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

Date: 15 March 2017

Committee:
HEALTH AND WELLBEING BOARD

Date: **Thursday, 23 March 2017**
Time: **9.30 am**
Venue: **Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND**

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

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

Members of Health and Wellbeing Board

VOTING

Shropshire Council Members
Karen Calder - Health Portfolio & Chair
Lee Chapman - Adults Portfolio
David Minnery - Children & Young People Portfolio
Prof Rod Thomson - Director of Public Health
Andy Begley - Director of Adult Services
Karen Bradshaw - Director of Children Services

Shropshire CCG
Dr Simon Freeman – Accountable Officer
Dr Julian Povey – Clinical Chair
Dr Julie Davies – Director of Performance & Delivery

Jane Randall-Smith – Shropshire Healthwatch
Rachel Wintle – VCSA

NON-VOTING (Co-opted)
Neil Carr - Chief Executive, South Staffordshire & Shropshire Foundation Trust

Simon Wright - Chief Executive, Shrewsbury & Telford Hospital Trust

Jan Ditheridge - Chief Executive Shropshire Community Health Trust

Dr Tony Marriott - Chair GP Federation

David Coull – Chairman, Shropshire Partners in Care (Chief Executive Coverage Care Services)

Mandy Thorn - Business Board Chair (Managing Director Marches Care)

Bev Tabernacle – Director of Nursing, Robert Jones & Agnes Hunt Hospital.

Your Committee Officer is: **Karen Nixon** Committee Officer
Tel: 01743 257720 Email: karen.nixon@shropshire.gov.uk

AGENDA

1 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

2 DISCLOSANBLE PECUNIARY INTERESTS

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

3 MINUTES (Pages 1 - 6)

To confirm the Minutes of the Health and Wellbeing Board meeting held on 9 February 2017, which are attached.

Contact Karen Nixon Tel 01743 257720.

4 PUBLIC QUESTION TIME

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

5 SYSTEM UPDATE - STP (including Neighbourhoods) (Pages 7 - 12)

a) Optimity Report – a report will be made. Contact: Prof Rod Thomson, Director of Public Health.

b) CCG Structure – a verbal update will be made. Contact Julie Davies, Shropshire CCG.

c) SaTH Scrutiny Report – a report is attached. Contact Julie Davies, Shropshire CCG.

d) A&E Delivery Group Update – Julie Davies, Shropshire CCG.

6 HWB DELIVERY REPORT (Pages 13 - 46)

a) BCF Performance and Outline Plan – Report attached. Contact: Sam Tilley, Head of Planning and Partnerships, Shropshire CCG, Tel 01743 277500.

b) Healthy Lives Programme and Social Prescribing – Report attached. Contact: Jo Robins, Public Health Consultant, Tel 01743 253935.

c) Alcohol Strategy – Clear Self-assessment tool – report attached. Contact: Gavin Hogarth, Public Health, Tel 01743 253935.

d) Leadership Programme – a verbal report will be made. Contact: Andy Begley, Director of Adult Services, Tel 01743 258911.

7 EVERYBODY ACTIVE EVERY DAY UPDATE

A presentation will be made.

Contact: Miranda Ashwell – Programme Lead, Physical Activity Tel 01743 453537.

8 COMMISSIONING HEALTHWATCH AND INDEPENDENT NHS COMPLAINTS ADVOCACY SERVICE FOR SHROPSHIRE (Pages 47 - 52)

A report is attached.

Contact: Prof Rod Thomson, Director of Public Health, Tel 01743 252003 or Neil Evans, Commissioning Development Manager Tel 01743 253019.

9 SOCIAL VALUE CHARTER FOR SHROPSHIRE (Pages 53 - 58)

A report is attached.

Contact: Neil Evans, Commissioning Development Manager Tel 01743 253019.

10 HWB COMMUNICATIONS AND ENGAGEMENT

A report WILL FOLLOW.

Contact: Val Cross, Health and Wellbeing Officer, Tel 01743 253994.

11 FOR INFORMATION (Pages 59 - 94)

Ambulance Service Update
The Ambulance Service attended the Health and Adults Scrutiny Committee on 20th February 2017. Presentation attached for information.

Shropshire Council

Committee and Date

Health and Wellbeing Board

23 March 2017

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 9 FEBRUARY 2017
9.30 - 11.40 AM

Responsible Officer: Karen Nixon
Email: karen.nixon@shropshire.gov.uk Tel: 01743 257720

Present
Councillor Karen Calder (Chairman)
Simon Freeman, Lee Chapman, Professor Rod Thomson, Andy Begley, Karen Bradshaw, *Steve Gregory, Dr Julian Povey (Co-Chair), Jane Randall-Smith, *Cathy Riley and Rachel Wintle.

Also present: Penny Bason, John Bickerton, David Coull, Gerald Dakin, Peter Downer, Kate Garner, Jane McKenzie, Cathy Riley, David Sandbach, Madge Shineton, Mandy Thorn and Sam Tilley.

43 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Apologies for absence were received from ;

David Minnery – Portfolio Holder for Children and Young People
Dr Julie Davies – Director of Performance and Delivery
Jan Ditheridge – Chief Executive, Shropshire Community Health Trust
Neil Carr – Chief Executive, South Staffs & Shropshire Foundation Trust
Simon Wright - Chief Executive, Shrewsbury & Telford Hospital Trust
Dr Tony Marriott – Chair GP Federation
Bev Tabernacle – Robert Jones & Agnes Hunt Hospital
Clive Wright – Chief Executive, Shropshire Council

Substitutions were made as follows;

*Cathy Riley for Neil Carr, South Staffs & Shropshire Foundation Trust
*Steve Gregory for Jan Ditheridge, Shropshire Community Health Trust

44 DISCLOSABLE PECUNIARY INTERESTS

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

45 MINUTES

RESOLVED:

That the Minutes of the meeting held on 8 December 2016 be approved as a correct record and signed by the Chairman.

Arising thereon;

Keeping Adults Safe in Shropshire - Minute 38. c) and d).

It was agreed that the Joint Case Audit feedback and performance data be chased up and that the information on domestic violence also be followed up through the Business Manager's Board.

System Update – Minute 39 b) STP Neighbourhoods Update

It was agreed that 'Leadership' be looked at in more detail by the Delivery Group.

46 PUBLIC QUESTION TIME

Three public questions were received from David Sandbach (copy attached to the signed minutes).

Question 1 and 2 were taken together;
Dr Freeman confirmed that to date, Shropshire CCG had not considered using Better Care Funds to provide citizens with an online tool such as 'Rally Round', but perhaps they should consider this in the future.

A discussion then ensued in respect of the full sharing of patient information by GP practices in Shropshire and the level of service afforded in places elsewhere (such as Thornley which was given as an example). It was agreed that this was a complex issue and that transparency and consistency was key in moving forward with this.

Question 3 was partly answered by Dr Freeman on behalf of the SaTH trust representative who was unable to attend the meeting. It was true that serious problems faced both the Royal Shrewsbury Hospital and the Princess Royal Hospital. There were communication issues which it was hoped would be improved, especially in the light of the imminent appointment of an Urgent Care Director to get things flowing better. It was unacceptable and improvements needed to be made.

47 SYSTEM UPDATE

a) STP & Future Fit

Dr Simon Freeman Accountable Officer updated the Board on the latest developments.
The preferred FF option was Shrewsbury, but due to an objection lodged by Telford & Wrekin authority the STP Project Board would be meeting shortly to agree the Terms of Reference for an Independent Review to take place on this in March 2017.

Who would be footing the bill for the cost of this extra review was unknown at this stage, but it was anticipated that there may need to be a change in the constitution in the future, though this was still to be worked through.

A discussion ensued about the public perception and confusion that existed around the STP and Future Fit and ensuring proper engagement. The Chair offered the assistance of the Communications and Engagement Group if required. Dr Freeman said he would need to discuss this with Simon Wright in the first instance, whilst it was generally agreed that improvements were required.

ACTION: S Freeman

Concerns about transparency were raised and it was confirmed that everything would be made public in future, which was welcomed.

Arising on the STP and FF update – Karen Calder requested that 'Communications and Engagement Delivery Group' be put onto the next H&WB agenda.

ACTION: P Bason

Rachel Wintle highlighted that in October 2016, it had been agreed that the Voluntary Sector be invited onto the STP Board. To date no more had happened and Rachel Wintle asked if this could be picked up. Dr Freeman undertook to take this forward.

ACTION: S Freeman

b) STP Neighbourhoods

Neighbourhood work is key. It was noted that this work will be rolled out via the Local Joint Committee's (LJC's) in future.

c) A&E Delivery Group

It was agreed that 'STP' should be a standing item on ALL future H&WB agenda's.

ACTION: P Bason

d) Ambulance Update

Unfortunately no-one attended the meeting from the Ambulance Service. It was agreed that this item should go to the next H&WB meeting in March.

ACTION: P Bason

48 DELIVERY GROUP REPORT - BETTER CARE FUND UPDATE

Sam Tilley, Head of Planning and Partnerships, Shropshire CCG, updated the Board on performance to date in 2016/17 via the local performance report and provided current information on the likely requirements for the BCF in future years (copy attached to the signed minutes).

The Chair welcomed the strong performance to reduce non-elective (NEL) admissions had continued and that this was rated green for this period.

In respect of Multi-Disciplinary Team Hub meetings taking place and driving actions for discharge patients, the Chair asked why patients who had not had relevant actions completed were escalated at 3.00pm to Executives to support with unblocking barriers?
Sam Tilley undertook to look at this and also the rationale behind twice weekly community conference calls, held with all community leads, ICS and independent providers to unblock barriers to discharge and support to progress plans for DTOC patients.

ACTION: S Tilley

It was noted that guidance was still awaited for BCF Funding 2017/18 to 2018/19. Significant delays, meant challenging times for the team involved. It was hoped this would soon be published.

RESOLVED

a) That the content of the Better Care Fund Performance report be noted.
b) That the current position in relation to BCF planning for 2017/18 to 2018/19 be noted.

49 SHROPSHIRE ALL AGE CARER'S STRATEGY

The Health and Wellbeing Officer introduced and amplified a report (copy attached to the signed minutes) on the All-Age Carers Strategy for Shropshire 2017/18. Five priorities had been identified through consultation and surveys with carers, local and national best practice and a local multi-agency working group. These priorities focussed on the overarching aim which was: 'Carers are supported to remain emotionally, mentally and physically well and feeling safe'.

An Action Plan to meet the needs of these priorities had been produced and leads for four out of five areas had been identified. It was hoped that the lead from Children's Services would be identified for Priority 4 very shortly. The Board

welcomed this and the work that was underway to ensure that firm outcomes would be achieved.

RESOLVED:

a) That the Strategy be approved by the Board, subject to linking this into the Better Care Fund.

b) That a lead from Children's Services be identified for Priority 4 – to be confirmed by the Director of Children's Services.

c) That the Carers Strategy be linked in to businesses that employ carers - Penny Bason to take this forward.

50 BI-ANNUAL UPDATE FROM SHROPSHIRE HEALTHWATCH

The Chief Officer, Healthwatch Shropshire (HWS) introduced and amplified the Healthwatch Biannual report covering the period July 2016 to end December 2016 and highlighted activity during that period. Through listening to everybody's voices, the wide scope of the work undertaken by HWS and how the intelligence gathered was used was highlighted in the report (copy attached to the signed minutes).

With regard to the three new priorities set for 2016-17, the second priority of Young People's experiences (17-25) of health services and their information needs – project being undertaken by Keele University students and Shrewsbury College students – it was agreed that this work should also be linked in to Children's Services

ACTION: K Bradshaw

It was suggested that a triangulation meeting between the Chair of the Health and Wellbeing Board, the HWS Chief Officer, the Health and Wellbeing Officer and Scrutiny would be beneficial and should be arranged shortly, which was agreed.

ACTION: P Bason

RESOLVED:

a. That the contents of the report be noted.

b. That links be made to the new priority in 2016/17 of Young People's experiences by Children's Services.

c. That a triangulation meeting between the Chair of the Health and Wellbeing Board, the HWS Chief Officer, the Health and Wellbeing Officer and Scrutiny be arranged.

51 **FOR INFORMATION ITEMS**

a) H&WB Sub-Group Reports – for information
- Children's Trust – Karen Bradshaw – this was supported
- Mental Health Partnership Board – Andy Begley – this was noted.

b) Minutes of the A&E Delivery Group – for information
The minutes were noted and it was agreed that these should be provided to the next Health and Wellbeing meeting for information.

In conclusion it was suggested that another Joint Board meeting be held with Telford and Wrekin after the local elections in May 2017. This was agreed.

ACTION: P Bason

<TRAILER_SECTION>

Signed …… (Chairman)

Date:

The Shrewsbury and Telford Hospital NHS Trust

Reporting to:	**JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE** **Tuesday 7 March 2017**
Title	Fragile Clinical Services - Briefing
Sponsoring Director	Debbie Kadum, Chief Operating Officer
Author(s)	Carol McInnes - Assistant COO, Unscheduled Care Carolynne Scott – Assistant COO, Scheduled Care
Previously considered by	
Executive Summary	This briefing paper provides an update to the Health Overview and Scrutiny Committee on fragile Clinical Services at the Shrewsbury and Telford NHS Trust and actions being taken to ensure long term fundraising.
Strategic Priorities 1. Quality and Safety	☐ Reduce harm, deliver best clinical outcomes and improve patient experience. ☐ Address the existing capacity shortfall and process issues to consistently deliver national healthcare standards ☐ Develop a clinical strategy that ensures the safety and short term sustainability of our clinical services pending the outcome of the Future Fit Programme ☐ To undertake a review of all current services at specialty level to inform future service and business decisions ☐ Develop a sustainable long term clinical services strategy for the Trust to deliver our vision of future healthcare services through our Future Fit Programme
2. People	☐ Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work
3. Innovation	☐ Support service transformation and increased productivity through technology and continuous improvement strategies
4 Community and Partnership	☐ Develop the principle of 'agency' in our community to support a prevention agenda and improve the health and well-being of the population ☐ Embed a customer focussed approach and improve relationships through our stakeholder engagement strategies
5 Financial Strength: Sustainable Future	☐ Develop a transition plan that ensures financial sustainability and addresses liquidity issues pending the outcome of the Future Fit Programme
Board Assurance Framework (BAF) Risks	☐ If we do not deliver **safe care** then patients may suffer avoidable harm and poor clinical outcomes and experience ☐ If we do not work with our partners to reduce the number of patients on the **Delayed Transfer of Care** (DTOC) lists, and streamline our internal processes we will not improve our 'simple' discharges. ☐ Risk to **sustainability** of clinical services due to potential shortages of key clinical staff ☐ If we do not achieve safe and efficient **patient flow** and improve our processes and capacity and demand planning then we will fail the national quality and performance standards ☐ If we do not get good levels of **staff engagement** to get a culture of continuous improvement then staff morale and patient outcomes may not improve ☐ If we do not have a clear **clinical service vision** then we may not deliver the best services to patients ☐ If we are unable to resolve our (historic) shortfall in **liquidity** and the structural imbalance in the Trust's **Income & Expenditure** position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment

Care Quality Commission (CQC) Domains	☐ Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well led
☐ **Receive** ☐ **Review** ☐ **Note** ☐ **Approve**	**Recommendation**

UPDATE ON THE SUSTAINABILITY OF SERVICES PROVIDED BY SHREWSBURY AND TELFORD HOSPTIALS NHS TRUST (SaTH)

1. Emergency Department Update

There are 5 Substantive Consultants for both Emergency Departments at RSH and PRH and 4 Locum Consultants. Across the substantive and locum staff a 1:5 on call is worked (1:4 = tipping point). One of the Locum Consultants leaves 1 April 2017 and the Trust is advertising for a replacement.

2. Ophthalmology

A Stakeholder Workshop is being held on 14 March 2017 to discuss and review options for the long term sustainability of this service. The service remains closed to new referrals for glaucoma, general surgery and Adult surgical squint surgery.

Due to short notice sickness the Trust is unable to offer glaucoma surgery. Alternative providers have been sought for approximately 12 patients waiting for surgery.

Following the engagement exercise on 14 March 2017 an option paper will be presented at the Public Session of the Trust Board on 30 March 2017 for a decision on the preferred option for long term sustainability. Depending on the decision this may need to come back to HOSC with a recommendation to consider formal consultation.

3. Neurology Outpatient Service

Commissioners have been informed of a proposed temporary change to the Neurology Outpatient Services provided by SaTH. The service has consistently been flagged to commissioners and NHS Improvement as being a particularly challenged speciality with constraints in delivering national access targets due to consultant workforce gaps.

Currently, SaTH employs 2 wte Consultant Neurologists. This is supported by 1 wte locum post. The national average is 1 Neurologist per 80,000 people. This would equate to 6 wte for our local population. Despite our best efforts, we are unable to secure additional locum capacity to fill the gap.

This workforce position has led to increasing delays in patients waiting to be seen. On average, new routine patients are waiting 30 weeks for their first appointment and 9 weeks for an urgent referral. In order to deliver the RTT standard this should be 7-9 weeks for routine patients and 2-4 weeks for urgent referrals.

Clearly, there is a potential risk to patients waiting excessively to be seen and/or reviewed. We have, as you would expect, undertaken a series of actions to mitigate against this risk.

These actions include:

- Providing detail to both RAS & TRACS TRAQS for Shropshire & Telford CCGs on a weekly basis highlighting the average waiting times for new referrals, so this information can be shared with patients prior to them making their choice of provider alongside the details of other provider services who have shorter waiting times.
- If patients do choose SaTH as their provider, they are asked to contact the booking team should their condition resolve itself prior to their appointment to avoid missed appointments which can be reallocated (our current DNA position = 10%).
- Referrals are assessed by the consultants with some patients being advised to choose an alternative provider with shorter waiting times where possible. There is however an element of patient choice to be considered in this scenario as patients can still choose to wait for a SaTH appointment.

Despite these actions, we are concerned that a significant residual risk to patient safety remains in place. Consequently, we have recently undertaken a piece of work to identify possible short term options to reduce this identified risk.

The options included:

- Do nothing - this option would include maintaining the current level of service delivery alongside acceptance of new referrals while continuing to try and recruit.
- Hold an Executive to Executive discussion with neighbouring trusts regarding clinical support to alleviate the backlog.
- Suspend all routine referrals to the service for 6 months.
- Suspend all referrals to the service for 6 months.

These options alongside the identified risks and benefits of each option have been presented to SaTH executives for consideration. It was determined that option 1 (do nothing) is not viable as SaTH has held this position for some time without success. Option 2 has been attempted previously without success. It was agreed however that this discussion would be progressed alongside option 4, the suspension of all referrals to the service for 6 months.

In response to the level of clinical risk that has been identified, SaTH has formally advised commissioners of our intention to temporary close the Neurology Outpatient Service to all new referrals for a 6 month period with effect from 20 March 2017. We are working with commissioners to work through the necessary steps and detail to put this into effect, including communication with patients. All current patients on the waiting list will be seen with an expected reduction in waiting times from 30 weeks to 12 weeks within 3 months.

During the next 6 months the Unscheduled Care Group team will be developing an options paper for the long term sustainability of this Service.

4. Dermatology Outpatient Service

The Dermatology Outpatient Service is provided by SaTH and St Michaels Street Clinic. The SaTH current substantive workforce is;

- Consultant x 1
- Locum Consultant x 1
- GP's with Special Interests x 5
- Cancer Nurse Specialists x 3
- RGN's x 2

The Locum resigned week commencing 22 February 2017 with immediate effect. Several options are being pursued to maintain service delivery. A single Consultant led service is not viable due to the need for all Cancer 2 week referrals to be supervised by a Consultant. During periods of annual leave without alternative Consultant presence all clinics would have to be cancelled (10 weeks per year – 950 new/2WW patients and 850 follow up patients). Failure to appoint into either a substantive or Trust Locum Consultant post will leave the service in a very fragile position with only a single Consultant to deliver and oversee all aspects of the service. During Consultant annual leave the service would require an alternative provider to be secured to accommodate Acute Dermatology in-patient activity. An options paper for the long term sustainability of this service is being developed.

5. Spinal Service

SaTH has 1 Consultant who specialises in spinal surgery. This Consultant went on long term sick with no notice week commencing 13 February 2017. Commissioners have been informed that with immediate effect the Trust cannot take referrals for spinal problems. SaTH is in discussions with the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust regarding their capacity to support this service for the County.

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Shropshire Council

NHS Shropshire Clinical Commissioning Group

Shropshire together

Health and Wellbeing Board

23rd March 2017

BETTER CARE FUND PERFORMANCE AND OUTLINE PLAN

Responsible Officer Sam Tilley

Email: sam.tilley2@nhs.net Tel: Fax:

1. Introduction

1.1 The Health and Wellbeing Board is asked to consider the content of the report with particular reference to the 2016/17 Better Care Fund Quarter 3 Performance Report

2. Recommendations

2.1 The Health & Wellbeing Board is asked to:

- Note the content of the Better Care Fund Performance Report
- Note the current position in relation to BCF planning for 17/18- 18/19

REPORT

3. Purpose of Report

3.1 To update the Health and Wellbeing Board on performance to date in 2016/17 via the 2016/17 Quarter 3 performance report and to provide current information on the likely requirements for BCF in future years.

4. Background

4.1 As in 2015/16, following approval of BCF Plans, NHS England require quarterly performance submissions based on a predefined performance

template. The submission of the Quarter 3 performance template was due on 3 March 2017 and was approved via the Health & Wellbeing Delivery Group.

4.2 The Policy Framework and Planning Guidance for BCF in 17/18 and 18/19 was due for release on 7th December 2016, but has not yet been released. A series of updates from the BCF national team have provided us with some headline guidance which is detailed later in the report.

5. BCF Performance and scheme activity

5.1 The current local performance report, attached, is summarised below:

- Strong performance to reduce Non Elective (NEL) admissions to hospital has been continued for the third consecutive quarter and is rated green for the period.
- Performance in quarter 3 has shown an improvement compared to quarter 2 but still remains worse than target. Intelligence suggests that this situation is continuing to improve but will require very careful monitoring to ensure continued improvement.
- Performance against this metric has been mixed in quarter 3 with October and November performance worse than target and December performance better than target. Work continues to carefully monitor and improve this position.
- Reablement - performance against this metric remains challenging and is both lower than target and lower than last year's performance. Intelligence suggests that this is due to an increase in the numbers of patients with complex needs who may need to return to hospital for care. Work is continuing to gain more insight into how performance against this metric can be improved.
- Local Metric – Admissions to Redwoods with a diagnosis of dementia. This metric measures the number of people admitted to Redwoods with a diagnosis of dementia as a proportion of the population with a diagnosis of dementia. This is an annually reported target which reports in quarter 3. The target for 2016/17 was to reduce this proportion from 1.4% to 1.2%. Current data suggests that we have exceeded this target at a position of 1.02% and is therefore rated green
- Patient Experience Metric – for 2016/17 this focuses on patient experience of discharge from Hospital in line with the CQC inpatient survey. This reports annually in Q1 and showed an improvement on the 2015/16 position. Performance against this target is therefore rated as green.

5.2 Please refer to the attached Quarter 3 performance template for more detail

5.3 The following extract from the Regional BCF Q3 performance analysis report summarises performance across the region suggests that local performance is in line with performance across the region:

Performance against national and local Performance Metrics remains largely disappointing, with only one of the six metrics expected to be delivered by a majority of HWB areas. None of the region's HWB areas expects to meet all six performance targets whilst just six areas expect to meet 3 or more targets (up from 5 in Q2). Performance is least positive in respect of Delayed Transfers of Care, where 9 areas now expect no improvement from 2015/16 levels (up from 7 in Q2) whilst only 1 area is on target.

5.4 A number of actions have taken place to address performance issues and ensure patients are getting the best care as follows:

- ICS have launched 'home from hospital workers' to work on wards to support with developing trusted assessor roles and promote a home first philosophy. This has resulted in fewer requests/ need for high level care packages and improved flow considerably.
- Commissioners are reviewing the service specification and reporting requirements
- Shropshire Council have completed a tender process for domiciliary block contracts to ensure access to care contractually going forwards.
- Multi-Disciplinary Team Hub meetings take place at both sites and drive actions for discharge. Patients who have not had relevant actions completed continue to be escalated at 3pm to Executives to support with unblocking barriers.
- Twice weekly community conference calls continue to be held with all community hospital leads, ICS and independent providers to unblock barriers to discharge and support to progress plans for DTOC patients.
- Commissioner have a presence every day at the discharge hubs to ensure all partners are contributing to the discharge process.
- Internal ICS DTOC process in place to identify any delays within immediate care to ensure whole system flow.
- The current 2017 position compared to 2015 is that in excess of 10% of patients are being discharged home for rehabilitation from an acute setting
- Following the roll out of the Discharge to Assess, DTOC performance at SATH, (Oct – Dec 16) has been 34% lower than the equivalent months in the previous year. This includes a 72% reduction in DTOC for patients waiting completion of assessment.

5.5 All BCF High Impact Schemes for 2016/17 are either fully or partially implemented. An area of significant activity has seen the development of the package of prevention schemes (Healthy Lives Programme) and the linkage of these with developments in community services and Primary Care. The joint venture with Shropshire Fire and Rescue Service (Safe and Well) is now up and running and generating pre-emptive referrals for patients at risk in key focus areas. Activity across the Healthy Lives programmes is becoming more seamless, with a single project management system being employed for all prevention related activity.

BCF Planning for 17/18 & 18/19

5.6 The Policy Framework and Guidance for BCF 17/18 and 18/19 has been delayed and there is currenlty no definitive position on when this will become available. High level information was cascaded via the BCF National Team late in 2016 and has been shared previously with the Health & Wellbeing Board.

5.7 Despite this delay work is underway to gather the information we will need to develop the narrative plan. Work is progressing to review BCF budget lines to confirm the impact of investment and opportunities for realising efficiencies and increasing joint working between the CCG and Council.

6. Engagement

6.1 There continues to be extensive engagement across all partners in the delivery of the BCF as set out in the Engagement section of the BCF narrative plan. The BCF Refence Group have agreed to meet less regularly but to focus on specific tasks- e.g. planning for 17/18.

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

7.1 A specific Risk Log is included in the BCF narrative plan. The H&WB Delivery Group review the associated risk assurance framework at each meeting. Equalities issues are embedded throughout the plan. The plan also includes a section outlining the financial commitments supporting delivery. Rural issues are referenced thorughout the plan.

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 3rd March 2017.

The BCF Q3 Data Collection

This Excel data collection template for Q3 2016-17 focuses on budget arrangements, the national conditions, income and expenditure to and from the fund, and performance on BCF metrics.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an overview of progress with your BCF plan, the wider integration of health and social care services, and a consideration of any variances against planned performance trajectories or milestones.

Cell Colour Key

Data needs inputting in the cell
Pre-populated cells
Question not relevant to you

Throughout this template cells requiring a numerical input are restricted to values between 0 and 100,000,000.

Content

The data collection template consists of 8 sheets:

Checklist - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements - this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the BCF Policy Framework 16-17 and BCF planning guidance.
4) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
5) Supporting Metrics - this tracks performance against the two national metrics, a DTOC metric, a Non-Elective Admissions metric, locally set metric and locally defined patient experience metric in BCF plans.

6) Additional Measures - additional questions on new metrics that are being developed to measure progress in developing integrated, cooridnated, and person centred care.
7) Narrative - this allows space for the description of overall progress on BCF plan delivery and performance against key indicators.

Checklist

This sheet contains all the validations for each question in the relevant sections.

All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:

The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 7 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This section requires the Health & Wellbeing Board to confirm if funds have been pooled via a Section 75 agreement. Please answer as at the time of completion.

If it had not been previously stated that the funds had been pooled can you now confirm that they have now?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Policy Framework 16/17 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf) and Better Care Fund Planning Guidance 16/17 (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/) have been met through the delivery of your plan. Please answer as at the time of completion.

It sets out the eight conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' or 'No - In Progress' that these have been met. Should 'No' or 'No - In Progress' be selected, please provide an estimated date when condition will be met, an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed.

Full details of the conditions are detailed at the bottom of the page.

4) Income and Expenditure

This tracks income into, and expenditure from, pooled budgets over the course of the year. This requires provision of the following information:

Forecasted income into the pooled fund for each quarter of the 2016-17 financial year
Actual income into the pooled fund in Q1, Q2 & Q3 2016-17
Forecasted expenditure from the pooled fund for each quarter of the 2016-17 financial year
Actual expenditure from the pooled fund in Q1, Q2 & Q3 2016-17

Figures should reflect the position by the end of each quarter. It is expected that the total planned income and planned expenditure figures for 2016-17 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan or amendments to forecasts made since the previous quarter.

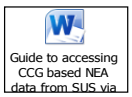
5) Supporting Metrics

This tab tracks performance against the two national supporting metrics, a Delayed Transfers of Care metric, a Non-Elective Admissions metric, the locally set metric, and the locally defined patient experience metric submitted in approved BCF plans. In all cases the metrics are set out as defined in the approved plan for the HWB and the following information is required for each metric:

An update on indicative progress against the six metrics for Q3 2016-17
Commentary on progress against each metric

If the information is not available to provide an indication of performance on a measure at this point in time then there is a drop-down option to indicate this. Should a patient experience metric not have been provided in the original BCF plan or previous data returns there is an opportunity to state the metric that you are now using.

Guidance on accessing CCG based NEA numerator data from SUS via the 'Activity and Planning Report' has been circulated in tandem with this report in order to enable areas to perform their own in year monitoring of NEA data. This guidance document can also be accessed via the embeded object below.



NEA denominator population (All ages) projections are based on Subnational Population Projections, Interim 2014-based (published May 2016) found here:
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Please note that the Non-Elective Admissions per 100,000 population (All ages) population projections are based on a calendar year.

Delayed Transfers Of Care numerator data for actual performance has been sourced from the monthly DTOC return found here:
http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

DTOC denominator population (18+) projections are based on Subnational Population Projections, Interim 2014-based (published May 2016) found here:
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Please note that the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+) population projections are based on a calendar year.

Actual and baseline data on Re-ablement and Residential Admissions can be sourced from the annual ASCOF return found here:
http://content.digital.nhs.uk/searchcatalogue?productid=22085&q=ascof
Please note these are annual measures and the latest data for 2015/16 data was published 05/10/2016. Plan data for these metrics in 2016/17 were submitted by HWBs within Submission 4 planning returns and final figures are displayed within the 'Remaining Metrics Enquiry' tab of the Submission 4 report.

6) Additional Measures

This tab includes a handful of new metrics designed with the intention of gathering some detailed intelligence on local progress against some key elements of person-centred, co-ordinated care. Following feedback from colleagues across the system these questions have been modified from those that appeared in last years BCF Quarterly Data Collection Template (Q2/Q3/Q4 2015-16). Nonetheless, they are still in draft form, and the Department of Health are keen to receive feedback on how they could be improved / any complications caused by the way that they have been posed.

For the question on progress towards instillation of Open APIs, if an Open API is installed and live in a given setting, please state 'Live' in the 'Projected 'go-live' date field.
For the question on use and prevalence of Multi-Disciplinary/Integrated Care Teams please choose your answers based on the proportion of your localities within which Multi-Disciplinary/Integrated Care Teams are in use.

For the PHB metric, areas should include all age groups, as well as those PHBs that form part of a jointly-funded package of care which may be administered by the NHS or by a partner organisation on behalf of the NHS (e.g. local authority). Any jointly funded personal budgets that include NHS funding are automatically counted as a personal health budget. We have expanded this definition following feedback received during the Q3 reporting process, and to align with other existing PHB data collections.

7) Narrative

In this tab HWBs are asked to provide a brief narrative on overall progress, reflecting on performance in Q3 16/17.
A recommendation would be to offer a narrative around the stocktake themes as below:
Highlights and successes
What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?
Challenges and concerns
Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?
Potential actions and support
What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

Better Care Fund Template Q3 2016/17

Data Collection Question Completion Checklist

1. Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

2. Budget Arrangements

Funds pooled via a S.75 pooled budget? If not previously stated that the funds had been pooled can you confirm that they have now? If no, date provided?
Yes

3. National Conditions

			7 day services		
	1) Are the plans still jointly agreed?	2) Maintain provision of social care services	3i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	3ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	4i) Is the NHS Number being used as the consistent identifier for health and social care services?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter (in-line with signed off plan) and how this is being addressed?	Yes	Yes	Yes	Yes	Yes

4. I&E

		Q1 2016/17	Q2 2016/17	Q3 2016/17
Income to	Forecast	Yes	Yes	Yes
	Actual	Yes	Yes	Yes
	Please comment if there is a difference between the annual totals and the pooled fund	Yes		
Expenditure From	Forecast	Yes	Yes	Yes
	Actual	Yes	Yes	Yes
	Please comment if there is a difference between the annual totals and the pooled fund	Yes		
Commentary on progress against financial plan:		Yes		

5. Supporting Metrics

		Please provide an update on indicative progress against the metric?	Commentary on progress
	NEA	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
	DTOC	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
	Local performance metric	Yes	Yes
	If no metric, please specify	Please provide an update on indicative progress against the metric?	Commentary on progress
Patient experience metric	Yes	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
	Admissions to residential care	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
	Reablement	Yes	Yes

6. Additional Measures

	GP	Hospital	Social Care	Community	Mental health
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes

	To GP	To Hospital	To Social Care	To Community	To Mental health
From GP	Yes	Yes	Yes	Yes	Yes
From Hospital	Yes	Yes	Yes	Yes	Yes
From Social Care	Yes	Yes	Yes	Yes	Yes
From Community	Yes	Yes	Yes	Yes	Yes
From Mental Health	Yes	Yes	Yes	Yes	Yes
From Specialised Palliative	Yes	Yes	Yes	Yes	Yes

	GP	Hospital	Social Care	Community	Mental health
Progress status	Yes	Yes	Yes	Yes	Yes
Projected 'go-live' date (mm/yy)	Yes	Yes	Yes	Yes	Yes

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Yes

Total number of PHBs in place at the end of the quarter	Yes
Number of new PHBs put in place during the quarter	Yes
Number of existing PHBs stopped during the quarter	Yes
Of all residents using PHBs at the end of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	Yes

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes

7. Narrative

Brief Narrative	Yes

Data sharing			
4ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	4iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	4iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	5) Is there a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes

Q4 2016/17
Yes

Yes

Specialised palliative
Yes
Yes

To Specialised palliative
Yes
Yes
Yes
Yes
Yes
Yes

Specialised palliative
Yes
Yes

Cover

Q3 2016/17

Health and Well Being Board	**Shropshire**
Completed by:	Samantha Tilley
E-Mail:	sam.tilley2@nhs.net
Contact Number:	01743 277 545
Who has signed off the report on behalf of the Health and Well Being Board:	Cllr Karen Calder (Chair, Health and Wellbeing Board)

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	36
4. I&E	17
5. Supporting Metrics	13
6. Additional Measures	67
7. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:	Shropshire

Have the funds been pooled via a s.75 pooled budget?	Yes
If it had not been previously stated that the funds had been pooled can you confirm that they have now?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question, which is pre-populated, the data is from a previous quarterly collection returned by the HWB.

National Conditions

Selected Health and Well Being Board: Shropshire

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within this quarter (in-line with signed off plan) and how this is being addressed?

Condition (please refer to the detailed definition below)	Q1 Submission Response	Q2 Submission Response	Please Select ('Yes', 'No' or 'No - In Progress')	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:
1) Plans to be jointly agreed	Yes	Yes	Yes		
2) Maintain provision of social care services	Yes	Yes	Yes		
3) In respect of 7 Day Services - please confirm:					
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes	Yes	Yes		
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	No - In Progress	No - In Progress	No - In Progress	01/04/20	This work is underway but is still in its early stages of development and is in line for the phase 3 national target for 7 day servics as detailed in the SCCG Operationa
4) In respect of Data Sharing - please confirm:					
i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes	Yes	Yes		
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes	Yes	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes	Yes	Yes		
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes	Yes	Yes		
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes	Yes	Yes		
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	Yes	Yes		
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	Yes	Yes		
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	Yes	Yes		

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissionin

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Car a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change conseque Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services
Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.
Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

- To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
- To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf).
By 2017 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made again standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

4) Better data sharing between health and social care, based on the NHS number
The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of informat right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:
- confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
- confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and
- ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
- ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated h services, supported by care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.

This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas sh as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

8) Agreement on local action plan to reduce delayed transfers of care (DTOC)

Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (d population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

- Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
- Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
- Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
- Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
- Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
- Demonstrate engagement with the independent and voluntary sector providers.

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Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Shropshire

Income

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£7,565,025	£5,056,006	£5,056,006	£5,056,006	£22,733,043	£22,733,045
	Forecast	£7,565,025	£5,056,006	£5,056,006	£5,056,006	£22,733,043	
	Actual*	£5,948,910	£5,065,006				

Q3 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£7,565,025	£5,056,006	£5,056,006	£5,056,006	£22,733,043	£22,733,045
	Forecast	£7,565,025	£5,056,006	£5,056,006	£5,056,006	£22,733,043	
	Actual*	£5,948,910	£5,065,006	£6,663,622			

Please comment if one of the following applies: - There is a difference between the forecasted annual total and the pooled fund - The Q3 actual differs from the Q3 plan and / or Q3 forecast	work to refine processes to ensure a streamlined system of payment in the new year are progressing

Expenditure

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£5,300,140	£5,889,784	£5,771,561	£5,771,561	£22,733,046	£22,733,046
	Forecast	£5,300,140	£5,889,784	£5,771,561	£5,771,561	£22,733,046	
	Actual*	£5,300,140	£5,511,033				

Q3 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£5,300,140	£5,889,784	£5,771,561	£5,771,561	£22,733,046	£22,733,046
	Forecast	£5,300,140	£5,889,784	£5,771,561	£5,771,561	£22,733,046	
	Actual*	£5,300,140	£5,511,033	£5,960,936			

Please comment if one of the following applies: - There is a difference between the forecasted annual total and the pooled fund - The Q3 actual differs from the Q3 plan and / or Q3 forecast	increase in capital expenditure to reconcile slippage in Q2

Commentary on progress against financial plan:	The Local Authority continues to see a delay in the CCG paying over sums due to the Pooled Fund. However, work is underway to refine processes to ensure a streamline system of payment in the new year

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB. Pre-populated Plan figures are sourced from the Q1 16/17 collection whilst Forecast, Q1 and Q2 Actual figures are sourced from the Q2 16/17 return previously submitted by the HWB.

National and locally defined metrics

Selected Health and Well Being Board:	Shropshire

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Performance against this metric has been better than plan for three consecutive quarters, this trajectory is expected to continue.

Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	Performance in quarter 3 has shown an improvement compared to quarter 2 but still remains worse than target. Intelligence suggests that this situation is continuing to improve however will require very careful monitoring and ongoing improvement.

Local performance metric as described in your approved BCF plan	Number of people admitted (un-planned) to Redwoods Hospital with a diagnosis of dementia as a proportion of those with a dementia diagnosis.
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	This metric is reported annually with the target for the year to reduce admissions by a further 0.2% on 15/16. The indicator for 16/17 is 1.02% compared to 1.4% in 15/16 which exceeds the 0.2% reduction target.

Local defined patient experience metric as described in your approved BCF plan	CQC inpatient survey "leaving hopsital" measures show an improvement against the baseline 15/16 position
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	This is an annually reported metric. The target for 2016 is 6.9/10. The 2016 score has been released and shows an improvement on the 2015 score from 6.8/10 to 7.1/10

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	Performance against this metric has been mixed in quarter 3 with October and November performance worse than target and December performance better than target. Work continues to carefully monitor and improve this situation

Additional Measures

Selected Health and Well Being Board: Shropshire

Improving Data Sharing: (Measures 1-3)

1. Proposed Measure: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Measure: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Hospital	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally	Not currently shared digitally
From Mental Health	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally
From Specialised Palliative	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via Open API

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Live	Live	Live	In development	Live	In development
Projected 'go-live' date (dd/mm/yy)				01/09/17		01/09/17

3. Proposed Measure: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot being scoped

Other Measures: Measures (4-5)

4. Proposed Measure: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	17
Rate per 100,000 population	5.4

Number of new PHBs put in place during the quarter	1
Number of existing PHBs stopped during the quarter	0
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	88%

Population (Mid 2016)	312,408

5. Proposed Measure: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?	Yes - throughout the Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?	Yes - throughout the Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures were updated to the mid-year 2016 estimates as we moved into the new calendar year.

Narrative

Selected Health and Well Being Board:	Shropshire

Remaining Characters	31,220

Please provide a brief narrative on overall progress, reflecting on performance in Q3 16/17. A recommendation would be to offer a narrative around the stocktake themes as below:

Highlights and successes

What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?

Challenges and concerns

Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?

Potential actions and support

What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

Q3 metrics display a mixed position with continued strong performance in reducing NEA but continued challenges in DToC, reablement and residential care admissions. System wide work to fully understand these challenges and put in place mitigating action continues with some evidence of impact with recent monthly performance showing some signs of improvement.

Working relationships between partners continue to strengthen despite the significant financial challenges across the system, particularly for the CCG and the Local Authority. The appointment of a permanent AO for the CCG and the appointment of personnel in senior positions in SC Adult Services will help to stabilise this work. The Leadership Programme supported via the BCF national team continues to support these relationships and is helping to shape exciting new arrangements for joint commissioning.

An area of significant focus has seen the alignment of BCF, the Shropshire Healthy Lives Programme and the STP particularly through the neighbourhoods workstream. Progress has been made across these programmes and activity is becoming more seamless. External input to further develop the Neighbourhood model has been commissioned by SCCG, Shropshire Council and Shropshire Community Health Trust and along side this the CCG is undertaking a comprehensive review of Comunity services to inform future models of delivery. Further to this a key part of this system wide work is to refine and improve our data collection systems to measure the impact of these system wide schemes.

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Health and Wellbeing Board
23 March 2017

PARTNERSHIP PREVENTION PROGRAMME, HEALTHY LIVES

Responsible Officer Jo Robins/Penny Bason
Email: Jo.robins@shropshire.gov.uk Tel: Fax:
Pennybason@shropshire.gov.uk

1. Summary

1.1 This paper provides an update on the recent visit to the Wellbeing Enterprises CIC Prevention Programme in Halton by members of the Partnership Prevention Programme together with a short update on progress to date and next steps.

1.2 Members have previously received comprehensive reports about the programme and there is a suite of documentation available including PID's, action plans, notes of the steering group, presentations, briefing notes, extracts from the JSNA and information on metrics available and can be requested or viewed from previous HWBB papers.

1.3 As a reminder - this Partnership Prevention Programme, **Healthy Lives**, will focus on taking a whole system approach to reducing demand on services and relies on working together in partnership to deliver activity; it supports integration across health and care as set out in the Health and Wellbeing Strategy and is an integral component of the STP Neighbourhoods Workstream.

1.4 The recent visit to the Halton project was part of the approach being adopted by the steering group to investigate national good practice and exemplar projects with the aim of adopting and integrated key learning and evidence to ensure that local programme are built on the latest available evidence. This was also an opportunity to share the good practice and USP's of the Shropshire model.

2. Recommendations

2.1 Receive the update on the key learning from the Wellbeing CIC visit
Endorse the approach being adopted by the Healthy Lives Steering Group

2.2 Agree the approach to develop a social prescribing model which recognises and builds on the assets already in place in Shropshire such as the Community and Care Co-ordinators, the Compassionate Communities programme, the programmes in the Better Care Fund, the Let's Talk Local model and behaviour change programmes.

2.3 Endorse the implementation of the pilot and the evaluation of the pilot.

2.4 Support the model which includes a range of measures that demonstrate impact on health and well-being.

REPORT

3. Purpose of Report

3.1 The purpose of the report is to provide an update on the recent visit to the Wellbeing Enterprises CIC Prevention Programme in Halton by members of the Partnership Prevention Programme together with a short update on progress to date and next steps and general direction of travel.

4. Report

4.1 Various reviews of social prescribing have taken place over recent years with different degrees of robustness. NHS England have commissioned a thorough and comprehensive review of the evidence base through a leading university that will report later in the year. This will culminate in a set of best practice models for areas to use, a set of guidelines and a toolkit for implementation. An affiliated national social network has been created alongside this.

4.2 Nationally Recognised Exemplar Projects include:-

- Halton Wellbeing Enterprises (CCG commissioned in part)
- Gloucester CCG
- Rotherham
- Newcastle Upon Tyne West CCG – Ways to Wellness
- Bromley by Bow

4.3 Each of the above have slightly different approaches but the same common aim about offering an alternative or sometimes a supplementary offer to patients over and above medicalised care. They have all been evaluated by external academic institutions Typical measures include :-

1. Number of patient attendances at GP practice
2. Attendances at Accident and Emergency Departments
3. Emergency/unplanned hospital admissions
4. Number of planned hospital admissions
5. Number of unplanned continuous inpatient episodes of care
6. Reduction in home visiting across healthcare and social care frontline staff
7. Engagement of the community sector in supporting non medical health and wellbeing of patients
8. Awareness of Social Prescribing amongst healthcare and social care frontline staff
9. Involvement of third sector organisations and groups in supporting the non medical health and wellbeing of patients
10. Patient satisfaction and feedback

4.4 The Impact of the Programmes

4.4.1 Wellbeing Enterprises CIC (Halton CCG commissioned in part)

Wellbeing Enterprises CIC in place for nine years. Funded by Halton CCG GP's prescribe into the programme combination of personalised 1 to 1 support, education courses (social Prescribing) and social action (volunteering, social entrepreneurship)

4,4.2 Data - significant numbers and collected over a period of time
Significant improvements in the levels of mental health need and overall health of those using the programme

- Financial savings to the public sector of .55p for each £ invested.
- Calculated return on investment, ratio for every £ spent produces a value of £8.90
- Meets the cost effectiveness for QALY
- The programme is cost effective and provides good value for money
- The information for the fiscal conclusions is more limited only providing info on mental health
- Value for money but no control group

4.4.3 Gloucester CCG

4.4.4 Data – reasonable numbers although measured over a period of six months

- Improvements in wellbeing with positive outcomes for patients
- Reductions in emergency admissions
- Reductions in emergency attendance
- Reduction in the cost of emergency admissions
- Reduction in primary care consultations
- Some savings assumptions identified

4.4.5 The GP's are proactively supporting this programme and a dedicated team has been established in the CCG to develop further business cases.

4.4.6 Rotherham CCG

4.4.7 Data – significant numbers over a period of time with a focus on :-
- Long term conditions
- Reduction in patient admissions
- Reduction in A and E attendance
- When patients over age 80 excluded results are better
- Reduction in non elective inpatient admissions
- Reduction in out-patient attendance

4.4.8 Other key findings have identified
- major well being improvements with 83% of patients made progress in one outcome area (feeling positive, lifestyle, reduced social isolation and lonliness, increased independence) and improved quality of life for patients and carers.
- In addition they have established cost effectiveness, return on financial investment of .33p for each £ invested in the first year. When the over 80 year

olds are taken out of the calculations the savings in the first year are greater (£534 saved per patient with a return on investment of £0.46p)
- The figures show the cost to re-coup will be achieved in 2.5 years,

4.4.9 Newcastle Upon Tyne West CCG

4.4.10 Commissioned Ways to Wellness and established in 2015, programme is delivered through the VCS with local GP practices
Data available over a period of time.
Initially funded through the Health Social Enterprise Investment Fund, Big Lottery and the use of social impact bonds. Newcastle West CCG committed to paying back if Ways to Wellness can demonstrate improvement on agreed outcome measures including reduced hospital visits and improvements around wellbeing
-

4.4.11 Bromley by Bow

4.4.12 Significant data and evaluation over a period of years.Longest and most well established social prescribing model in the country operates a central building within an area of deprivation with a focus on vulnerable groups of adults, young people, long term unemployed, and older people who often present with health conditions that prevent a barrier to work. Offer holistic support packages designed around the needs of the patient/client

4.4.13 Key Learning From the visit to Wellbeing CIC Halton

1 Whilst the model is built on a CIC and the focus is on improving wellbeing there was significant learning for the team in relation to the following:-
2 The training package
3 Development of an in house model but with a focus purely on wellbeing
4 Long term work with primary care whereby staff are visible in the practice and a core part of the team – now describe people rather than conditions
5 Staffing model – including the recruitment, development and deployment of staff who are able to spend time with the practices and the clients
6 The impact on the economy and their entrepreneurial vision and trade off with local businesses
7 Local people taking control of their own lives and the development of a critical mass in the community
8 Recording of data and external evaluation
9 Development of an APP – places
10 Think broadly and consider whether we have included everyone that we need to in our programme ?

4.5 Key Learning From Shropshire

1 Our approach to evaluation and a control group to compare the impact of interventions
2 Our ability to access the GP records and place the data onto the record

3 Our approach to behaviour change and access to programmes delivered by public health
4 Our focus on integration across adult social care and working directly with the community development teams and Let's Talk Local teams.
5 Our Healthy Conversations training packages covering lifestyle interventions

4.6 Next Steps

- To apply the key learning from the visit into our local pilot and establish cross border working

- Implement the pilot programme in Oswestry working with the voluntary sector and local providers of behaviour change programmes.

- Lead in conjunction with the national social prescribing network for England the development of a Midlands wide Social Prescribing network

- Commission an academic institution to evaluate the pilot programme.

5. Engagement

5.1 Each programme/ project of the Prevention Programme is required to engage with a wide range of stakeholders, including patient/ service user representatives, as part of the development and delivery of any programme or change of service.

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

6.1 The purpose of the HWBB is to reduce inequalities in health, as such all programme development will, to the best of our ability, develop services where equity is at the core of decision making.

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

Health and Wellbeing Board
23rd March 2017.

CLeaR ALCOHOL SELF-ASSESSMENT REPORT

Responsible Officer:
Gavin Hogarth

Email: Gavin.hogarth@shropshire.gov.uk Tel: 01743 253982

1. Summary

1.1 Public Health England have developed a CLeaR tool to support local areas to improve their response to reduce alcohol related harms. The purpose of this report is to provide an overview of the CLeaR Alcohol Self-Assessment Model and a proposal to undertake the assessment locally to support delivery of the Alcohol Strategy 2016 -2019 and the Local Alcohol Action Area[2] programme.

2. Recommendations

The Health and Wellbeing Board:

2.1 Note the contents of the report.

2.2 Support the completion of CLeaR in Shropshire through directing within their organisations contribution to the process.

2.3 Promoting the CLeaR assessment with partner agencies as part of the wider strategic response to alcohol related harm.

2.4 Agree to the proposed timeline for the completion of CLeaR.

-

REPORT

3. Risk Assessment and Opportunities Appraisal

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

N/A

4. Financial Implications

N/A

5. Background

5.1 CLeaR is an evidence based improvement model developed by Public Health England. It stimulates discussion among partners about local opportunities to improve outcomes and reduce alcohol related harms through effective collaborative working.

5.2 The CLeaR model aims to measure and improve outcomes through three key areas:

- **C**hallenge - Reviews local services that deliver interventions to prevent or reduce alcohol related harm against current evidence.
- **Lea**dership - Considers the extent to which strategic leadership is supporting comprehensive action to reduce alcohol harm. A key area is whether commissioning decisions are informed by a robust understanding of local need.
- **R**esults looks at the data used locally to evidence the outcomes delivered by the partnership against national and local priorities.

5.3 The CLeaR process requires the engagement and participation of a wide range of key partners and stakeholders such as treatment providers, licencing, trading standards, housing providers, police, emergency services, hospitals and representatives from local health and wellbeing boards in order to complete the range of self-assessment questions.

5.4 The self-assessment questions cover areas such as vision and governance, planning and commissioning, partnership, communications and prevention.

5.5 Participants to the CLeaR assessment will be encouraged to respond providing evidence to their organisations current position. It is not the intention the assessment should take long to complete and participants should go with their first thoughts on answers to the questions. Once completed the assessments will be collated to provide an overview of the current Shropshire position in response to alcohol related harm. This will help to identify areas of focus where further development work is required in order to work effectively to reduce alcohol related harm.

6 Additional Information

6.1 The CLeaR model is a key tool to support Shropshire's involvement is the governments Local Alcohol Action Area^2 (LAAA^2) Programme.

6.2 LAAA^2 is a two-year (2017-2019) initiative which aims to prevent alcohol related crime and disorder and reduce alcohol related health harms through strong, sustained and effective partnership working.

6.3 Shropshire has been included in the 'preventing alcohol related crime and disorder' stream of the programme, specifically 'how can local areas improve the collection, sharing and use of data between A&E departments, local authorities and the police'. The CLeaR self-assessment will form a key component to the LAAA^2 action plan.

6.4 The outcome of CLeaR will also form a key component in the delivery of the Shropshire Alcohol Strategy 2016 – 2019.

7. Proposal

7.1 It is proposed the CLeaR process should take a two-stage approach. The first is for all stakeholders to complete the assessment, then once collated a workshop is held to look at local gaps and develop appropriate responses. The timeline for completion of CLeaR is as follows:

- Week beginning Monday 8th May: DAAT distribute CLeaR self-assessment questions to partners and stakeholders to complete and return by Friday 2nd June.
- Week beginning Monday 5th June: DAAT collate CLeaR responses.
- Friday 16th June: Workshop for partners and stakeholders for overview of CLeaR results and agreed next steps.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) NONE
Cabinet Member (Portfolio Holder) Karen Calder
Local Member N/A
Appendices N/A

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Health and Wellbeing Board
23rd March

COMMISSIONING HEALTHWATCH AND INDEPENDENT NHS COMPLAINTS ADVOCACY SERVICE FOR SHROPSHIRE

Responsible Officer Neil Evans
Email: Neil.Evans@shropshire.gov.uk Tel: Fax:

1. Summary

1.1 This report sets out the steps required to secure a Local Healthwatch for Shropshire beyond 2018, options for achieving this and seeks advice from the health and Wellbeing Board as to the scope and extent of the engagement activity to support this process.

2. Recommendations

2.1. Feedback is given on the nature, scope and extent of the engagement work required to develop a specification for Healthwatch Shropshire to ensure it is effective and resilient into the future.

2.2. Feedback is given as to whether any, or all, of the emerging commissioning models set out in Section 6 below should be investigated.

2.3. Feedback is given as to the nature of the involvement of the Health and Wellbeing Board in the recommissioning of Healthwatch Shropshire

REPORT

3. Risk Assessment and Opportunities Appraisal

3.1 Risk Assessment

A risk register will be established and updated as the commissioning project progresses. Healthwatch Shropshire (HWS) have also created and maintained their own operational and strategic risk assessment. Ongoing risks are common to both HWS and the Health and Wellbeing Board. Risks include uncertainty over future available funding for the Healthwatch function and capacity for HWS to be able to effectively deliver all their statutory functions whilst at the same time gathering and sharing views on the wide range of health and care changes and activities currently under way.

3.2 Human Rights

It is unlikely that there are any relevant Human Rights issues impacting this project.

3.3 Equalities

An Equalities and Social Inclusion Impact Assessment (ESIIA) will be established and updated as the commissioning project progresses. The ESIIA will be informed by the engagement activity undertaken to support the commissioning of Local Healthwatch.

3.4 Communities

Local Healthwatch exists to ensure that individuals and communities are able to have their views heard and shared with health and care services and commissioners. Through its own engagement activity, which involves many volunteers, members and stakeholders, Healthwatch has a positive impact on communities throughout Shropshire.

3.5 Environment
It is unlikely that there are any relevant environmental issues impacting this project.

4. Financial Implications

4.1 The IHCAS contract is fully funded and the Healthwatch contract is partly funded from the Local Reform and Community Voices Grant. The balance is funded out of the Local Government Finance Settlement. Current contract values are £24,000 per annum for IHCAS and £191,487 (plus a potential further £8,000 per annum to support a research grants programme) for Healthwatch.

4.2 Engagement and commissioning activity will incur costs associated with staff time, publicity and, if required, venue hire.

5. Background

5.1 Healthwatch is the independent consumer champion for health and social care and was created under the Health and Social Care Act 2012 legislation to replace the LINks (Local Involvement Networks). Each local authority area is required to have a Local Healthwatch. Healthwatch Shropshire Ltd was formed in 2013 and is funded by Shropshire Council through a contract which runs until 31st March 2018. Healthwatch Shropshire (HWS) also delivers the Independent Health Complaints Advocacy Service (IHCAS) for Shropshire, again contracted until March 2018.

5.2 HWS was originally commissioned by Shropshire Council following extensive engagement throughout 2012 with stakeholders and users of health and social care services. This took the form of a Transition Board with representation from the main health and care bodies in Shropshire, an online questionnaire, public meeting and attendance at various stakeholder groups throughout the county. This, combined with the legislative requirements for Healthwatch, helped to shape the specification and procurement exercise.

5.3 The statutory functions of a local Healthwatch are:

Function 1 – Providing advice and information about access to services and support for making informed choices
Function 2 – Making the views and experiences of people known to Healthwatch England (HWE) and provide a steer to help it carry out its role as national champion
Function 3 – Recommending investigation or special review of services via Healthwatch England or direct to the Care Quality Commission
Function 4 - Promoting and supporting the involvement of people in the commissioning and provision of local care services. This includes operating an 'Enter and View' process
Function 5 – Gathering views and understanding the experiences of patients and the public
Function 6 – Making people's views known
Function 7 – Provide access to the Independent Health Complaints Advocacy Service. HWS is also the contracted IHCAS provider

Healthwatch must produce a statutory annual report.

5.4 Following a competitive procurement process in which 2 tenders were received the contract to form Healthwatch Shropshire was awarded to Shropshire Rural Community Council with the requirement that they form a distinct Healthwatch organisation from April 2013. Healthwatch Shropshire Ltd became fully independent from SRCC in 2016.

5.5 Throughout the contract term a stakeholder group consisting of representatives from key stakeholder organisations has met regularly with HWS to review the effectiveness of HWS and to discuss emerging themes and trends. HWS has a seat on the Health and Wellbeing Board and Delivery Group and provides reports on progress.

5.6 HWS undertook a 'Reflective Audit' (based on a national tool developed for Healthwatch) with stakeholders in 2015 which comprised 18 questions, with participant responses being a mix of multiple choice, ratings scales, and self-generated narrative text. It was sent by email to 46 recipients as a SurveyMonkey online questionnaire. This highlighted areas where HWS was performing at a level above other local Healthwatch and also some areas for development. In addition feedback from stakeholders identified a long list of achievements by HWS including the Pharmacy Service review, Mental Health review and the quality of their engagement. Development areas included the need to continue to raise awareness of their activity amongst stakeholders, strengthen the relationship with some NHS organisations and to review their activity specifically focussed on social care.

5.7 HWS is unique in running an annual research grant scheme for the voluntary and community sector, supported by the Local Authority. The grants provide another way for HWS to find out what works well and where there are challenges for people in the county in using health and social care services, especially for those whose voices are seldom heard. Research projects so far have focussed on:

- People with Asperger's syndrome and high level autism
- Deaf people
- Visually impaired people
- Older LGBT
- Parents and carers of disabled children
- Death education and young people
- People who using adult social care
- Householders suffering from fuel poverty

5.8 Since HWS won the contract for IHCAS in 2016 they are starting to see the benefits of joining up the intelligence gained through the IHCAS contract with their wider intelligence gathering activities.

6. Next Steps

6.1 In order to ensure that a new contract is in place from 1st April 2018 a number of decisions and activities need to be undertaken. Procurement advice is that a competitive procurement will need to be undertaken. The outline key stages and timeline required to get to a contract 'go-live' date of 1st April 2018 are shown below:

March – April 2017	Plan and prepare engagement. Develop questionnaire
May – June 2017	Stakeholder and public engagement
July 2017	Stakeholder event (priorities and co-production)
July – Sept 2017	Develop and finalise specification(s)
Sept – Nov 2017	Tender period
November 2017	Tender evaluations, presentations
6th December 2017 (provisional)	Shropshire Council Cabinet decision on preferred bidder

Jan – March 2018	Contract mobilisation
1st April 2018	New contract commences

6.2 Feedback is requested from the Health and Wellbeing Board as to the scope and extent of the engagement required to develop a specification for Healthwatch Shropshire to ensure it is effective and resilient into the future.

6.3 Nationally the Healthwatch commissioning landscape has evolved slowly over the first 4 years. Of the 152 local Healthwatch the vast majority are single-authority entities. Two areas have a combined Healthwatch – Dorset (including Poole and Bournemouth) and Central West London (Hammersmith & Fulham, Kensington & Chelsea and Westminster). 7 providers hold multiple local Healthwatch contracts (covering 25 local authorities). It is permissible to have a single Healthwatch board responsible for 2 or more local authority areas.

6.4 New models are emerging to reflect a range of commissioning and provider needs such as efficiency, shared functions and shared health and care economies. Commissioning models include:

- Joint commissioning across 2 or more local authority areas, often linked to common CCGs or health providers. A single contract and specification applicable to all areas is agreed and commissioned.
- Collaborative commissioning where neighbouring areas with common priorities and health providers agree to common specification requirements but commission separately – this may result in different Healthwatch providers or one Healthwatch provider delivering 2 or more contracts
- Collaborative delivery where 2 or more local Healthwatch agree to share and collaborate on certain functions, eg back office, intelligence systems, specialisms

6.5 It is worth noting that any collaborative or jointly commissioned approach across 2 or more local authority areas has the potential to be complex which may result in the timetable for recommissioning being delayed by up to a further 12 months.

6.6 Feedback is requested from the Health and Wellbeing Delivery Group/ Board as to whether any, or all, of the above emerging commissioning models should be investigated.

7. Conclusions

7.1 Effective engagement with the right stakeholders is important to ensure that Healthwatch Shropshire will continue to be effective in the context of the evolving health and social care landscape of Shropshire. The local Healthwatch organisation will need to be resilient and able to continue to represent the voice of patients and service users in the context of future public sector funding pressures alongside significant changes in health and care service delivery.

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

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Shropshire Council

NHS
Shropshire Clinical Commissioning Group

Shropshire together

Health and Wellbeing Board
23rd March 2017

SOCIAL VALUE CHARTER FOR SHROPSHIRE

Responsible Officer
Email: Neil.evans@shropshire.gov.uk Tel: 01743 253019

1. Summary

1.1 The Public Services (Social Value) Act 2012 (the 'Act') places a statutory duty on public sector commissioning organisations to consider:

1. how what we propose to procure might improve social, economic and environmental wellbeing of the 'relevant area' (for example, for the Council this is the Shropshire Council area); and
2. through procurement, how we might go about securing those improvements.

1.2 'Social Value' means social, economic and environmental benefits or outcomes that have been created. The Act does not prescribe in detail the nature of the social, economic and environmental improvements to be secured, which means that there is flexibility for local areas to define the nature of such improvements based on local needs and requirements.

1.3 During the time of implementation of the Act we recognised that, as the principles of the Act apply to all public commissioning organisations, there was benefit in setting up a Social Value Group in order to develop a common approach to securing Social Value in Shropshire.
The Social Value Group is comprised of representatives from Shropshire Council, Shropshire CCG, local Housing Associations, West Mercia Police & Crime Commissioner and NHS Commissioning as well as voluntary sector and provider representation.

1.4 The Social Value Group has developed a Social Value Charter for Shropshire (attached as Appendix A). Adopting the Social Value Charter is not a requirement of the Act but it does serve to demonstrate a commitment to 3 key, locally defined, principles to support improvements in social, economic and environmental wellbeing for Shropshire. These 3 key principles are:

1. Supporting the Shropshire economy
2. Promoting wellbeing in Shropshire
3. Shropshire is a great place to live

1.5 Public sector commissioning bodies which operate in Shropshire (Shropshire Council, Shropshire CCG, Housing Associations, Police & Crime Commissioner, NHS Commissioning) can become a signatory to the Charter through adopting the Charter via their approvals processes. Businesses, parish & town councils and community groups can also sign up to the Charter. Shropshire Council's adoption of a Social Value Charter will require a Cabinet recommendation to Council.

1.6 By adopting the Social Value Charter Shropshire Council, the public sector commissioning bodies are committing to:

- Embedding Social Value in their commissioning strategies and plans
- Incorporating appropriate and proportionate Social Value requirements which reflect the Charter in their procurement, contracts and grants documentation
- Capturing data and intelligence which demonstrates the Social Value generated through their commissioning and procurement activity

1.7 Shropshire Council adopted the Social Value Charter on 23rd February 2017 and Shropshire CCG adopted the Charter on 15th February 2017.

2. Recommendations

2.1 That the Health and Wellbeing Board notes the implementation of the Social Value Charter for Shropshire.

REPORT

3. Risk Assessment and Opportunities Appraisal

3.1 Risk and Opportunities Assessment

3.1.1 An engagement exercise was carried out for a 12 week period between September and December 2016. The exercise was primarily aimed at key stakeholder groups including the Voluntary & Community Sector, business groups, parish & town councils and provider organisations.

3.1.2 Feedback from this exercise established that adoption of a Social Value Charter would help to improve social, economic and environmental outcomes for Shropshire. In addition, by adopting the measures suggested in Appendix 2, there will be better coordination of Social Value outcomes between the public sector bodies and a more coherent demonstration of value generated.

3.2 Human Rights

3.3.1 It is unlikely that there are any relevant Human Rights issues impacting this project.

3.3 Equalities

3.3.1 An Equality and Social Inclusion Impact Assessment (ESIIA) was developed alongside the engagement exercise and has now been finalised. The ESIIA has determined that there will be no negative impacts on any of the protected characteristics groupings and a medium positive impact on the social inclusion grouping. This is due to the Charter principles supporting, amongst others, initiatives to address social and rural isolation, contributions to community infrastructure and keeping people connected.

3.4 Communities

3.4.1 It is likely that the Social Value Charter will have a positive impact on Shropshire communities.

3.5 Environment

3.5.1 One of the 3 Social Value strands is around environmental benefits and it is likely that the Social Value Charter will have a positive impact in this area

4. Financial Implications

4.1 Organisations adopting the Charter will commit to the locally defined principle of supporting the Shropshire economy which includes support for the local supply chain, local jobs, skills development and inward investment. It is anticipated that there will be indirect

financial benefit to the local economy arising from adoption of the Charter, although this will be difficult to quantify.

5. Background

5.1The Public Services (Social Value) Act 2012 made it a legal requirement for any public body (councils [but not town or parish councils], Clinical Commissioning Groups, Police and Crime Commissioners, Housing Associations) to consider how it may improve social, economic and environmental outcomes in its area and how it might secure this through its procurement activity.

5.2 Social Value is a measure of additional benefits that can be generated for the local area through the way that the public sector commissions, and contractors deliver, services or works. For example a care provider may provide value through promoting care provision as a positive career choice in schools or colleges which in the longer term will assist with local recruitment to the sector; or a building contractor may commit to the creation of local employment and training opportunities and extend this into the supply chain; or an advice services provider may provide volunteering opportunities.

5.3 In Shropshire a Social Value Group was formed prior to the legislation going live in 2013 in order to consider a coordinated approach across the county's commissioners. The group is chaired by Cllr Lee Chapman and consists of representatives from:

- Shropshire Council
- Shropshire CCG
- NHS Midlands & Lancashire Commissioning Support Unit
- Office of the West Mercia Police & Crime Commissioner
- Shropshire Voluntary & Community Sector Assembly
- Housing via Severnside Housing
- Provider organisations via Shropshire Providers' Consortium

5.4 The Social Value Group developed a Social Value Commissioning and Procurement Framework in 2014. The framework is designed to guide Council officers and members on how to embed Social Value into the council's commissioning and procurement activity. The framework sets out what Social Value means to the council, how it can help us to deliver on our outcomes and priorities and how we will apply it in practice. In addition, the framework sets out how we will ensure, through our commissioning and procurement activity, that we achieve the greatest possible impact on behalf of Shropshire's residents. It identifies how customer outcomes are linked to the council's priorities and suggests measures, milestones or specific indicators by which Social Value can be demonstrated.

5.5 The Social Value Charter was developed from work undertaken with Social Enterprise UK and the Institute for Voluntary Action Research. The work identified the need for a common understanding of Social Value across the public sector partners, common outcomes and a need to raise the profile of Social Value more generally. Other local authority areas have implemented Social Value Charters as a way to achieve these aims.

6. Additional Information

6.1 The Social Value Charter will be launched on 9th March 2017. The launch of the Social Value Charter gives an opportunity to raise the profile of Social Value in Shropshire and there are some practical steps that will need to be taken. These will be:

1. Development of a Shropshire Social Value logo
2. Launching the Social Value Charter:
    a. media briefing (2nd March) – Lee Chapman
    b. press release and photo-opportunity on 9th March at a meeting of the Social Value Group

c. circulate through existing networks including SALC, VCSA, SPIC and other provider networks, Business Board, Cogs procurement group
d. intranet and internet, staff newsletter, members' briefing

3. Further development of the Social Value website on www.shropshire.gov.uk
4. Ability for organisations to 'sign-up' online through a simple registration process
5. A database of organisations which have signed up

6.2 In terms of embedding Social Value in commissioning practice the key will be to simplify and further embed Social Value thinking in commissioners' activity and to make information and resources available. Information is available to commissioners on Shropshire Council's intranet and external website and we will be developing a Social Value module on the new Learning Pool training resource. Reminders and updates will be issued periodically using the intranet and staff newsletter.

6.3 In addition to developing the commitments set out in the Charter, we have developed a set of measures to assist commissioners, initially for 'Supporting the Shropshire economy', which can be incorporated into contract and contract monitoring documentation where appropriate. This will allow us to start to build a profile of value created. Additional measures relating to the Charter commitments of 'Promoting wellbeing in Shropshire' and 'A great place to live' will be developed and added during 2017.

7. Conclusions

7.1 A Social Value Charter will provide a focus for improving social, economic and environmental outcomes for Shropshire residents and communities. Measures adopted to support the Charter aims will assist with demonstrating what, and how much, Social Value is generated as a result of procurement activity undertaken by all public sector bodies in Shropshire.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder)
Local Member
Appendices **See below Appendix A – A social value charter**

Appendix A

A Social Value Charter for Shropshire

The Social Value Charter for Shropshire sets out how public sector commissioners, service providers, voluntary, community & social enterprise organisations and businesses will aim to improve the social, economic and environmental wellbeing of Shropshire.

The Social Value Charter aims to clearly communicate the Social Value priorities for Shropshire and to create a framework within which commissioners, providers and other stakeholders will operate.

These principles have been developed by the Shropshire Social Value Group which consists of representatives from the Local Authority, Health, Police & Crime Commissioner's Office, Housing and the Voluntary & Community Sector.

The Charter is aligned to the Shropshire Council Social Value Commissioning & Procurement Framework, the Cogs Shropshire Procurement Charter and other related frameworks.

Charter signatories will commit to the Charter principles and must demonstrate either how they are currently delivering Social Value in accordance with these principles or how they plan to achieve compliance in accordance with a timetabled plan.

It is our long-term aspiration that future commissioning and contracting decisions made by signatory organisations will take full account of the principles of this Charter by being formally incorporated into new contracts and procurement policies.

Commissioners will:

- Embed Social Value in their commissioning strategies and plans
- Incorporate appropriate and proportionate Social Value requirements which reflect this Charter in their procurement, contracts and grants documentation
- Capture data and intelligence which demonstrates the Social Value generated through their commissioning and procurement activity

Contracted Providers will:

- Operate in a way which maximises the Social Value generated through their activities
- Provide clear evidence and data to commissioners which demonstrate the Social Value they generate through their contracted activities

Other Charter Signatories will:

- Operate in a way which maximises the Social Value generated through their activities

By signing up to this Charter signatories commit to the following principles, either by fully adopting the Charter at the time of signature or alternatively making a commitment to full adoption within a clear timetable.

The Charter principles are as follows:

1. Supporting the Shropshire economy:
    a. Supporting / purchasing from the local supply chain where possible
    b. Supporting or creating the conditions for growth in the Shropshire economy
    c. Developing education, skills and training opportunities within the Shropshire economy
    d. Employment opportunities for local people
    e. Good conditions of employment and fair wage rates and structures

2. Promoting wellbeing in Shropshire:
    a. Keeping people connected and maximising use of community infrastructure
    b. Initiatives to address social and rural isolation
    c. Supporting people and communities to be self-reliant, resilient, safe and mutually supportive
    d. Addressing the social, economic and environmental factors which contribute to poverty and inequality (prevention)
    e. Residents are involved in the design and delivery of integrated and accessible quality services

3. A great place to live:
    a. Support or contribution to community initiatives
    b. People are able to contribute through volunteering opportunities
    c. People have a good, decent and appropriate place to live
    d. People are proud to live in Shropshire and have a stake in their communities
    e. A green and sustainable county

Implementation of the Charter
Charter signatories will commit to supporting the three principles set out above. Measures to demonstrate how signatories to the Charter are delivering on their commitments will be implemented in stages linked to these three principles.

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

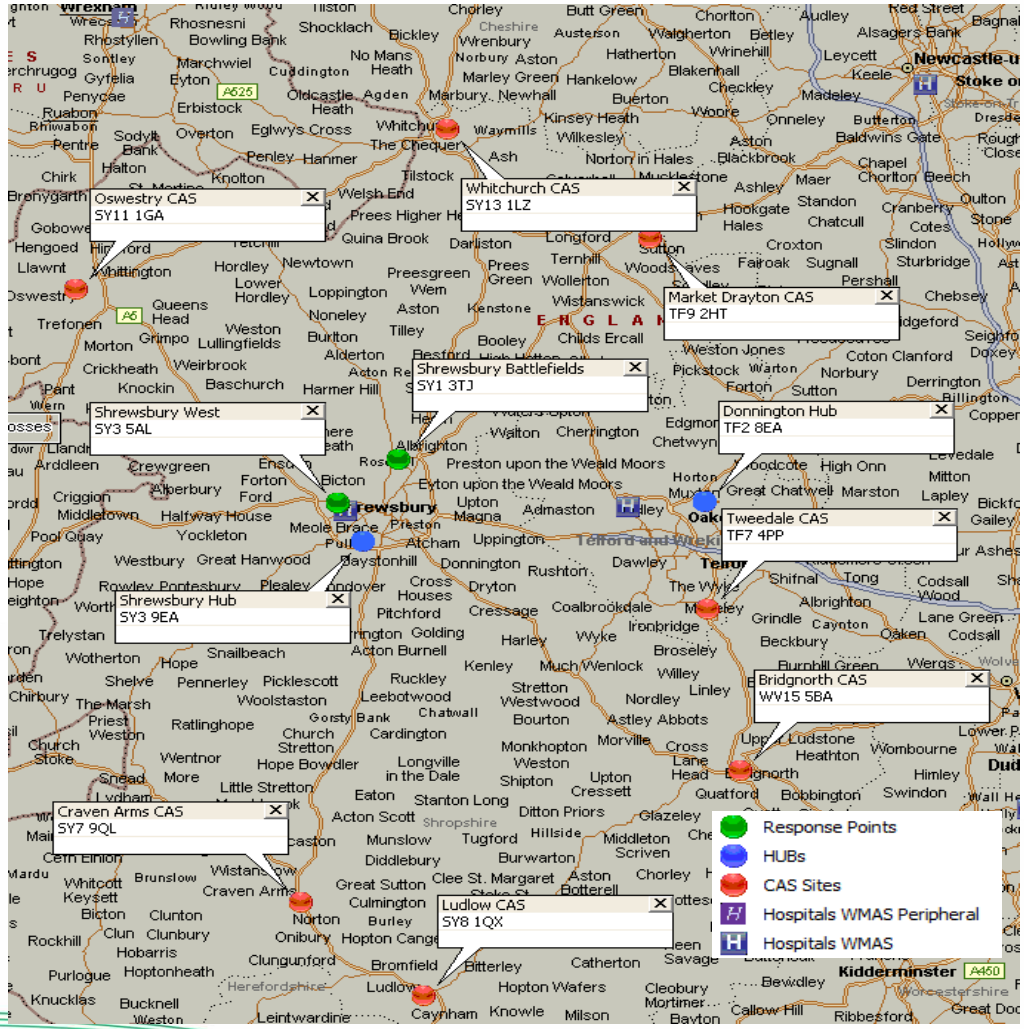
- Educate Trust clinicians and implement the *ReSPECT form in order to improve understanding and treatment of patients with specific careplans such as those people at the end of their life
- Work with partner agencies to provide improved care pathways for patients ie mental health, maternity and end 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 minutes
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

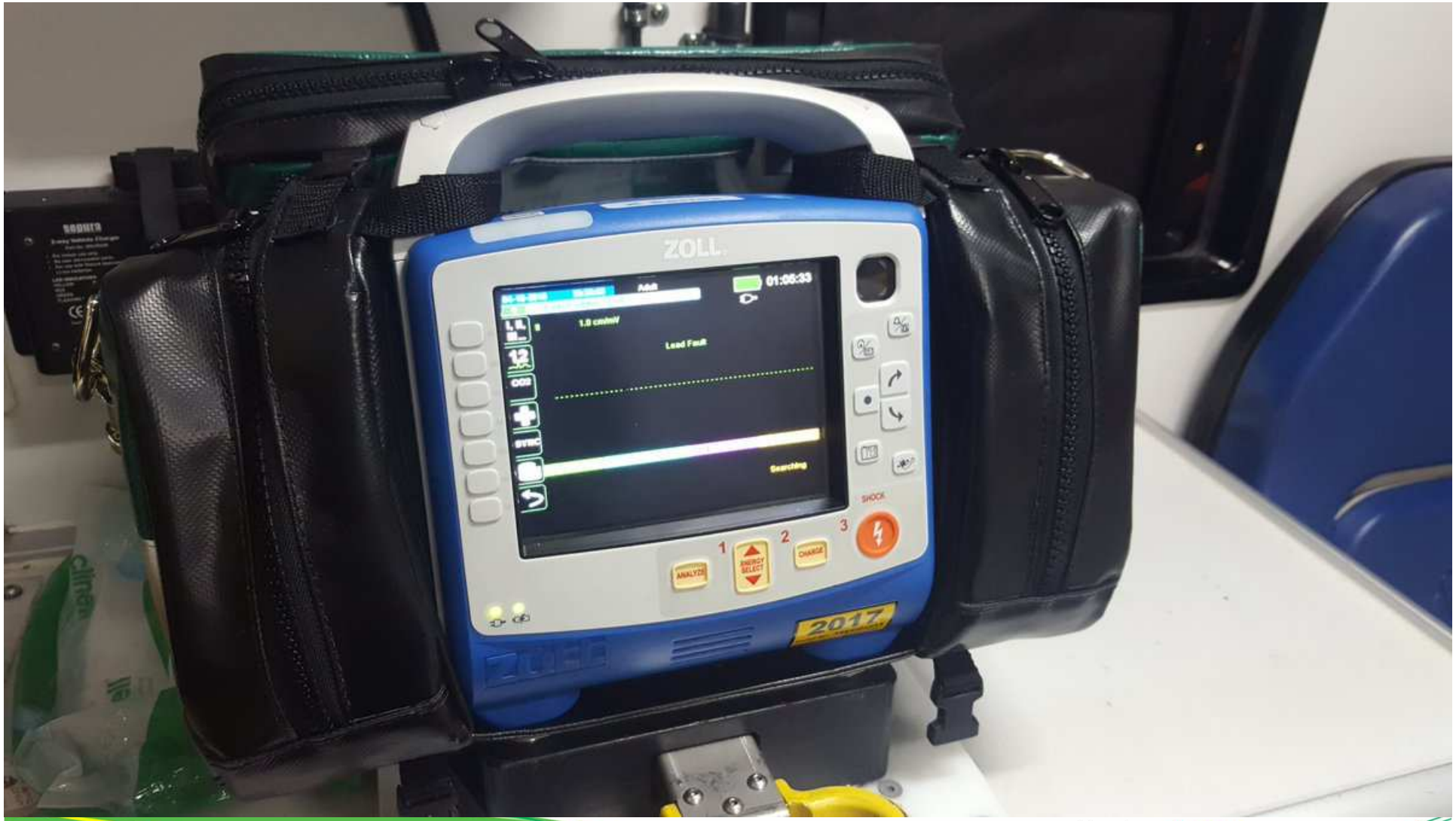
- Around 10% of activity

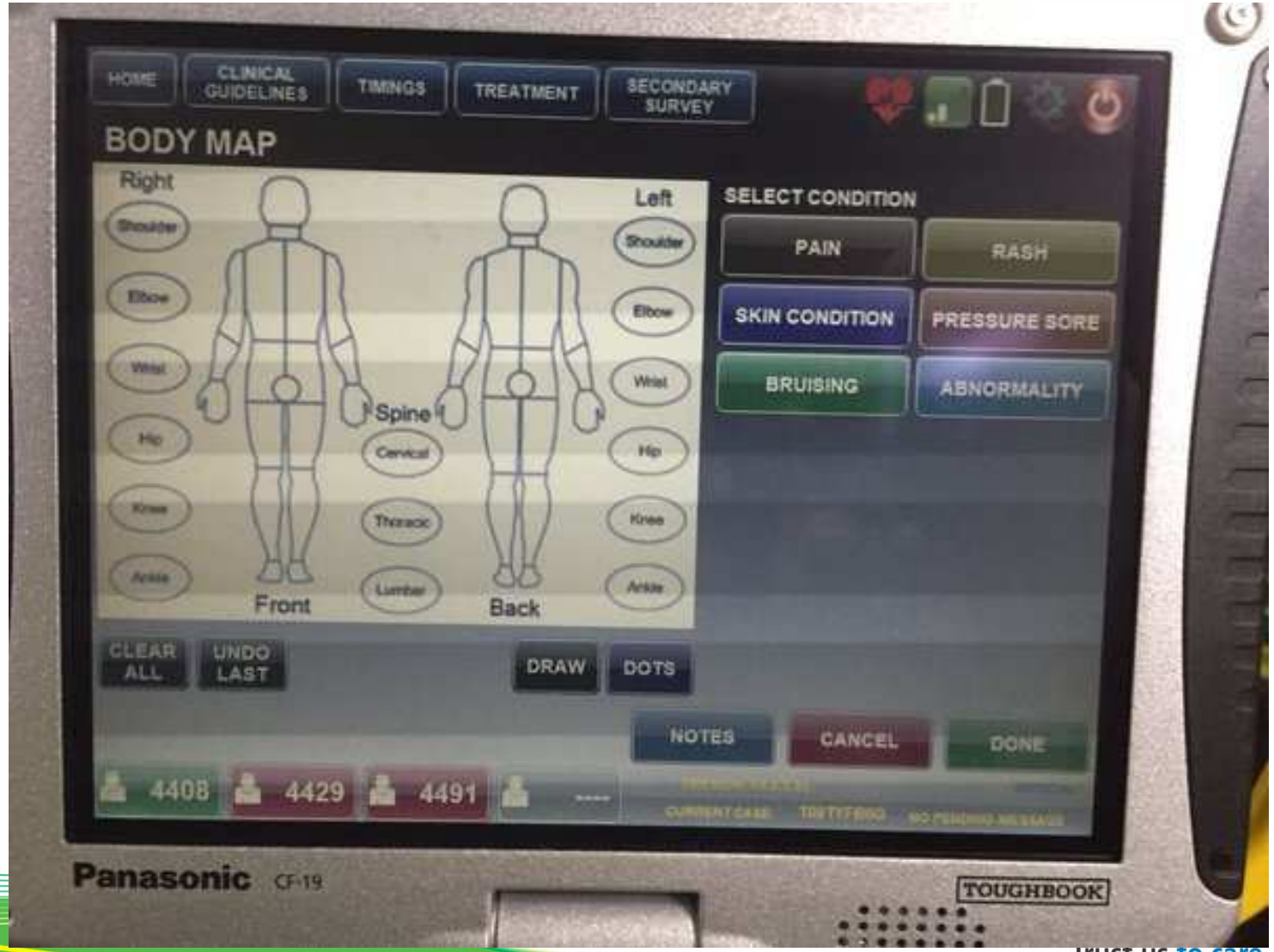
- Cat 4 T - Transport
- Cat 4 H – Hear and Treat

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
Lead Fault
Searching
ANALYZE
ENERGY SELECT
CHARGE
SHOCK
2017

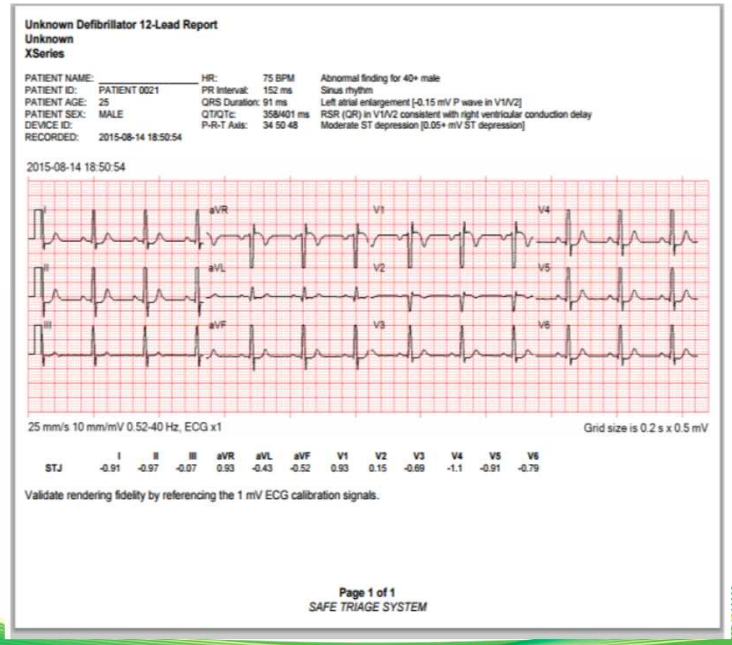

HOME
CLINICAL GUIDELINES
TIMINGS
TREATMENT
SECONDARY SURVEY
BODY MAP
Right
Left
Shoulder
Elbow
Wrist
Hip
Knee
Ankle
Spine
Cervical
Thoracic
Lumbar
Front
Back
SELECT CONDITION
PAIN
RASH
SKIN CONDITION
PRESSURE SORE
BRUISING
ABNORMALITY
CLEAR ALL
UNDO LAST
DRAW
DOTS
NOTES
CANCEL
DONE
4408
4429
4491
Panasonic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



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]	[redacted]	Male	88 years	Illness-?stroke symptoms	STROKE / TIA			✗	✗	GO		
	1 Minutes		KQBG	Female	82 years	Chest Pain Cardiac Upper Back Pb	OTHER: CHEST PAIN			✓	✗	GO		
	7 Minutes		KQBG	Female	85 years	Illness-hip and knee pain				✗	✓	GO		
	11 Minutes		JQBG	Female	12 years	Trauma	DISLOCATION KNEE			✓	✗	GO		
	12 Minutes		KQBG	Female	73 years	Illness-?pe sob	PLEURITIC CHEST PAIN,PULMONARY EMBOLISM			✓	✓	GO		
	23 Minutes		JQBG	Male	84 years	Illness-chest and upper back pain - pacemaker fitted 3/4 wk ago				✓	✓	GO		
	32 Minutes		JQBG	Female	28 years	Fitting	CONVULSION,EPILEPSY			✗	✓	GO		
	44 Minutes		JQBG	Female	87 years	Illness-? fit - now stopped	CONVULSION			✓	✓	GO		
	44 Minutes		JQBG	Female	89 years	Illness-abnormal ecg, bradicardic & dizzy				✓	✓	GO		
	49 Minutes		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