Shropshire and Telford & Wrekin Clinical Commissioning Groups

Draft Strategic Plan

2014/15 – 2018/19

Version control

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

Contents

Foreword

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

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

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

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

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

CM/DE

Shropshire/Telford & Wrekin – People and Place

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Case for Change

An Opportunity for Improvement

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

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

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

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

A challenge to be addressed

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

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

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

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

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

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

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

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

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

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

Patient Engagement in the Development of Our Strategy

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

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

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

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

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

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

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

Our (Emerging) Vision for Service Transformation

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

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

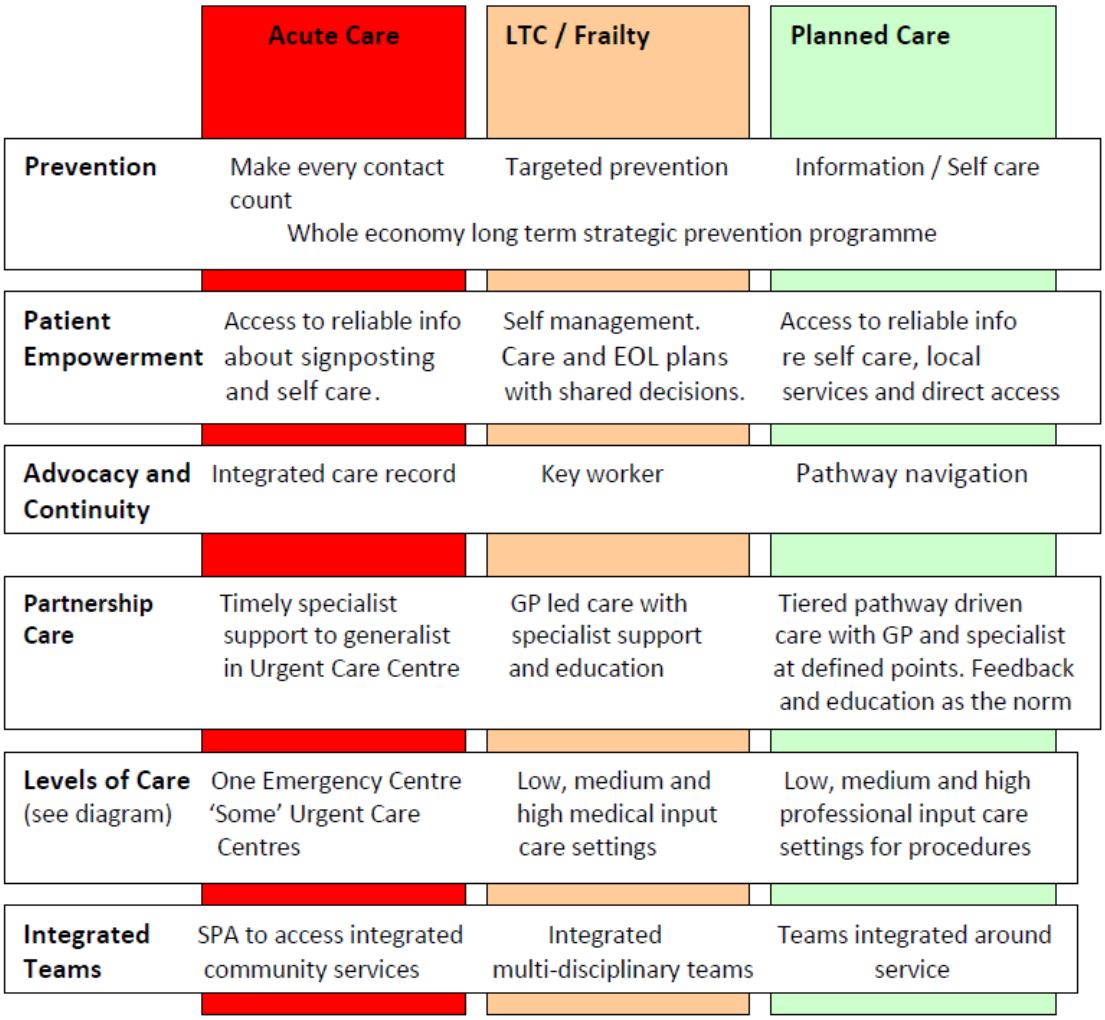
31. The Clinical Reference Group met again on January 29th 2014, during which it confirmed the output from the first meeting, suggested what success would look like and how to measure it and discussed the clinical and design principles applicable to the three main areas of health care delivery:

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Improving Outcomes

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

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

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

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

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

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

Increasing the proportion of older people living independently at home following discharge from hospital

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

In Telford ……***to be completed***.

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

To be completed

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

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

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

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

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

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

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

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

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

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

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

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

Patient Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Quality

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

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

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

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

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

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

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

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

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

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

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

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

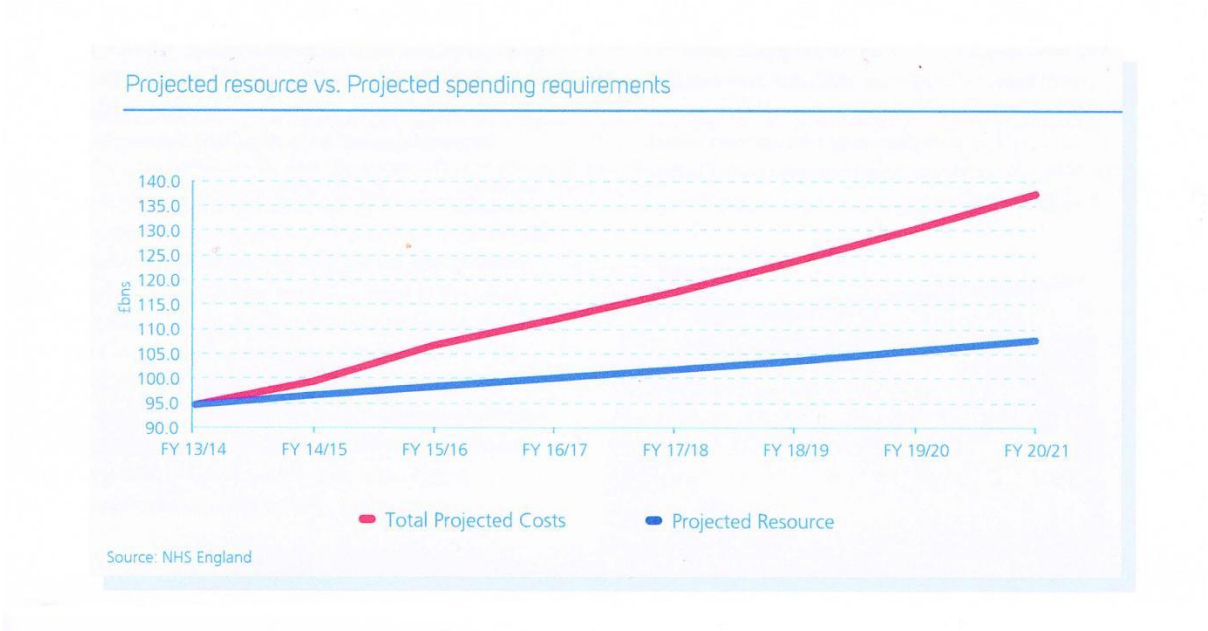
93. Continuous monitoring of staff experiences and the establishment of clear areas for quality improvement in workforce metrics within commissioned services will continue to support the need to ensure the integration of future workforce requirements.

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

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

Sustainability

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



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

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

Telford & Wrekin CCG

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

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

Shropshire CCG

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

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

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

Delivering Service Transformation

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

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

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

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

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

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

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

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

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

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

A Shared Commitment

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

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

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

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

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

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

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

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

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

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

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

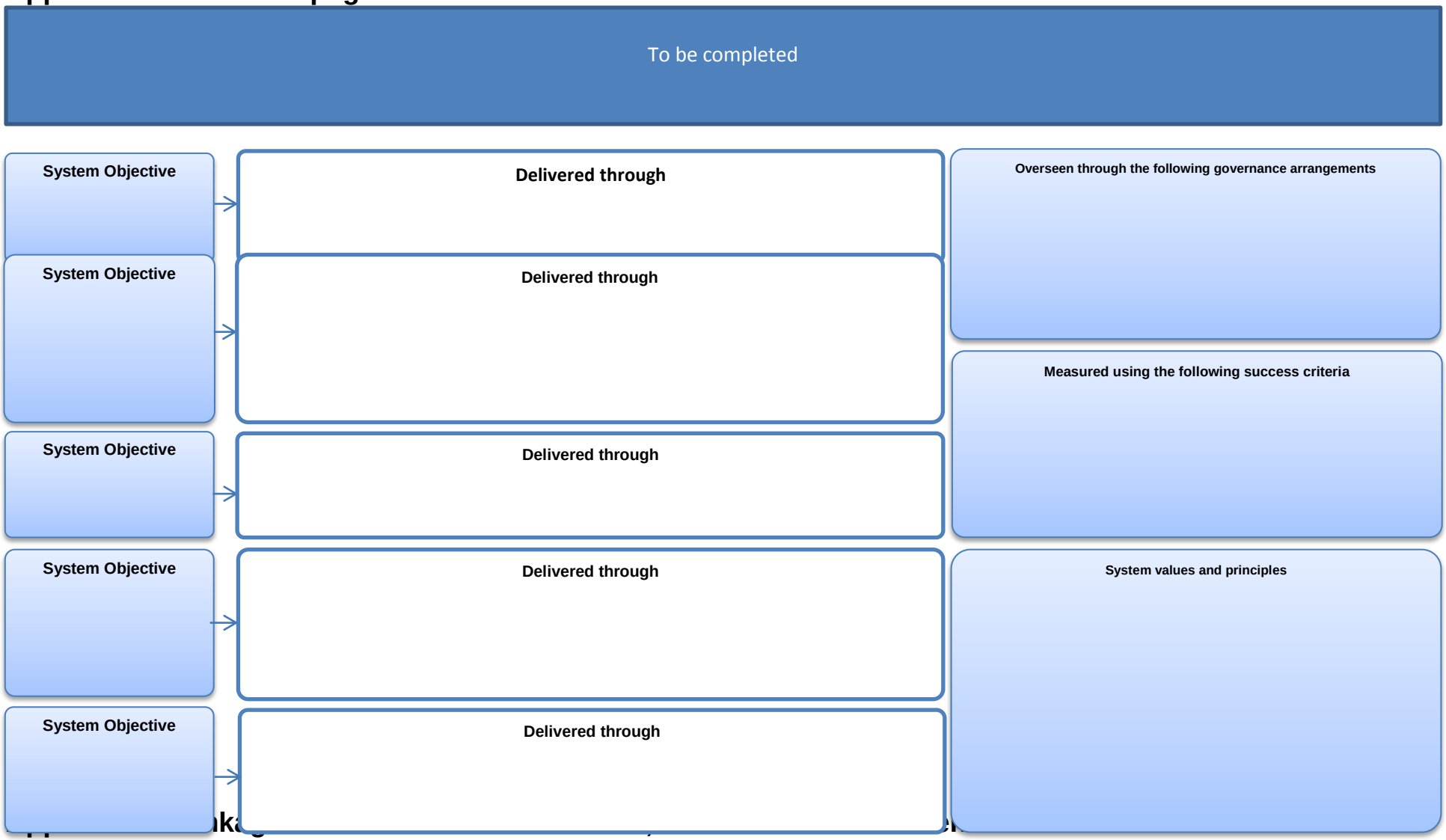
- We will share organisational plans and be transparent about budgets, costs, activity and utilisation data where that is required to enable the best joint decision making and the agreement of three-year financial strategies for each part of the health and social care system and for the system overall.

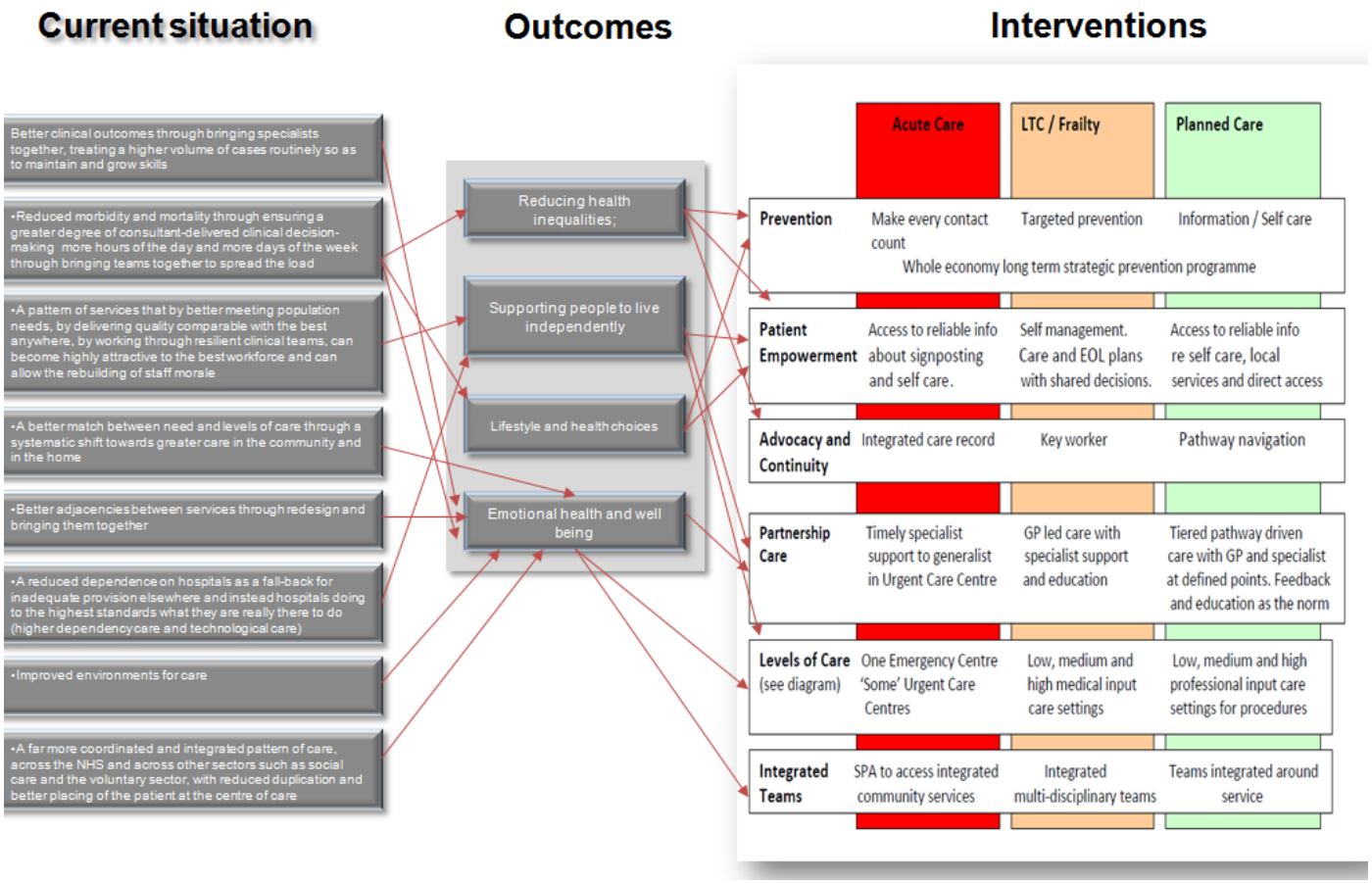
- We will respect the need for individual organisations to pursue their own objectives alongside these whole system objectives. We recognise that aspects of the system will be subject to competition, whether through national policy or local decisions made by commissioners, and that this may in some circumstances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

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

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

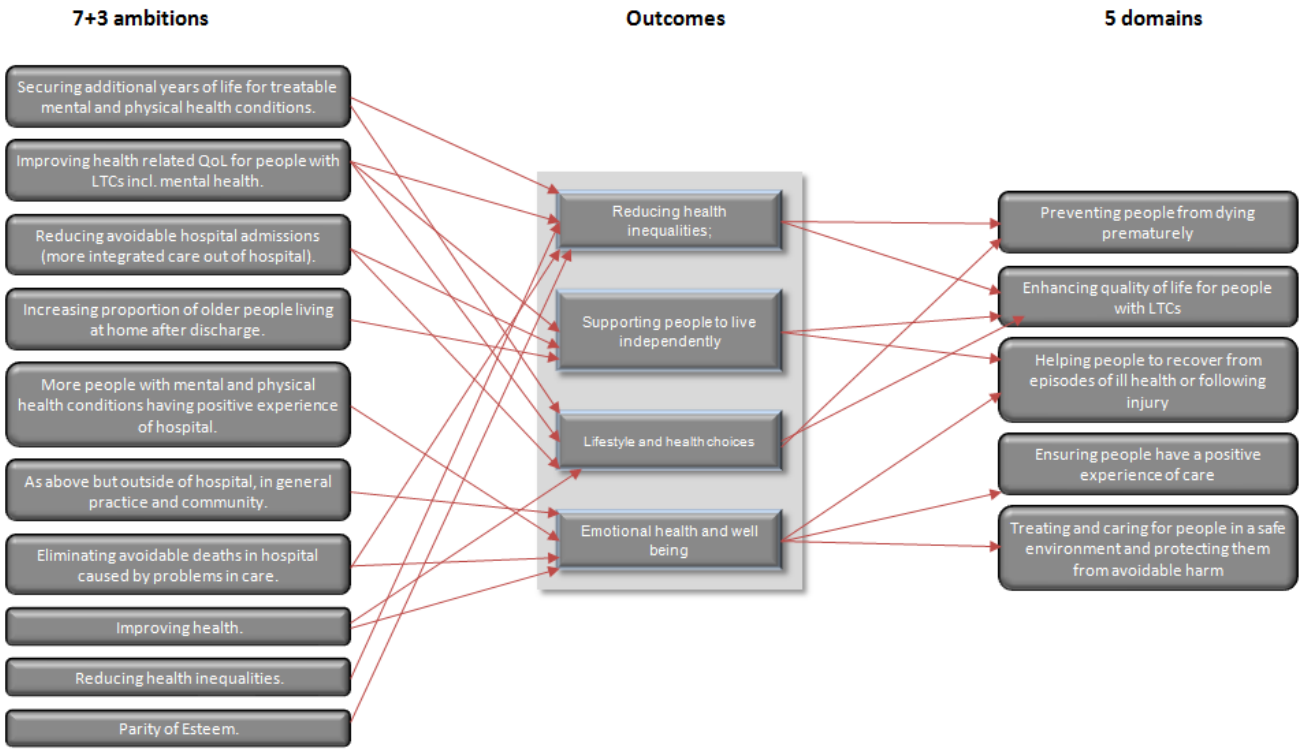
Appendix A: Plan on a page





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

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



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

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

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