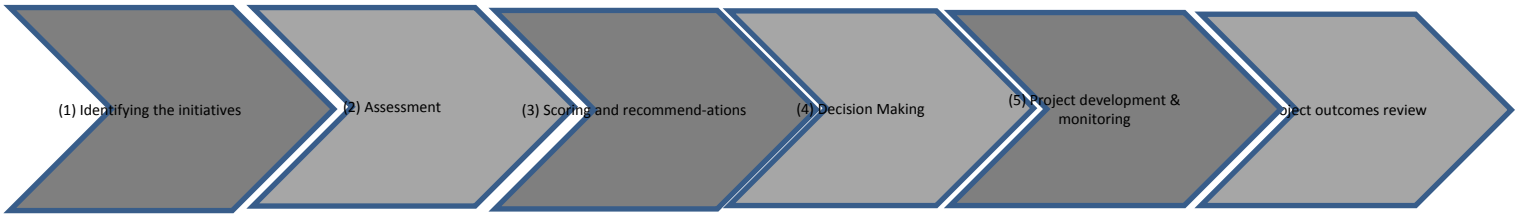
This approach will provide the public, patients, healthcare providers, members and the Governing Body and others with clarity and assurance about how the CCG will manage commissioning priorities and requirements over the years ahead.

What Approach is Taken to Prioritisation?

Priorities for commissioning healthcare services are set at the Shropshire CCG as part of an annual planning cycle, where decisions are made about schemes and investments for the year ahead and beyond. The process involves a systematic review of the CCGs vision and strategy and the development of individual plans to meet system objectives, so that the investment decisions reflect local priorities.

The outcome of the annual priority setting process is then captured in our operating plan moving forward. This operating plan is then used to measure our performance and progress throughout the year. The CCG may sometimes have to review decisions about priorities and investments made as part of the earlier planning process to ensure the organisation complies with all its statutory duties or changing requirements. In this instance, the principles of the prioritisation process within this document will also be upheld. No significant decisions for investment or redistribution of funds will be made without making use of this defined process. Adoption of this process and policy will not obviate the requirement of the CCG to publicly consult on significant service change.

Figure 1: The prioritisation process is formed of 6 stages



This policy focuses upon stages 1 through to 3 of the prioritisation process (See Appendix I).
The Shropshire CCG has, along with other commissioners in England adopted a systematic approach which results in a ranked list of key priorities.
These stages will now be explained:

Identifying the Initiatives

Potential schemes for transformation, investment or disinvestment will be identified from a wide range of sources, which may include:

- Local JSNA guidance
- Strategic Commissioning Plan
- National & Local targets / operational standards
- The Sustainability and Transformation Plan
- The Future Fit Programme
- Horizon scanning about technology
- National directives
- Clinical & strategic networks
- Provider performance reports
- Health & Well Being Strategies
- Quality, Safety & patient experience reports
- Locality Delivery & Programme Board Plans
- Patient & Public Involvement
- Recommendations from Public Health England,
- Recommendations from NICE
- Medicines Management guidance
- Developments previously considered and not supported
- Service benchmarking indicators such as 'Rightcare'

- Development proposals from providers
- Engagement activities including focus groups
- NHS Right Care programme
- Commissioning for Value packs
- Patient surveys
- Programme budgeting

- Complaints & compliments, the PALS office
- Other applicable evidence

When a potential initiative is identified, a commissioning manager will complete a Project Identification Sheet (Appendix II). The sheet captures key information for the CCG's Clinical Commissioning Committee who will make the recommendations to the CCG's Governing Body. CCG staff will complete the Project Identification Sheet with as much evidence as possible supporting the case for transformation, involving a range of stakeholders as required, including GPs, patients, such as the Shropshire Patient Participation Group, voluntary groups, the local authorities and public health specialists. Each form will require a supporting equality and quality impact assessment and risk assessment.

CCG Engagement Approach for Prioritisation

The following principles for decision making regarding prioritisation apply:

- The public will be engaged in the prioritisation process
- Member practices will also be involved as required
- The CCG Board has a role to oversee and approve proposals for prioritisation. They will refer any proposals that are high value, high risk or deemed contentious to the CCG Governing Body
- The CCG Governing Body, as the legally accountable body for NHS resources in Shropshire, will ultimately make the decision in public about the prioritisation process
- Engagement and consultation will be carried out following Shropshire CCG Engagement and Consultation Guidelines
- The CCG will retain an auditable documentation trail regarding all key decisions from the Clinical Commissioning Committee
- A review process will be put in place so that any affected stakeholders can request a review of the decision making process, in line with the approach to transparency and openness

Draft project identification sheets will be posted on the CCG's website to invite feedback from patients, service users, providers and stakeholders. Additional information and updates will be added to the Prioritisation Identification Sheet, in light of the comment received. The completed sheet and any supporting papers are then submitted to the CCGs Clinical Commissioning Committee for consideration.

Note: The risks associated with each scheme will not form part of the scoring process. They will instead be managed and reported in accordance with the CCG's risk management framework. The CCG Governing Body will ensure that any priorities posing a high risk to the organisation or patients should be highlighted in the CCG Risk Register. Each risk will have a named risk owner, will have mitigating actions and be reviewed on a monthly basis.

Assessment

The Project Identification Sheet presented in Appendix II will be the template used to capture key information as part of the priority assessment process. This task will be completed by the commissioning managers at the Shropshire CCG.

The Clinical Commissioning Committee will meet to consider each project identification sheet, discuss the content and make recommendations to the CCGs Governing Body.

The next stage is the scoring process. The approach involves a modified version of the Portsmouth Scorecard, which has been used successfully in Shropshire in previous years.

The scoring criteria are published in section 3 and within the appendices.

Scoring and Recommendations

Each scheme will be scored by the respective Commissioning and Clinical Leads against ten criteria, which are grouped together into factors which reflect the importance of the scheme and deliverability. When scored, the criteria are weighted with the overall score for the quality based criteria in each section accounting for 65% of the overall mark and the financial criteria, 35%.

Figure 2 below describes the criteria and how they are categorised:

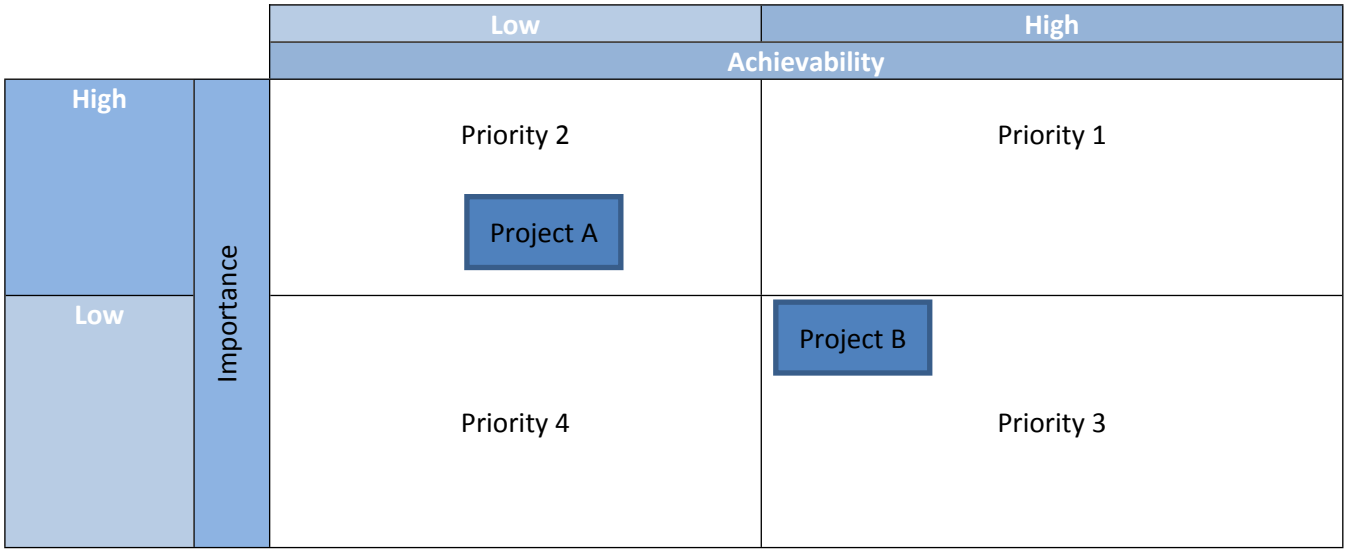
Figure 2: Scoring criteria and weighting Priority Selector Matrix for

	Importance	Achievability
65%	Patient Benefit	Stakeholders
	Clinical Benefit	Building and Equipment
	National Priority	Workforce
	Local Priority	Service Delivery
35%	Financial Benefit	Investment Required

Note: Appendix II shows the marking criteria for the scheme and Appendix III the weighted scoring matrix.

Once all the weighted scores have been agreed, the results are plotted on a prioritisation matrix by the Commissioning Leads. This process helps health professionals consider capacity to deliver and the schemes identified to be recommended to be taken forward. Figure 3 below provides a schematic example of the prioritisation selector matrix that helps with establishing the most suitable phasing of project work.

Figure 3: Priority Selector Matrix



After the above analysis and discussion, the priorities are approved and recommendations are made by the Clinical Commissioning Committee to take forward the projects.

Note: Prioritisation of healthcare is likely to be a sensitive issue and is liable to attract public interest and scrutiny, so consideration of national guidance will be required, for instance NHS England and NHS Improvement documents such

as the Competition and Pricing Frameworks. Good record keeping in relation to decisions and the rationale used to reach a decision is important and the policy requires that full documentation is maintained.

Decision Making, Project Development and Project Outcome Testing

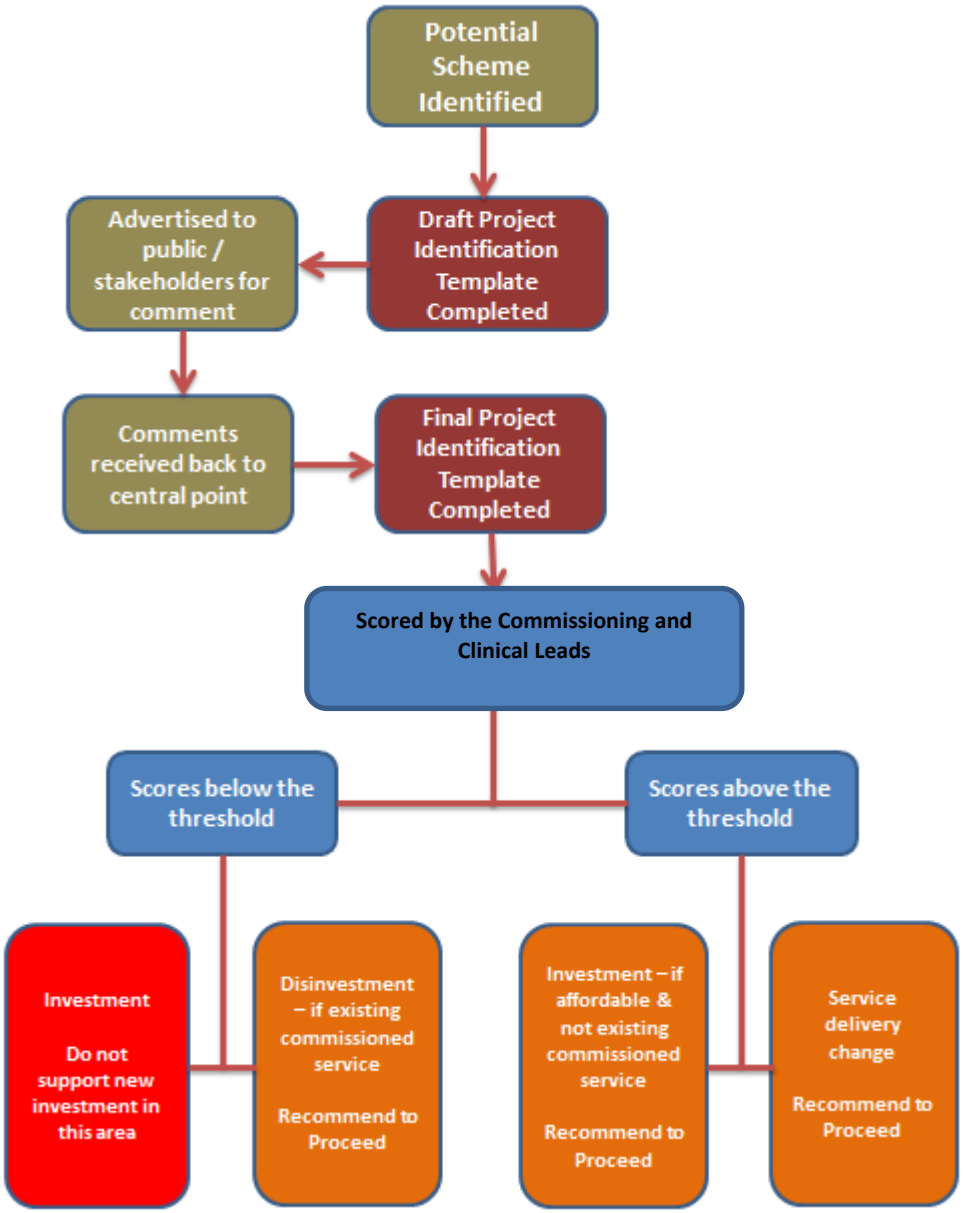
Following the recommendations of the schemes to be taken forward, a final decision (Stage 4) will be made by the CCG's Governing Body.

The results of the prioritisation process will be published on the CCG's website. If the proposal represents significant service change, there will be a consultation process with the public. The schemes will then be further developed (Stage 5) by CCG staff and system stakeholders for implementation. This will include consultation and stakeholder engagement in line with CCG policy and processes.

Following the delivery of all projects, outcomes and benefits will be carefully reviewed and assessed with feedback to the Clinical Commissioning Committee.

APPENDIX I: Process Flow for Stages 1 – 3 of the Prioritisation Process

The process is aligned with the CCG's business cycle and has three main components: strategic planning, procuring services and monitoring & evaluation. This is a sub-set of the decision making / governance framework.



APPENDIX II: Project Identification Sheet

NHS
Shropshire
Clinical Commissioning Group

PROJECT IDENTIFICATION SHEET

Unique Reference Number		Commissioning Manager / Lead Name	
Name of Project			
Clinical Lead		Sponsoring Executive	

Background to the Proposal
Please provide an overview of the proposal *Include details of background, scope, rationale* *What is the supporting data / comparative benchmark data?* *Is the CCG an outlier?*
Aims and Objectives
What are the deliverable outcomes & benefits from this proposal? *If it is a de-commissioning proposal, what are the potential impacts?*
Governance
Where is the accountability for this proposal? *e.g. Exec Team / Locality Group / STP / Clinical Commissioning Committee*
Assumptions & Constraints
Please provide details of any identified

Project Milestones		QIPP	
Please provide indicative dates for each of these gateways. If not applicable enter N/A		***Which QIPP Element does this proposal relate to ? (X)***	
Project Scoping		Quality	
Health Needs Assessment / Evidence Gathering		Innovation	
Patient Engagement & Stakeholder Assessment		Productivity	
Investment Appraisal		Prevention	
Service Specification		***Which QIPP Level? (X)***	
Procurement & Contracting		Individuals / Organisation	
Service Implementation & Planning /			
Mobilisation			
Service Review & Project Close		National	

Risks & Mitigations	Equality & Quality Impact Assessment
Please outline the key risks & attach a copy of the risk assessment form.	*Please highlight any impact on any of the protected groups and attach a copy of the completed Pre-pare toolkit*

Headline Financial Impact

	Recurrent	Non-Recurrent	***If non-recurrent over which financial years (where year 1 is 2017/2018)***				
			Year 1	Year 2	Year 3	Year 4	Year 5
Investment							
Saving							

Headline Activity Impact

Provider	POD / Block	Impact (+ / -)	Year of Impact

Outcome	
Importance Score	
Achievability Score	
Prioritisation Map Quadrant	
Outcome *(Proceed / Hold / Cancel)*	

IMPORTANCE CRITERIA
1. Patient Benefit
• *How would this improve convenience and ease of access for users of the service?* • *How many patients would benefit from this service?* • *To what extent would it contribute to reducing health inequalities?* • *To what extent would it contribute to adopting a preventative and early intervention approach that promotes people's independence and wellbeing?* • *To what extent would it contribute to patient choice*
2. Clinical Benefit
• *How does this enhance the implementation of clinical practices designed to improve quality of life (eg admission avoidance or case management)* • *How does it enable the achievement of evidence-based health outcomes (eg through implementation of NSFs, NICE)* • *Give examples of the clinical evidence that supports this submission*
3. National Priority
• *How does this address the key national priorities set out in the outcome frameworks, the reform agenda and the FYFV?*
4. Local Priority
• *How does the scheme address key local priorities and objectives? (eg Health & Wellbeing strategies, JSNA or other local health assessments)* • *To what extent is there pressure for change in the health economy from local people or organisations outside of the health economy (eg patient groups, politicians)* • *To what extent is there pressure for change in the health economy from internal factors (eg workforce, equipment, changes in regulations, alternative providers)*
5. Financial Benefit
• *Would the initiative result in financial savings?* • *What is the timeline for the release of these savings?* • *What is the risk to their release?*

ACHIEVABILITY CRITERIA
6. Stakeholders
• *To what extent are Stakeholders within the local health community supportive of this scheme?* • *What is the likely reaction of local patient groups and politicians to the scheme?*
7. Buildings & Equipment (including technology and connectivity)
• *To what extent would this scheme require change to buildings and equipment?* • *Are there any implications for void space* • *Have these impacts been considered as part of the financial investment / benefit criteria?* • *What are the information technology requirements, considering connectivity e.g. N3?*
8. Workforce
• *Would this initiative require the current workforce to be re-deployed?* • *What new or additional skills would be required for the scheme to start or long-term training once staff have been appointed?* • *To what extent will new ways of working / skill mix be utilised differently e.g. Nurse led follow up, multi-disciplinary team working etc.*
9. Service Delivery
• *To what extent does this require complex service change?* • *What are the interdependencies on other projects / services?* • *Does this include cross-organisational working?* • *Would this affect the viability of other services or impact on service delivery for other commissioners?* • *Is there a provider capable of delivering the service required through this project?* • *Has this scheme been implemented successfully elsewhere?*
10. Investment Required
• *Would the initiative require any additional financial investment?* • *Is this recurrent / non recurrent?* • *Would it be funded by savings elsewhere?* • *Is it possible to release those savings?*

PRIORITISATION PROCESS MARKING CRITERIA

IMPORTANCE CRITERIA				
11. Patient Benefit				
• To what extend would the initiative improve convenience and ease of access for users of the service				
0 No information provided	**1** Unable to determine from the information provided	**2** Slight improvement in access OR May cause small access issues	**3** Some improvement in access OR May cause some access issues	**4** Significant improvement in access to services OR Does not cause new access issues
• How many patients would benefit from improved convenience and ease of access?				
0 No information provided	**1** 0% - 25% Of impacted population	**2** 25% - 50% Of impacted population	**3** 50% - 75% Of impacted population	**4** 75% - 100% Of impacted population
• To what extend would the initiative contribute to reducing health inequalities				
0 No information provided	**1** No reduction OR May create a significant HI gap	**2** Some reduction OR May create a marginal HI gap	**3** Significant reduction OR May create a small HI gap	**4** HI gap completely closed OR Does not create a HI gap
12. Clinical Benefit				
• To what extent would the initiative enhance the implementation of clinical practices designed to improve the quality of life? (eg admission avoidance or case management)				
0 No information provided	**1** There would be no improvement in the quality of life of the impacted cohort OR There could be a significant reduction in the quality of life of the impacted cohort	**2** There would be minor improvement in the quality of life of the impacted cohort OR There could be some reduction in the quality of life of the impacted cohort	**3** There would be significant improvement in the quality of life of the impacted cohort OR There could be minor reduction in the quality of life of the impacted cohort	**4** There would be a huge improvement in the quality of life of the impacted cohort OR There would be no reduction in the quality of life of the impacted cohort
• To what extent would the initiative enable the achievement of evidence-based health outcomes?				
0 No information provided	**1** There is little or no clinical evidence to support this project	**2** There is some clinical evidence to support his project	**3** There is a lot of clinical evidence to support this project	**4** The basis of this project is well documented best practice
13. National Priority				
• To what extent does the initiative address key national priorities?				
0 No information provided	**1** This scheme is not one of the key national priority areas	**2** This scheme starts to address key national priorities	**3** This scheme goes some way to supporting key national priorities	**4** This scheme is proposed specifically to address key national priorities
14. Local Priority				
• Does the initiative address key local priorities and objectives?				
0 No information provided	**1** This scheme is not supportive of local priorities and objectives	**2** This scheme starts to address local priorities and objectives	**3** This scheme goes some way to supporting key local priorities and objectives	**4** This scheme is proposed specifically to address key local priorities

• Is there pressure for change from people / organisations outside of the local health community? (eg patient groups / politicians)				
0 No information provided	**1** There is or would be no external interest in this scheme	**2** There might be some external interest in this scheme	**3** It is highly likely that there would be some external interest in this scheme	**4** There is or would be significant external interest in this scheme
• Is there pressure for change in this area from within the health economy?				
0 No information provided	**1** There is or would be no local interest in this scheme	**2** There might be some local interest in this scheme	**3** It is highly likely that there would be some local interest in this scheme	**4** There is or would be significant local interest in this scheme
15. Financial Benefit				
• Would the initiative result in financial savings?				
0 No information provided	**1** 0% - 2% of total service costs saved	**2** 2% -5% of total service costs saved	**3** 5% - 7% of total service costs saved	**4** Greater than 7% of service costs saved
• How long would it b before these are released or there is a return on any investment that will be required?				
0 No information provided	**1** No return on investment	**2** Long term return ie greater than 7 years	**3** Medium term return ie between 3 and 7 years	**4** Short term return ie immediate to 3 years

ACHIEVABILITY CRITERIA				
16. Stakeholders				
• Are stakeholders within the local health community supportive of this project?				
0 No information provided	**1** There is no local support for this project	**2** There is little local support for this scheme	**3** It is a lot of local support for this scheme	**4** There is significant local support for this scheme
• What is the likely reaction of local patient groups and politicians?				
0 No information provided	**1** There is or would be no local interest in this scheme	**2** There might be some local interest in this scheme	**3** It is highly likely that there would be some local interest in this scheme	**4** There is or would be significant local interest in this scheme
17. Buildings & Equipment (including technology and connectivity)				
• Does this require change to buildings and equipment				
0 No information provided	**1** There would be significant change required OR This would leave a significant space or equipment unutilised	**2** There would be some changes required OR There would be some space or equipment left unutilised	**3** Minor cosmetic changes would be required OR A small amount of space or equipment would be left unutilised	**4** There is very little or no impact on buildings or equipment OR OR The resource would be made available to be utilised more efficiently and effectively
18. Workforce				
• Will current workforce have to be redeployed				
0 No information provided	**1** There would be significant redeployment required OR Displacement of many staff	**2** There would be some redeployment OR Displacement of some staff	**3** A few staff would need to be redeployed OR displaced	**4** There is very little or no impact on staffing OR Staff could be used more efficiently and effectively
• Is this project reliant on securing new or additional skills or reliant on long-term on-going training once staff are appointed?				
0 No information provided	**1** There is a skills shortage within this area & staff would be difficult to recruit OR Staff will need constant on-going training	**2** It may prove difficult to recruit staff with the required skills OR Staff will need some on-going / refresher training	**3** It would not be difficult to recruit new staff with the required skill set OR There is little on-going training requirement	**4** Staff are already recruited who have the required skill sets & this service would see them use those skills more effectively
19. Service Delivery				
• Does this represent a complex service change?				
0 No information provided	**1** YES	**2** Fairly complex	**3** Some minor redesign	**4** NO
• Would this affect the viability of other services?				
0 No information provided	**1** YES	**2** It could do	**3** Minor impact	**4** NO
• Is there a provider in the marketplace capable of providing this service?				
0 No information provided	**1** NO	**2** Limited Choice	**3** A few providers	**4** Many providers
• Has this initiative been undertaken successfully elsewhere?				
0 No information	**1** NO	**2** Limited Success	**3** Some success	**4** Great success

provided				Best Practice
20. Investment Required				
• Would this initiative require significant financial investment?				
0 No information provided	**1** Significant recurrent investment AND/OR Longer term non-recurrent investment to support transition	**2** Some recurrent investment AND/OR Non-recurrent transitional support required	**3** No recurrent requirement AND/OR Short term non-recurrent investment	**4** No additional financial impact Saves money

APPENDIX III: Weighted Scoring Matrix

Scoring and Weighting Summary						Actual scores (example)	
Quality Indicators	**65%**						
Importance	Question weighting	Maximum score	Question weighted score	Overall weighted score	% contribution	Score awarded	Final weighted score
Patient benefit	20%	4	0.8	0.52	13.0%	4	0.52
Clinical benefit	20%	4	0.8	0.52	13.0%	3	0.39
National priority	15%	4	0.6	0.39	9.8%	4	0.39
Local priority	10%	4	0.4	0.26	6.5%	2	0.13
Total importance		**16**	**2.6**	**1.69**	**42%**	**13**	**1.43**
Achievability							
Stakeholders	10%	4	0.4	0.26	6.5%	2	0.13
Buildings and equipment	5%	4	0.2	0.13	3.3%	1	0.03
Workforce	10%	4	0.4	0.26	6.5%	3	0.20
Service delivery	10%	4	0.4	0.26	6.5%	1	0.07
Total achievability	100%	16	1.4	0.91	23%	**7**	**0.42**
TOTAL QUALITY		**32**	**4**	**2.6**	**65%**	**20**	**1.85**
Financial indicators	**35%**						
Importance							
Financial benefit	60%	4	2.4	0.84	21.0%	2	0.42
Achievability							
Investment required	40%	4	1.6	0.56	14.0%	1	0.14
TOTAL FINANCIAL	**100%**	**8**	**4**	**1.4**	**35.0%**	**3**	**0.56**
GRAND TOTAL		**40**		**4**	**100%**	**23**	**2.41**

Final Score		
Importance	Quality	**1.43**
	Financial	0.42
Total Importance Score		**1.85**
Achievability	Quality	0.42
	Financial	0.14
Total Achievability Score		**0.56**

APPENDIX IV: Responsibilities

Key roles and responsibilities in relation to this methodology:

Role	Responsibility
The CCG Chair and Accountable Officer	Overall responsibility for ensuring compliance with the methodology and that healthcare is commissioned in a consistent manner, promoting equity and fairness
The CCG Governing Body	Receive reports on the impact of the approach at agreed intervals; take into account the prioritisation in all investment decisions
Other healthcare commissioners	Comply with the document and its relevant procedures and highlight any need for future amendments. Ensure approved priorities for investment or disinvestment are implemented and remain on track to deliver both to agreed timescales
Healthcare providers	Refer to this document when requesting commissioners to invest in healthcare services in order to understand CCG rationale and processes followed
Healthcare professionals	Have access to the document so that they may understand the impact on their healthcare when expecting or requiring specific aspects of care
The general public, patients, carers	Support service users and patients to understanding the method
Clinical Commissioning Committee	Oversee the implementation and ongoing development of the policy and undertake the prioritisation process

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HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE
PROPOSED WORK PROGRAMME AS AT 30 Jan 17

DATE	ITEM	REASON FOR UNDERTAKING
20 February 2017 Deadline for reports Noon Thurs 9 Feb 2017	**Update from CCG** **West Midlands Ambulance Service**	To receive the new Investment Prioritisation Strategy from the CCG. Consider report made to CCG Board and accompanying presentation from Julie Davies To consider • The WMAS proposed withdrawal from the 'Physician Referral Unit' • Progress on working with the Fire and Rescue Service • Performance in Shropshire by postcode
27 March 2017 Deadline for reports: Noon Thurs 16 March 17	**Shared Lives and Community Living** **Mental Health Services** **Young Carers** *(Members of Young Person's Scrutiny Committee to be invited to attend)*	Committee to assess progress following the commissioning out of Shared Lives and Community Living To receive and consider the recommendations of the Regional Commission on Mental Health Report, particularly in relation to delayed discharges from hospital To ascertain what support is currently available for young carers and the plans for future support

Future Information Requests / Potential Items for the Work Programme:

- **The Health and Wellbeing Board has asked the Committee to look into measuring the outcomes of the 'Year of Physical Activity' launched in April 2015 – to be added to the Work Programme in 2017**
- **Annual Report of the Director of Public Health**
- **Availability of physiotherapy and occupational health services**

HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE
PROPOSED WORK PROGRAMME AS AT 30 Jan 17

- **Extent of and role of Frail and Elderly co-ordinators in GP surgeries – links with work of Neighbourhoods Group of STP. Joint HOSC?**
- **Return visits to Oak Farm, Innage Lane, and The Meres Day Care approx. Oct 2017 to consider any impacts following change of provider**
- **Sexual Health Services / Alcohol and Substance abuse – possible Joint Scrutiny with C&YP**