

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

Date: 24 October 2018

Committee:
Health and Wellbeing Board

Date: Thursday, 1 November 2018
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

Lee Chapman – PFH Health and Adult Social Care (Co-Chair)
Nicholas Bardsley – PFH Children's Services and Education
Lezley Picton – PFH Culture & Leisure

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 (Co-Chair)
Dr Julie Davies – Director of Performance & Delivery

Rachael Allen – Shropshire Healthwatch
Jackie Jeffrey – 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

Peter Loose – Chairman, Shropshire Partners in Care (Chief Executive, Bethphage)

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

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

Your Committee Officer is: **Michelle Dulson** Committee Officer

Tel: 01743 257719 Email: michelle.dulson@shropshire.gov.uk

AGENDA

1 Apologies for Absence and Substitutions

To receive apologies for absence and any substitutions notified to the clerk before the meeting.

2 Disclosable Pecuniary Interests

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

3 Minutes (Pages 1 - 6)

To confirm as a correct record the minutes of the meeting held on 13 September 2018.

Contact: Michelle Dulson Tel 01743 257719.

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 (Pages 7 - 90)

Regular update reports to the Health and Wellbeing Board are attached:

- i. The Sustainability and Transformation Plan for Shropshire, Telford & Wrekin
A report is attached.

- ii. Future Fit
A report is attached.

Contact: Phil Evans, STP Director, Telford and Wrekin CCG

- iii. Shropshire Care Closer to Home
A report is attached.

Contact: Lisa Wickes, Head of Out of Hospital Commissioning and Redesign, Shropshire CCG

6 Better Care Fund Performance (Pages 91 - 110)

A report is attached.

Contact: Penny Bason, Shropshire Council / Shropshire STP

7 Transforming Care Partnerships

A report is to follow.

Contact: Di Beasley, Telford and Wrekin CCG

8 0-25 years Emotional Health and Wellbeing Service (Pages 111 - 114)

A report is attached.

Contact: Lisa Wickes, Head of Out of Hospital Commissioning and Redesign, Shropshire CCG

9 Healthy Lives Update (Pages 115 - 124)

i. Health Lives Update

A report is attached for information.

Contact: Val Cross

ii. Social Prescribing update

A report is attached and a presentation will be given.

Contact: Jo Robins

10 Wellbeing and Independence Contract (Pages 125 - 164)

A report is attached.

Contact: Michelle Davies, Adult Social Care / Kate Garner, Shropshire Council

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Committee and Date

Health and Wellbeing Board

1st November 2018

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 13 SEPTEMBER 2018 9.30 - 11.23 AM

Responsible Officer: Shelley Davies

Email: michelle.dulson@shropshire.gov.uk Tel: 01743 257718

Present

Councillor Lee Chapman (Chairman)	PFH Health and Adult Social Care
Professor Rod Thomson	Director of Public Health
Councillor Lezley Picton	PFH Culture and Leisure
Councillor Nicholas Bardsley	PFH Children's Services and Education
Andy Begley	Director of Adult Services
Dr Julie Davies	Director of Performance and Delivery, Shropshire CCG
Lisa Wicks (substitute for Julian Povey)	Shropshire CCG
Ros Preen	Shropshire Community Health Trust
David Coull	Chairman, Shropshire Partners in Care (Chief Executive Coverage Care Services)
Mandy Thorn	Business Board Chair (Managing Director Marches Care)
Cathy Riley	Managing Director Shropshire Care Group, MPFT

Also in attendance:

Val Cross, Penny Bason, Phil Evans, Becky Jones, Ann-Marie Speake, Laura Fisher, James Warman, Rachael Allen, Chris Westwood, Councillor Madge Shingleton, Councillor Karen Calder.

29 Apologies for Absence and Substitutions

The following apologies were reported to the meeting by the Chair

Karen Bradshaw	Director of Children's Services
Sarah Hollinshead-Bland	Service Manager, Adult Safeguarding, Shropshire Council
Neil Nisbet	Finance Director and Deputy Chief Executive, SaTH
Nicola McPherson	VCSA

30 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.

31 Minutes

RESOLVED:

That the Minutes of the meeting held on 8 March 2018, be approved and signed by the Chairman as a correct record subject to the following amendments:

- Cathy Riley – Managing Director Shropshire Care Group, MPFT to be added to the list of those present; and
- Neil Carr - Chief Executive, SSSFT to be removed from the list of those present

32 Public Question Time

A public question was received from Mr John Bickerton, local resident in relation to the Community Enablement Team (copy attached to the signed Minutes). In response, the Director of Public Health confirmed that the budget for the Community Enablement Team had been secured to March 2019 and advised that a full response on the matter would be provided in writing to Mr Bickerton.

A public question was received from Nicola McPherson, Chief Officer, Mayfair Community Centre in relation to the recently published Civil Society Strategy (copy attached to the signed Minutes). The following response was provided by Dr Julie Davies, Shropshire CCG:

Shropshire CCG and Local Authority are working together to ensure the requirements within the recently published Civil Societies Strategy are reviewed in line with the existing Compact, to ensure there the Shropshire Compact is aligned.

The CCG and LA have consolidated the grant funding through the Better Care Fund in 2018-19, this was to ensure the Voluntary Sector organisations were integrated into the provider process.

The Better Care Fund has been a key opportunity for Voluntary and Third Sector providers, which has been incredibly well received. Shropshire Local Authority and CCG will be reviewing how engagement with the Voluntary Sector is managed going forward, particularly in response to the need and voices of Shropshire residents.

Gail Fortes-Mayer (gail.fortesmayer@nhs.net) will be the CCG contact in relation to this matter.

33 System Update

33i The Sustainability and Transformation Plan for Shropshire, Telford & Wrekin

Phil Evans, STP Director introduced the STP Programme update (copy attached to the signed Minutes). He noted that further information on two elements of the STP would be discussed further under separate agenda items and reported that interviews for the new Chairman would take place on 26 September 2018.

The STP Director referred to the Integrated Care System Development Programme offered by NHS England. The Chairman referred to similar programmes that had failed due to lack of drive to pull together and queried why this programme would be different. In response the STP Director explained that 20 STPs were involved in this programme, therefore the output would be better and added that the new independent Chair was a key element of the programme.

33ii Future Fit

Phil Evans, STP Director introduced the Future Fit update (copy attached to the signed Minutes). The STP Director informed the Board that the consultation had finished on 11th September 2018 he noted that there had been a very high volume of responses received and outlined the timescale for the next phase of the programme.

The STP Director drew attention to the RAG rated delivery dashboard and reported that all aspects were on target apart from the Equalities Impact Assessment and Travel and Transport (Ambulance Services) but assured the Board that both of these reports were on track.

In response to a question, the STP Director confirmed that the high response rate to the consultation had been anticipated and there was sufficient resources available to carry out analysis of the responses.

33iii Shropshire Care Closer to Home

Lisa Wickes, Head of Out of Hospital Commissioning & Redesign introduced the Shropshire Care Closer to Home update (copy attached to the signed Minutes). She referred to the stakeholder Event held in July which was well attended and noted that similar events were planned in future phases.

It was reported that a dedicated website accessible to all had now been set up. The design of Phase 2 had been presented to the Clinical Commissioning Committee on 15 August 2018 and added that there had been a slight delay by approximately 1 month in the timeline of Phase 3.

In response to a query regarding the IT Task & Finish Group to be set up to explore the IT and data infrastructure required to support the programme, the Head of Out of Hospital Commissioning & Redesign noted that Shropshire Council IT team had been asked to be involved in the group and she would welcome input from the independent sector.

In response to a question regarding the delay in Phase 3, the Head of Out of Hospital Commissioning & Redesign stated that the delay was around the demonstrator sites and noted that as the various consultations fed into the programme there was no clear timeline at present but it was hoped that a more defined timeline would be available by the next meeting.

RESOLVED: That the updates be noted.

34 Report from the HWB Joint Commissioning Group

Better Care Fund Update & Performance

Penny Bason, STP Programme Manager introduced her report (copy attached to the signed Minutes) which provided an update on the progress on the Better Care Fund (BCF) and the section 75 Partnership Agreement and outlined the following recommendations: to note the final Partnership Agreement, to approve the BCF Planning Template and BCF Annex and to note Q1 return.

The STP Programme Manager explained that the Partnership Agreement was due to be considered at the CCG Committee on 19 September 2018 following approval from the Joint Commissioning Group and being signed off by Shropshire Council. Members' attention was drawn to the quarter 1 returns set out at Appendix D of the report and it was noted that performance continued to be good.

The Chairman raised concern regarding the lack of progress in relation to the section 75 Agreement and highlighted the difficult position this presented for the Board. In response to these concerns Dr Julie Davies, CCG reported that she was not aware of any issues and was confident that the agreement would be signed at the Committee meeting on 19 September 2018. The Chairman stated that despite these assurances he was not comfortable approving the BCF Planning Template and BCF Annex in the absence of a legally signed agreement and therefore suggested that if all were agreed he would confirm approval remotely subject to confirmation that the Section 75 Legal agreement had been signed at the Clinical Commissioning Committee meeting on 19 September 2018.

RESOLVED:

- a) That the final Partnership Agreement be noted;
- b) That the Chairman be granted delegated powers to approve the BCF Planning Template and BCF Annex remotely subject to confirmation that the Section 75 Legal agreement had been signed at the Clinical Commissioning Committee meeting on 19 September 2018; and
- c) That the Q1 return be noted.

35 STP Estates update

Becky Jones, Strategic Estate Advisor gave a presentation on Shropshire, Telford and Wrekin – a community focused estates approach (copy attached to the signed Minutes). She informed the Board that the estates has the possibility to change lives through transforming the way we approach services delivery and noted that her role was to provide independent advice on how to use estates better for the community now and in the future.

The Strategic Estate Advisor explained that the approach was based on the 'Northfield Principles' and detailed the Health Village project in Staffordshire. She explained that Whitchurch had been identified for a similar project and there were also possible opportunities being discussed in Telford.

In response to a question in relation to the difference regarding the distribution of population in Shropshire compared to Staffordshire, the Strategic Estate Advisor agreed

that all areas were different and therefore each project would be bespoke and confirmed that all organisations would be involved including social care providers.

RESOLVED: That the update be noted.

36 Transforming Care Partnership (TCP) update

RESOLVED: Report deferred to the next meeting of the Health and Wellbeing Board.

37 Food Poverty Alliance - Action Plan

Chris Westwood, Service Delivery and Improvement Manager introduced his report on Food Poverty in Shropshire (copy attached to the signed minutes). Outlined work done by the Shropshire Food Poverty Alliance to develop a Food Poverty Action Plan for Shropshire to reduce the risk of families in Shropshire experiencing food poverty and added that this would be reported to a future meeting.

The Chairman stated that the report made for difficult reading and thanked the Service Delivery and Improvement Manager for the report noting that he was happy for a representative from the Board to attend Food Poverty Alliance meetings.

RESOLVED: That the report be noted.

Councillor Nick Bardsley joined the meeting at this point.

38 Technology Enabled Care Projects

James Warman, Assistive Technology & Telecare Co-ordinator introduced his report on Technology Enabled Care Projects (copy attached to the signed minutes). The Assistive Technology & Telecare Co-ordinator explained that the Housing Team were undertaking a series of Technology Enabled Care Projects to explore how different delivery models for existing telecare provision as well as seeing how the latest consumer technology can be used or repurposed as Technology Enabled Care.

The Assistive Technology & Telecare Co-ordinator outlined the three projects currently underway as detailed in the report:

- Hospital Discharge Telecare Pilot;
- The Broseley Project; and
- Beech Gardens Step-Down Beds.

In response to a question from Councillor Madge Shineton regarding areas that do not have internet access, the Assistive Technology & Telecare Co-ordinator explained that this was the first phase of projects such as one in the Broseley and later phases will look at issues such as internet access and 'not spots'.

RESOLVED: That the report be noted.

The Chairman announced that this would be the last meeting David Coull would attend as he was standing down as Chairman of SPIC at their next AGM. He thanked David for his considerable contribution to the Board and wished him well for the future.



Shropshire, Telford & Wrekin STP

Sustainability and Transformation Plan

Footprint Name and Number:
Shropshire and Telford & Wrekin (11)

Region:
Shropshire and Telford & Wrekin



STP Directors Update
Oct Draft 2018



Our vision for health and care services in Shropshire, Telford & Wrekin

<https://www.england.nhs.uk/systemchange/view-stps/shropshire-and-telford-and-wrekin/>

Priorities

- Focusing on neighbourhoods to prevent ill health and promoting the support that local communities offer to help people lead healthier lives and encourage them to care for themselves where appropriate.
- Multi-disciplinary neighbourhood care teams working closer together supporting local people with long-term health conditions, and those who have had a hospital stay and return home needing further care.
- Ensuring all community services are safe, accessible and provide the most appropriate care.
- Redesigning urgent and emergency care, creating two vibrant 'centres of excellence' to meet the needs of local people, including integrated working and primary care models.
- Making the best use of technology to avoid people having to travel large distances where possible – especially important to people living in the most rural communities in Shropshire and Powys.
- Involving local people in shaping their health and care services for the future.
- Supporting those who deliver health and social care in Shropshire, Telford and Wrekin, developing the right workforce, in the right place with the right skills and providing them with local opportunities for the future.

STP Development Programme



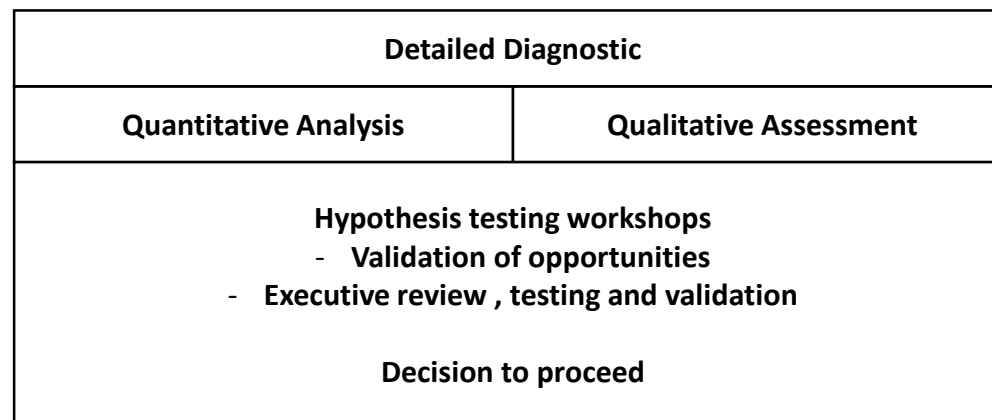


Facilitated offers delivered over a condensed time period:

- System Opportunity Diagnostic programme
 - Hypothesis testing, Validation and priority setting
 - Identification of transformation programmes and priorities
 - Qualitative self assessment
- System support (Facilitated learning events)
 - Leadership
 - Provider alliance
 - Structural architecture
- Development of ICS
 - ICS roadmap
 - Meeting the requirement of the ICS MOU



Launch Event & Mobilisation



Diagnosis and
design phase

(weeks)



Transformation Programmes

- Planning for mobilisation
- Define support, structure & budgets
- Engagement and communication

Delivery and Support

- Programme management and expert PMO
- Access to subject matter expertise
- Best Practice
- Monthly gateway reviews

System Capacity Building

- Supporting development of leadership capacity and capability
- Facilitated workshops
- Action learning sets
- Development of appropriate financial strategies
- Governance and decision making

Transformation
delivery and
improvement
phase
(weeks)



- NHSE has coordinated the production of a quantitative deep dive of all key analytical data and matrix:
 - Right Care (2017/18)
 - Model Hospital Programme
 - Getting it Right First Time (GIRFT)
 - Benchmarking from Social Care
 - Benchmarking from CHC
- It is acknowledged that for Shropshire CCG some of this analysis is available in its Optimity Report.
- Co-produced with NHSI, the information will be collated into a Hypothesis pack for Shropshire - mid September 2018
- Ambition is to support the identify any quick wins and to fully inform the production of an agreed set of transformation priorities.



- NHSE will co ordinate a qualitative self assessment exercise, the scope of which will be informed by the STP.
- Assessment will utilise the key concepts of the Integrated Care System (ICS) maturity index designed to provide a self assessment and anonymised baseline for the health system
- Approach:
 - Structured interviews around the core capabilities of: leadership and governance, readiness and commitment to operate as a single system, financial management, current performance, delivery and impact across the system.
 - Understanding the barriers to system development
- Output to shape the system **capacity support programme**



Diagnostic Review:

- Designed to support the system to identify opportunities available to the system
- Undertaken through both quantitative and qualitative analysis
- Quantitative data and information analysis output a report that seeks to quantify the identified opportunities.
- Qualitative diagnostic – self assessment to shape development programme

Facilitated Workshops – delivered over a number of sessions:

- To discuss data, information and evidence base
- Generate and test hypothesis
- Focused output on quantification of opportunities and next steps.
- Planning for delivery and system support
- Gateway signoff



Facilitated Programme Support / Action Learning Sets

- Support to executive leadership across the system
- Readiness and commitment to operate as a system across all partners
- Financial strategy and programme delivery
- Progressing the ICS – roadmap
- Meeting the requirements of the ICS MOU

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Transformation priority programmes

- Intensive review and detailed shaping of selected priority programmes
- Gateway signoff



The offer:

- North Midland DCO have agreement with National Team to access:
 - External support and subject matter exercise
 - Length of high impact delivery 3-6 months
 - Expert facilitation of programme and workshops
- Transitional support to move to sustainable business as usual at approximately 3 months
- Delivery team shared across multiple high impact areas
- ICS programme facilitation (Jointly funded)



- NHSE/I project team to meet weekly
 - Facilitator/alliance
 - Project manager
 - Locality Director/leads

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Steering group to meet 2 weekly

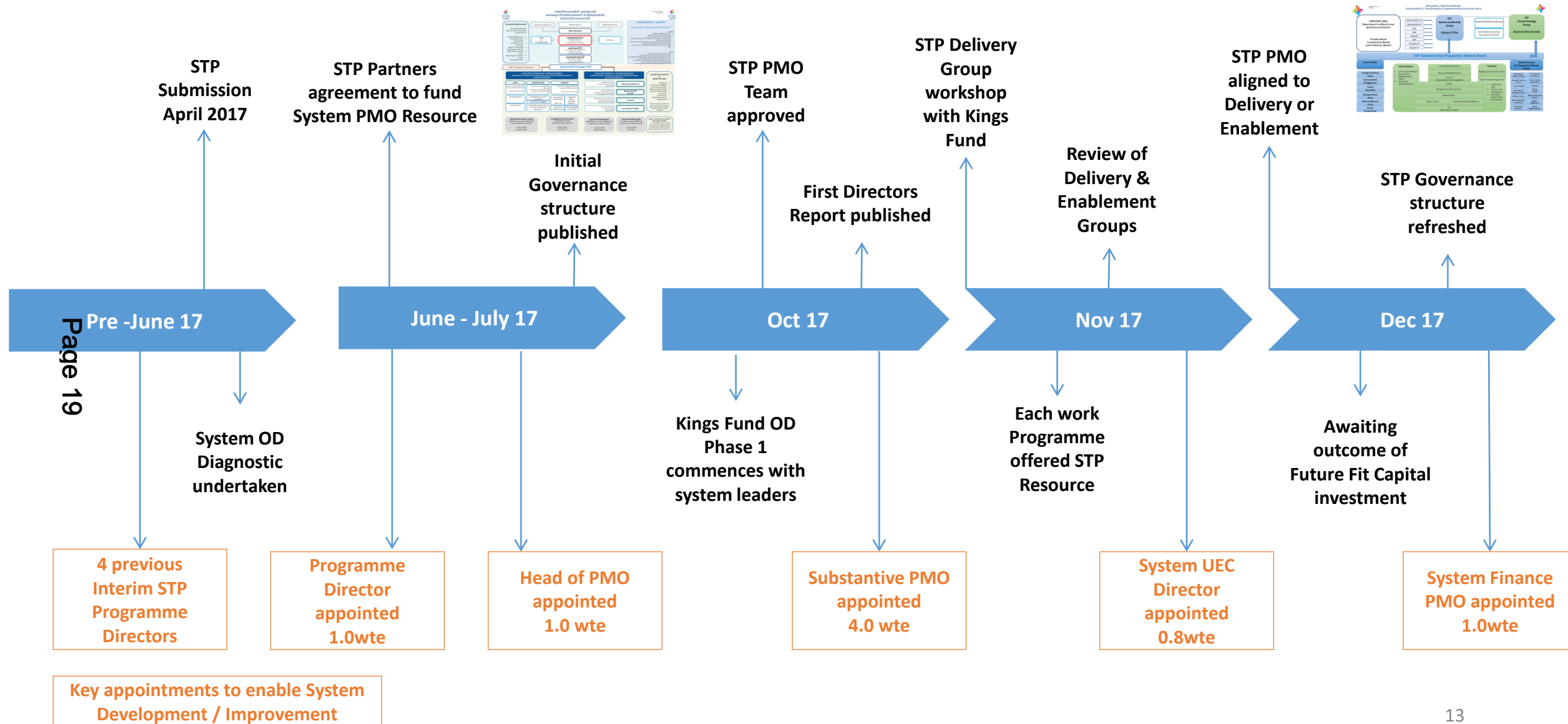
- STP leads
- Alliance lead
- Project manager
- Expert advisors/regional support



- Work through the ICS 12 week Development Programme (start date to coincide with new STP Chair appointment)
- Develop Shropshire, Telford & Wrekin ICS Roadmap
 - Clear system Governance and programme management support
 - Aligned to system priorities
 - Further develop System Strategic Commissioning
 - Identify System Redesign Requirements
 - Clinically Led, building on the work of the STP Clinical Strategy Group
 - Understand **WHAT** enablement requirements are needed and **HOW** they will be delivered and by **WHEN**
 - Financial alignment
 - Estates
 - Digital
 - Workforce
 - Back Office functions
 - Be clear how as a system we will continually improve and sustain those improvements



Timeline of key STP activities June 17 – Dec 17

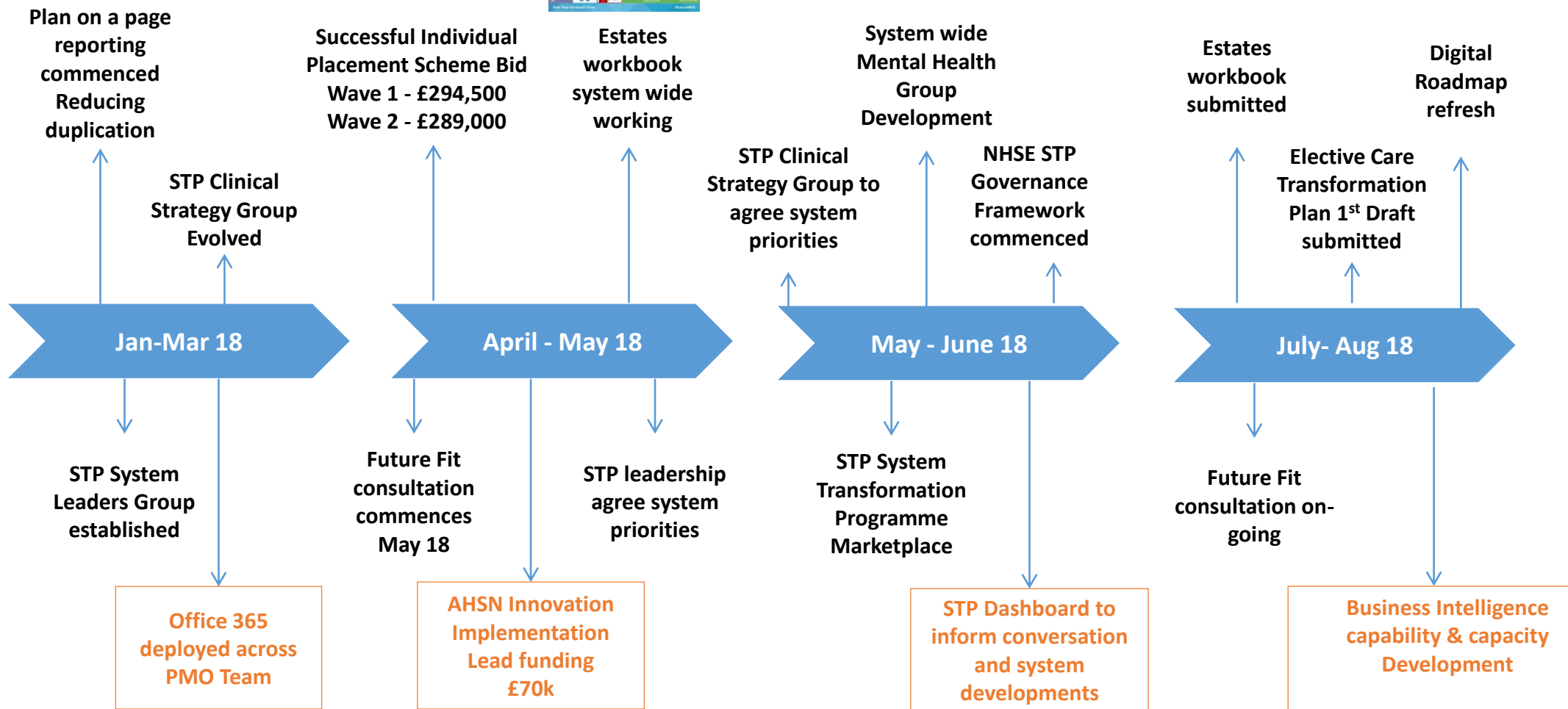




Timeline of key STP activities Jan 18 – Aug 18



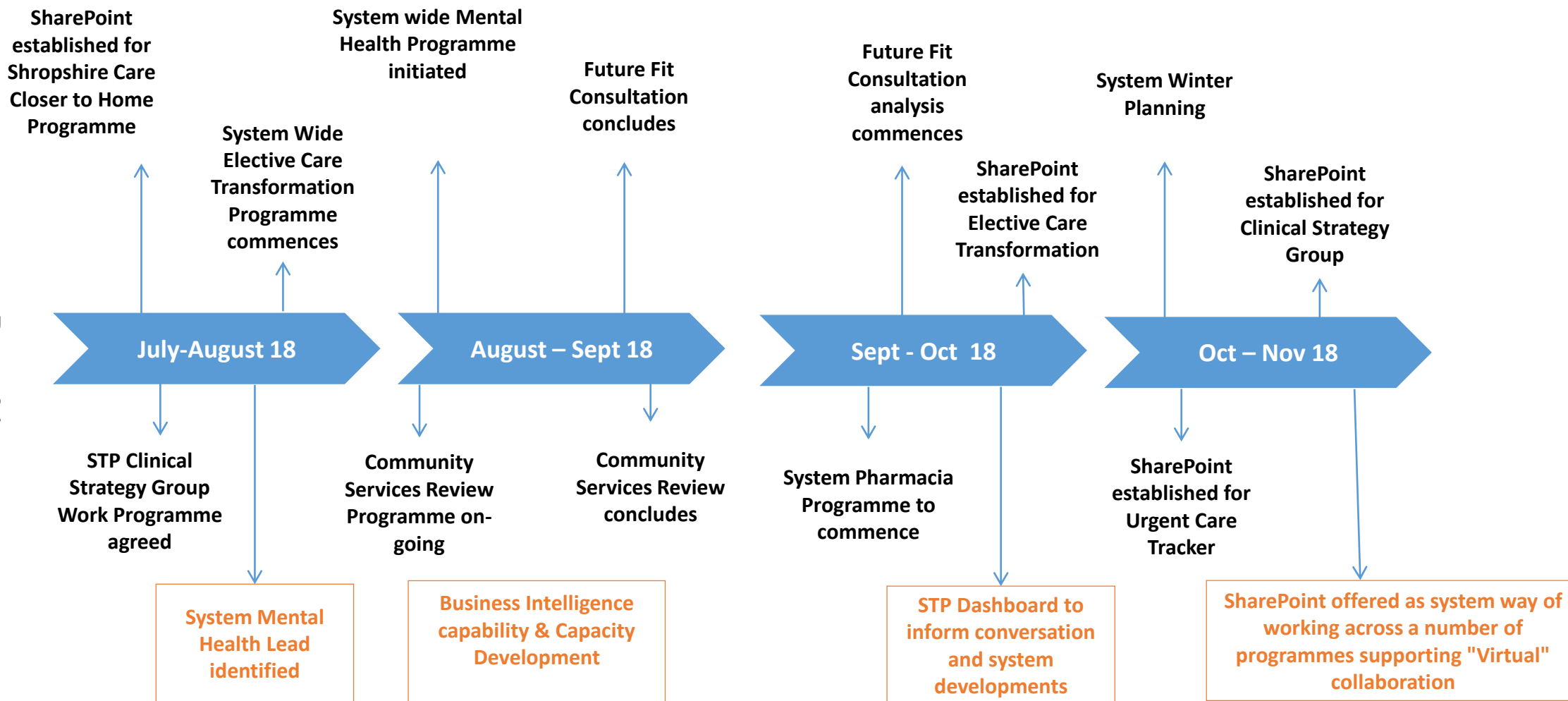
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Timeline of key STP activities July 18 – Aug 18

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Shaping STP System Thinking

- STP Review meetings with NHSE & I
 - Last review meeting was 6th Sept, we continue to be “Level 3” – making progress
- System wide working gaining momentum – next slide shows system wide groups
 - STP Leadership Group – Integrated Care System / Partnership developments
 - Clinical Strategy Group – meeting bi-monthly and work programme developing around STP Priority areas
 - Mental Health Group – just being establish
 - Elective Care Transformation – established and work programme drafted
 - Digital Enablement – Roadmap and work programme being reviewed
 - Population Health & Prevention – being established, system leads identified
 - Urgent Care, Frailty, Winter Planning – established and work programme underway
 - System wide Estates – submission completed
 - System Wide Pharmacia – draft formed and work programme being developed
 - Strategic Workforce Partnership working for our system transformation
 - Strategic planning
 - Organisational development
 - Education & training
 - Secondary Care reconfiguration (Future Fit) – consultation ongoing
 - Shropshire Community Services Review – work programme with GE Finnemore / Neil McKay
 - Out of Hospital Programmes
 - Shropshire Care Closer to Home
 - Telford & Wrekin Neighbourhood working



System Wide Working

Strategic Development & Leadership

Recruitment of independent STP Chair
STP System Leaders Group
Local Workforce Action Board (LWAB)
STP Clinical Strategy Group
Health & Well-being Boards
Community Services review work programme
System Communication & Engagement
System wide consultation and feedback through existing mechanisms

Strategic Enablement

Strategic Estates Group
Strategic Back Office
Digital Enablement Group
Strategic Workforce Planning

Strategic System Finances

System population health & prevention

System Business Intelligence

Strategic Delivery of change

Hospital reconfiguration (Future Fit)

Urgent & Emergency Care

Winter Planning

High Impact Changes

Frailty

IUC / 111

Out of Hospital Care Delivery

Shropshire Care Closer to Home

Telford & Wrekin Neighbourhoods

Primary Care Transformation

Mental Health Transformation

Cancer & End of Life

Elective Care Transformation – 8 workstreams identified

1. Procedures of Limited Clin Value
2. MSK
3. Ophthalmology
4. Diabetes
5. MRI
6. Out-Patients
7. Neurology
8. Dermatology

Pharmacia Programme

Local Maternity Services



Performance & Transformation Reporting Requirements

- 132 Deliverables categorised as:
 - **47 Operational deliverables**
 - Established indicators
 - Automated Data Collection through Statutory reporting (previously UNIFY)
 - **85 Transformation deliverables**
 - Mix of quantitative and qualitative standards
 - Data sources not established for all quantitative standards
 - Non statutory/local reporting required for some
 - Being built into FYFV Dashboard as data sources are identified
 - **Monthly reporting on ALL 85**

Note:

These requests come through a variety of routes and land in different parts of the system, all with different deadlines and requirements using a mix of templates that are continually being revised



Shropshire, Telford & Wrekin STP

Performance and Transformation overview

FYFV Programme	Constitutional Standards 18/19	RAG
Urgent and emergency Care	A&E 4 hour standard	Red
	DTOC	Green
	Ambulance	Green
	NHS 111	Green
Elective Care	RTT 18 week	Yellow
	52 week waits	Red
	Diagnostics	Green
	Wheelchair access	Red
Cancer	Cancer Waits	Yellow
Mental Health	IAPT Access	Green
	IAPT Recovery	Green
	Dementia Diagnosis	Green

FYFV Programme	85 Assurance Statements 18/19	RAG
Urgent and emergency Care	NHS 111 x 3	Green
	Ambulance x 3	Yellow
	Hospital to Home x 2	Green
	Hospitals x5	Yellow
	Technology x 8	Green
Elective Care	Avoidable demand x 4	Green
	Ophthalmology x 3	Green
Cancer	National Priorities x 10	Yellow
Mental Health	CYP x 2	Green
	CRHT x 2	Green
	OAP x 1	Green
	Liaison x 3	Green
	SMI x 1	Red
	Perinatal x 1	Green
	Suicide prevention x 2	Green
	IPS x 1	Green
	DQ x 1	Green
	Parity of esteem x 1	Green
	IAPT expansion x 1	Green
	EIP x 1	Green
	Dementia x 1	Green
	Workforce x 4	Green

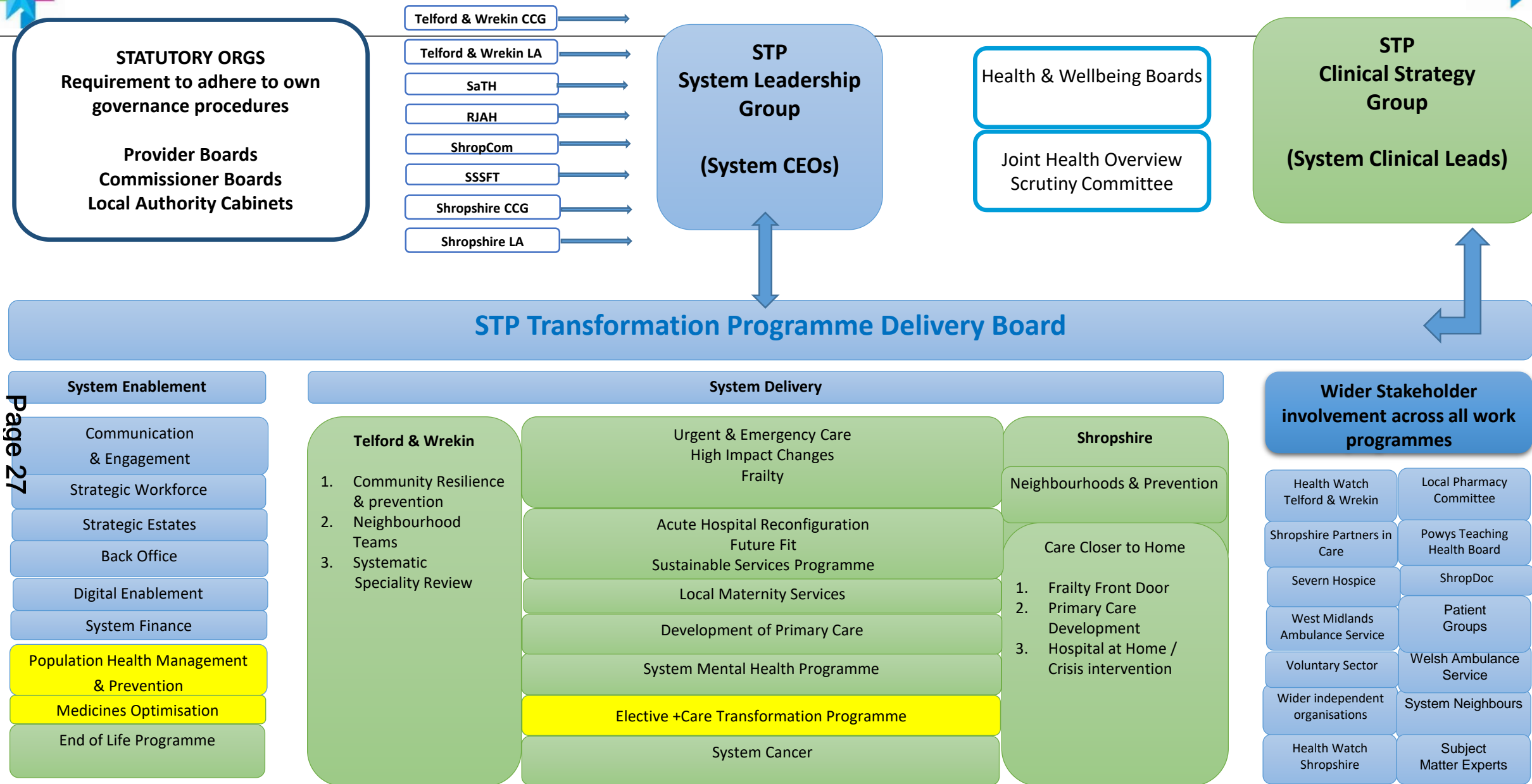
85 Assurance Statements 18/19	RAG
CHC x 3	Green
Maternity x 5	Green
Primary Care x 14	Green
7 day services x 1	Red
Transforming Care x 2	Green





Shropshire, Telford and Wrekin Sustainability & Transformation Programme Governance Structure

Draft – tba - changes





STP PMO Team

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Name	Role & capacity available	Key area's of responsibility / support
Phil Evans	Programme Director 1.0 wte	STP Leadership Group, system board meetings, external stakeholders, ICS development Oversight of Programme, escalation to STP System Leadership, strategic system developments
Joanne Harding	Head of PMO 1.0 wte	Clinical Strategy Group, End of Life Group, System Medicine Optimisation, workload allocation, system collaboration, system papers and overview, STP Dashboard development, SharePoint Admin Links to National STP/ICS Development, Transformation Programme Delivery Group
Jayne Knott	Senior Project Admin 1.0 wte	Support to STP Programme Director, UEC Programme Director, system meetings, point of contact for the PMO
Andrea Webster	Programme Manager 1.0 wte	Future Fit, Care Closer to Home, Telford Neighbourhoods Travel & Transport, support for Future Fit Consultation working with FF Programme Director
Rob Gray	Programme Manager 1.0 wte	Digital Enabling Group and sub-groups, link to all delivery workstreams from a digital perspective. HSLI and Local Digital Roadmap, system digital developments, SharePoint Admin
Penny Bason	Programme Manager 1.0 wte	Population Health, Better Care Fund
Paul Gilmore	Programme Manager 1.0 wte	STP Strategic Finance Group. Link to all delivery programmes from a finance perspective to support system financial understanding and modelling
Pam Schreier	Comms & Engagement 1.0 wte	STP comms and engagement, Future Fit consultation and wider STP Comms
Sara Edwards	Programme Manager 0.8 wte	Strategic Workforce Group, Primary Care Training Hub, link to delivery programmes from a workforce enabling perspective, inc Cancer & Mental Health, working alongside HEE
Maggie Durrant	Programme Manager 0.6 wte	Urgent Emergency Care - working with UEC Programme Director, system NHSE UEC Submissions Estates & Back office enabling groups
Jill Barker	Programme Manager 0.6 wte	Elective Care Transformation Programme, linking with CCG leads, preparing system readiness for NHSE Submissions and sign off IV Therapies & Therapy Services



Delivery Programmes	Exec Lead Clinical Lead Programme Director (where applicable)	Programme Key People	Clinical Lead Where appropriate	STP PMO Link to Programme Enablement
Urgent & Emergency Care	Julie Davies Claire Old			Maggie Durrant
Frailty	Fran Beck	Emma Pyrah Michael Bennett	Dr Jo Leahy	Penny Bason
Future Fit	Debbie Vogler	Pam Schreier		Andrea Webster
Local Maternity Services	Chris Morris	Fiona Ellis Helen White		
Primary Care	Nicky Wilde Rebecca Thornley	Phil Morgan	Dr Jo Leahy Dr Julian Povey	
Mental Health	Fran Beck	Frances Sutherland Steve Trenchard	Prof Tony Elliot	Sara Edwards
Elective Care	Julie Davies	Bethan Emberton Angie Parkes	Ophthalmology – Claire Roberts MSK -	Jill Barker
System Cancer	Gail Fortes-Myers	Sharon Clennell David Whiting	Dr Andy Inglis	Sara Edwards
Telford & Wrekin Neighbourhoods	Fran Beck	Anna Hammond Ruth Emery	Dr Jo Leahy	Andrea Webster
Shropshire Care Closer to Home	Julie Davies	Lisa Wicks Barrie Reiss-Seymour	Dr Jess Sokolov	Andrea Webster



Delivery Programmes	SRO / Exec Lead Clinical Lead Programme Director (where applicable)	Programme Key People	Clinical Lead Where applicable	STP PMO Link to Programme Enablement
Comms & Engagement		Pam Schreier Sophie Powers	n/a	Maggie Durrant
Workforce	Jan Ditheridge Victoria Maher	Heather Pitchford Nichola Bradford		Sara Edwards
Estates	Clive Wright Tim Smith	Becky Jones	n/a	Maggie Durrant
Back Office	Dave Evans Ros Preen		n/a	Maggie Durrant
Digital	Mark Brandreth Gail Fortes-Myers Andrew Boxall	Andrew Crooks Simon Adams	Andrew Roberts	Rob Gray
Finance	Claire Skidmore		n/a	Paul Gilmore
Population Health management	Kevin Lewis Helen Onions	Emma Sandbach	Kevin Lewis	Penny Bason
Medicines Optimisation	Gail Fortes-Myers	Lynne Deavin Mani Hussain	Jacqui Seaton Liz Walker	Jo Harding
End of Life	Derek Willis	Heather Palin	Derek Willis	Jo Harding
Clinical Strategy Group	Julian Povey		STP - Julian Povey Rachel McKeown – AHP's	Jo Harding



System Submissions to NHSE Governance

STP PMO currently support the following submissions to NHSE

1. Urgent & Emergency Care Tracker

- System Coordination of response by Prog Director Claire Old & Maggie Durrant
- Oversight and Exec sign off by Julie Davies on behalf of both CCGs

2. Elective Care Transformation Tracker

- System Coordination of response by CCGs & STP PMO Jill Barker
- Oversight & Exec sign off by Julie Davies on behalf of both CCGs

3. Mental Health Transformation – Tracker not yet available / required

- System Coordination of system Plan by STP Mental Health Strategy Group (co-chaired by Tony Elliot & Steve Trenchard (on behalf of both CCGs
- Oversight & Exec Sign off by Fran Beck on behalf of both CCGs

4. Clinical Vulnerable Services Stocktake

- Stocktake to establish vulnerable services across STP Footprint, support by Joanne Harding (STP PMO)
- Response coordinated through the Clinical Strategy Group on behalf of the system
- Sign off of final stocktake by STP Clinical Lead Julian Povey on behalf of the system

- All other submissions / reporting is unchanged and goes through existing Provider / Commissioner Governance processes
- Note STP has NO authority for sign off and existing governance arrangements MUST be met using Lead Execs as above



Appendixes

Following slides provide additional level of detail

These slides are “Live” and are continually updated as work programmes progressed, they are published bi-monthly



Commissioner Led Transformation Programmes



Phase 1

- Phase 1 is operationally functional, it is the Frailty Intervention Team (FIT) based within our local general hospital.
- The FIT works with frail patients to ensure that they experience as efficient an in-patient service as is possible.
- The FIT helps us to understand the scale of the problem we need to address as a health economy, and the potential impact that can be achieved through getting things right in the community for our population.

Phase 2

- Phase 2 is about introducing Case Management to primary care.
- This will enable risk-stratification of our patients.
- This will enable those most at risk of acute admission to be pro-actively managed.
- This will enable a clear understanding of what the requirements of the models in phase 3 are.
- This will enable effective, fit for purpose strategic workforce planning.

Phase 3

- Phase 3 will introduce a Hospital at Home Model, a Crisis Response Team and the provision of Step-up beds capable of managing high levels of need acuity.
- Phase 3 will enable the full benefits of case management to emerge.
- Phase 3 will provide for significant market-place development.
- Most importantly Phase 3 will enable us to serve our populations in a far more patient centred way than we can possibly achieve at this time.



Phase 1 - update

- This remains operationally functional, it is the Frailty Intervention Team (FIT) based within our local general hospital.
- FIT requirements in SaTH should taper off and reduce in time with the implementation of Phase 2. Positive impact reported with plans being developed to expand and rollout to PRH.

Phase 2 - update

- scoping and design work on Phase 2, risk stratification and case management has been completed
- Final preferred model for risk stratification and case management has been agreed. Being presented to the CCC for consideration in August.

Phase 3 - update

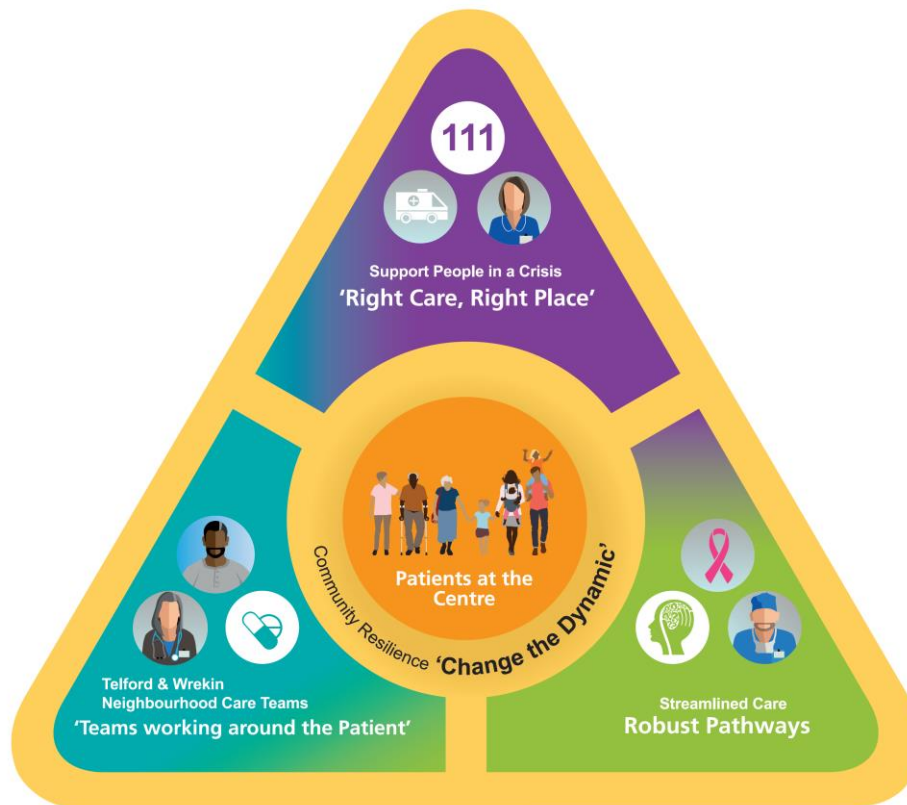
- Scoping and design of possible model options for Phase 3 (Crisis intervention, Rapid Response and Hospital at Home) has commenced.



Programme needs to:

1. Improve availability and access to activities that will prevent the development of poor health
2. Improve early identification of illness to stop further deterioration
3. Promote self-care/self-management
4. Demonstrably increase effective community support available to support out of hospital care
5. Enable Primary Care Resilience (feeds into Primary Care local strategy)
6. Reduce dependency on statutory services
7. Develop a sustainable workforce
8. Reduce social isolation
9. Empowerment for people and professionals
10. Introduce new roles and ways of working
11. Ensure robust information accessible for communities and the professionals working with them
12. Ensure there are services and activities available closer to home
13. Develop well connected services and communities

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System Partners / Enablers need to:

All stakeholders in the Telford and Wrekin area need to be open to change and new ways of working

Estates

- Support to ensure suitable estates to enable delivery, maximising to use of current resources available in addition to the development of new facilities

Communications

- Support with health literacy including mental health awareness

Digital

- Solution needed for shared patient records in particular those patients at risk
- Expertise/input regarding optimal use of assistive technology and how this can support the programme, and how IT can be utilised to work more effectively
- Develop data sharing agreement required across organisations

Workforce

- Supporting teams to develop a shared vision – neighbourhood working requires “virtual” teams and expertise on how this can work optimally is needed

Prevention

- Prevention is embedded throughout the programme, ensure awareness of programme and link where required

Out of Hospital

- Support with delivery of projects within programme – practical support needed

Mental Health

Development of STP wide strategy and governance .

Practical project support for AC OOA framework for 0-25 mental health (must do quickly) and OOA adult mental health placements (longer term QIPP)

Crisis pathway for 16-18 year old children (including children who don't meet tier 4 threshold, those who have challenging behaviour and setting up PARA registers)

Encouraging Healthy Lifestyles

Targeting obesity, smoking and alcohol

Community Resilience

To support strong communities and improving access to community resources, including drop in service for mental health crisis, support for carers, the development of wellbeing hubs

Direct Care in the Community

To include the introduction of a dedicated care homes team, development of integrated neighbourhood teams, and review of intermediate care beds

Specialty Review

To include Diabetes and Respiratory



What the neighbourhood Programme Looks like for a single locality – an example

Using the data to drive the change

Description of Neighbourhood Working has fed into the Pre Consultation Business Case, including 5 year activity profiling for the acute



Dementia diagnosis rate (add more context)
Rising hospital admissions (add more context)

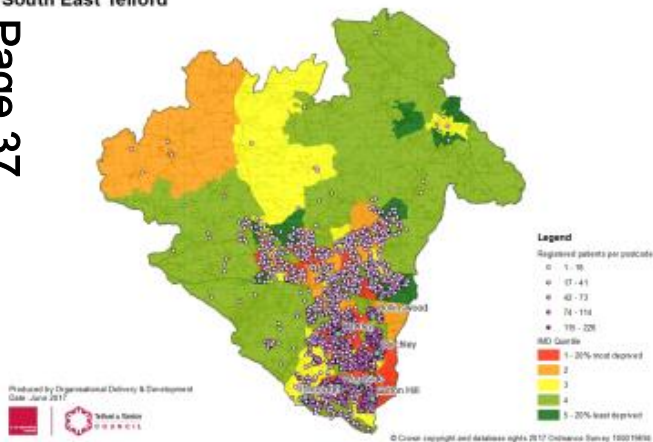


→ Diabetes outcomes need to be improved

Between 2016 & 2031 the T&W population is expected to increase by 23,300 (13.4%). Over half of these are 65 and over, with the 85+ ages more than *doubling* (117.6%) and the 65-84 ages increasing by 33.1%. All England is expected to grow 10.2%, a slower growth than T&W(13.2%). The largest difference is seen in the T&W 25- 44 age group which expects 11.6% growth compared with just 3.2% for England.

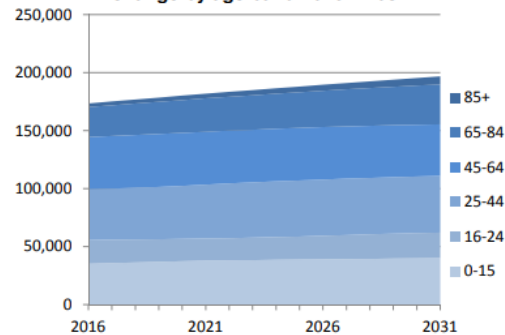
South East Telford

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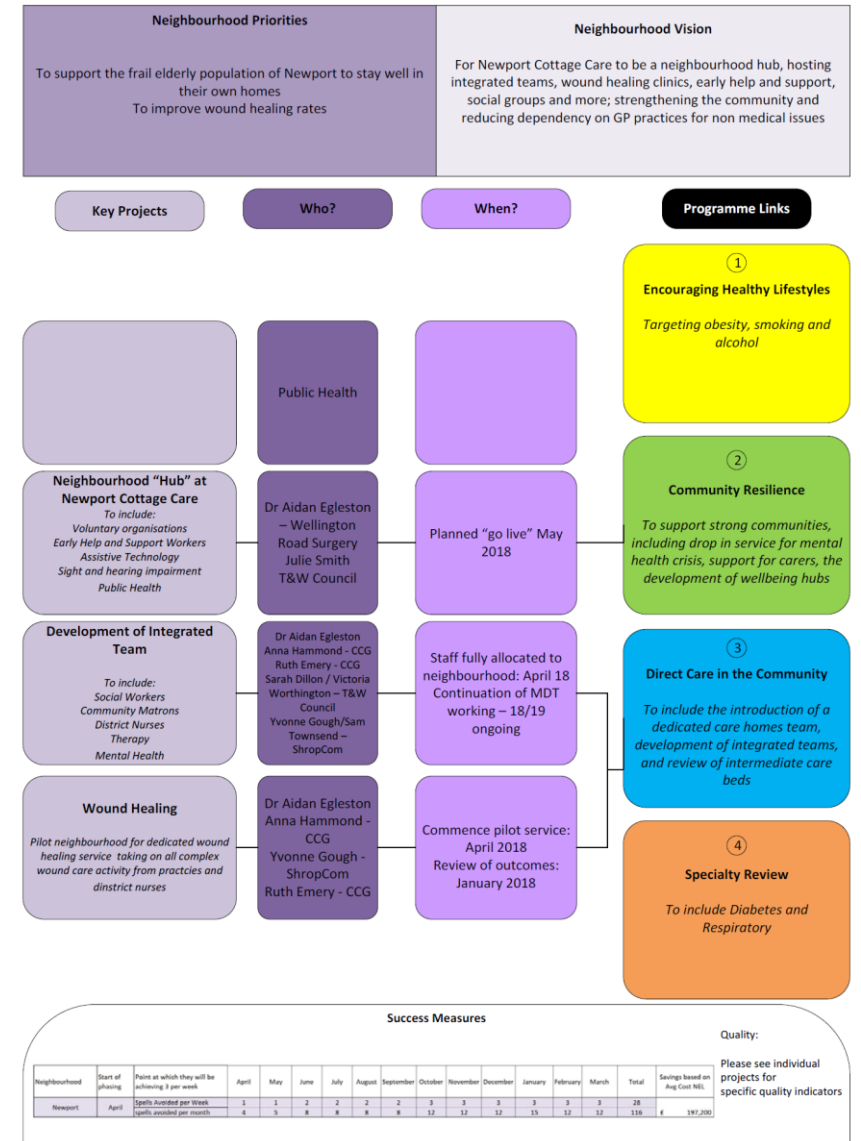


Practices and deprivation by neighbourhood – one of these for each n'hood has been produced

Figure 6: Telford and Wrekin projected population change by age band 2016 – 2031



NEWPORT LOCALITY: NEIGHBOURHOOD WORKING PROGRAMME PLAN ON A PAGE 2018/19 DRAFT

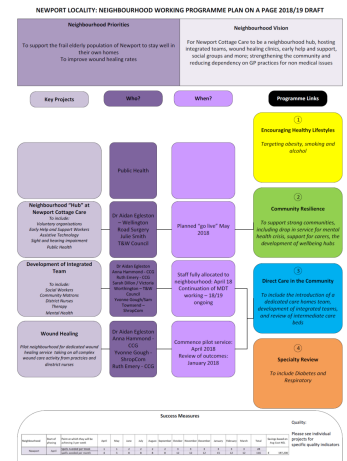
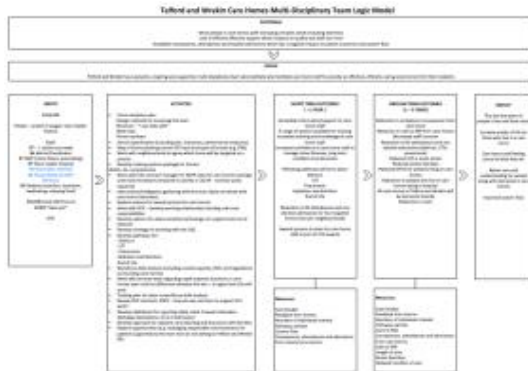
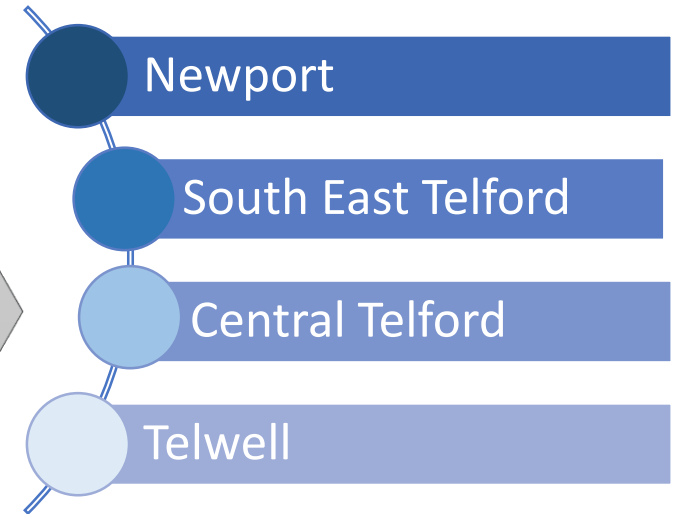




Telford Neighbourhoods – how it all fits together – delivering transformation

Case Study Examples to showcase progress

- Diabetes Management
- Hypertension Management
- Mental Health Hub – Branches
- Citizens Advice – Virtual Team
- Wound Healing project
- Community Information Portal
- Health Champions





Primary Care Programme – GPFV

Exec Lead – Nicky Wilde & Rebecca Thornley

Project Leads – Phil Morgan

Updated Aug 2018
Next update– Oct 18



Programme needs to:

The GPFV programme has five main elements:

New models of care

- Developing an approach to “working at scale” among practices using the guidance from NHS England to define and establish local “primary care networks”
- Linking practices working at scale to wider new models of care – i.e. Care Closer to Home (SCCG) and Neighbourhood Working (TWCCG)

Extended Access

- Ensuring that 100% of the population has access to GP (or other clinician) appointments 8am to 8pm Mon-Fri and at weekends/bank holidays (subject to local need) by Oct 1st 2018

Workforce

- Meeting national targets for increases in the number of GPs and other clinicians
- Retaining existing GP and other clinical staff in practices
- Developing at-scale approaches to workforce

Resilience/Workload

- Using the Resilience Fund to deliver practical, local solutions to increase resilience
- Implementing the 10 High Impact Actions

Estates and Technology Transformation Fund

- Delivering against key physical and digital projects, funded through the ETTF

In addition, CCGs are required to **invest** £3 per head, over two years, to enable Primary Care transformation.

System Partners / Enablers need to:

There are a number of enablers that would assist in the successful implementation of the GPFV programme:

Workforce

- The CCGs need to work with other health stakeholders to increase and improve the integration of workforce across different providers.
- The Care Closer to Home and neighbourhood working models, and the Future Fit strategy, need to be aligned to primary care strategic planning when considering workforce mobilisation

Digital Information and Technology

- Key projects within the GPFV, particularly extended access and implementing the 10 High Impact Actions, are dependent on IT/digital solutions

Estates Investment

- Working across key STP stakeholders (local authority, public health, secondary and community providers) to utilise and develop the current and future estate

The progress:

New models of care

- Practices in both CCGs are increasingly working in groups/localities – further work is being planned with NHS England, including attending a conference on Primary Care Networks in September
- Primary Care is inputting into the development of both Care Closer to Home (SCCG) and Neighbourhood Working (TWCCG)

Extended Access

- Current provision of evening and weekend appointments covers over 90% of the population
- Local pilots are being developed to ensure that the 100% target is met by October 1st

Workforce

- An STP Workforce Plan has been submitted with projects designed to address the recruitment and retention targets
- The CCGs are working with the STP workforce group to explore the possibility of developing banks for GPs and other clinicians.

Resilience/Workload

- Successful bids to the Resilience Fund have helped to increase resilience
- The CCGs are working with the national Time for Care team around the 10 High Impact Actions

Estates and Technology Transformation Fund

- A programme to install VOiP, VDI and WiFi across practices is being implemented
- Funding for 2018/19 projects (Skype and Telehealth) has been agreed
- Good progress has been made on a number of estates projects to address growing population GMS needs and to link with hospital service transformation

Interventions and process change milestones

Increased levels of working at scale between practices

100% of the population having access to GP appointments 8am to 8pm Mon-Fri and at weekends/bank holidays subject to local need

Targets for workforce recruitment and retention across primary care met

Successful implementation of the GPFV 10 High Impact Actions

Successful implementation of ETTF funded IT and estates projects

Risks to delivery

Risks

1. Lack of alignment between the at-scale primary care plans and the Care Closer to Home /neighbourhood plans
2. Continued uncertainty around continuation of funding for extended access pilots and the post-October 1st scheme(s)
3. Inability of CCGs/GP practices to attract new GP and non-doctor clinicians to the local area
4. Pressure on revenue budgets from ETTF-funded capital estates projects
5. A change in historical culture is required to enable transformation and collaborative change in Primary Care which will take time to embed
6. Difficulty in accessing up to date and meaningful data to identify unsustainable practices who need support with resilience funding

Data

Extended Access

- Over 90% of the registered population currently has access to GP (or other clinician) appointments 8am to 8pm Mon-Fri and at need – both CCGs are confident of achieving 100% access by 1st October 2018

Workforce

- NHS England targets for Shropshire STP are for 101 GPs and 47 non-Doctor clinicians to be recruited/retained by September 2020

Resilience/Workload

- Each of the practices across the STP need to implement at least two of the 10 High Impact Actions during 2018/19

Estates and Technology Transformation Fund

- VOiP Telephony Project – T&W - 16 sites now live for VOiP and Wi-Fi; SCCG – 16 sites now live for VOiP and Wi-Fi



Maternity Core Deliverables Overall RAG

X097	X098	X099	X100	X101	MTP1	MTP2	MTP3	MTP4	MTP5	MTP6
On Track	On Track	On Track	At Risk	On Track	On Track	On Track	On Track	On Track	On Track	On Track

Milestones

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Ref	Critical Milestones (Rolling)	Due Date	Current Assessment
1	Safety - LMS Trust level representative engaged with and actively participating in safety collaborative	30/08/18	On Track
2	Continuity of Carer - Roll out plan (may include plan to pilot as req.) in place which factors in both workforce and financial implications	07/09/18	At Risk
3	Safety - Saving Babies Lives Care Bundle survey 9 results shared across LMSs	30/09/18	On Track
4	Continuity of Carer - Through MVP Engagement plan in place for ensuring local woman have voice in the development of the continuity of carer pathway	30/09/18	On Track
5	Continuity of Carer - Mechanism in place for being able to capture how women feel and think about their continuity of carer pathway	30/09/18	On Track

Key

Complete	The Deliverable or Milestone has been completed within specified timeframe
On Track	The Deliverable or Milestone is currently on track to completed within specified timeframe
At Risk	The Deliverable or Milestone is currently at risk of not being completed within specified timeframe
Will not be met	The Deliverable or Milestone will currently not be completed within specified timeframe



Risks

Ref	Top Risks & Issues	Rating (Pre)	Mitigation	Rating (Post)
	The target of 20% women on a continuity of carer pathway by March 2019 is not met.	Medium risk	Clear project plan in place. Engagement work with staff planned.	Medium risk
	Effect of existing instability in maternity services on staff morale hinders continuity of carer pilot and roll out. (Publicity, change exhaustion and poor estate and working environments)	High risk	Supporting staff with resilience and health and wellbeing. Robust staff engagement and increasing understanding of models of continuity of carer. Ensuring that staff feel listened to.	Medium risk
	Capacity of front line staff to absorb additional activity generated by achieving safe CofC ratios.	High risk	Supporting staff with resilience and health and wellbeing. Robust staff engagement and increasing understanding of models of continuity of carer. Ensuring that staff feel listened to.	High risk
	Capacity of Senior management team to lead and deliver changes required to implement continuity of carer pathway.	High risk	Transformation Midwife in place until April 2019 to undertake scoping and planning activities and to support implementation.	High risk

Activities

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Key activities this reporting period	Key activities next reporting period
<ol style="list-style-type: none"> 1. LMS Transformation Midwife is in post to support delivery of transformation projects, including continuity of carer. 2. Continuity of carer project launched. 3. Co-production workshop took place to agree approach to working in co-production. 4. Additional scanning resource in place. 	<ol style="list-style-type: none"> 1. Commence Continuity of Carer Pilot. 2. Recruit transformation champions (front line staff with protected hours for LMS activities). 3. Complete implementation of projects funded through additional £150k non recurrent funding. 4. Implement AMU pilot (bringing it closer to consultant unit) 5. Deliver implementation plan for Specialist Perinatal Mental Health service. 6. Launch initiatives to increase midwife led births (Shrewsbury MLU refurbishment, emergency situation training for midwives, AMU pilot)

Challenges; learning; & good news

Further issues & challenges / learning / good news	Comments
Existing pressures in maternity services mean that the pace and scale of transformation may not be in line with national requirements.	
Funding of £251,467 confirmed for Specialist Perinatal Mental Health service for 2018/19 (joint with Staffordshire LMS).	
Health and Wellbeing Initiatives through LMS funding launched. Public Health and smoking cessation midwifery support increased from 1 st September.	



Core
Deliverables

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No.	Ref	Type	Deliverable
1.	X097	Next Steps	Deliver improvements in safety towards the 2020 ambition to reduce stillbirths, neonatal deaths, maternal death and brain injuries by 20% and by 50% in 2025, including full implementation of the Saving Babies Lives Care Bundle by March 2019.
2.	X098	Next Steps	Deliver full implementation of the Saving Babies Lives Care Bundle by 31 March 2019.
3.	X099	Next Steps	Deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 all women have a personalised care plan.
4.	X100	Next Steps	Increase the number of women receiving continuity of the person caring for them during pregnancy, birth and postnatally so that by March 2019, 20% of women booking receive continuity.
5.	X101	Next Steps	Deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 more women are able to give birth in midwifery settings.
6.	MTP1	System Ask	All services are investigating and learning from incidents, and share this learning through their LMS and with others by March 2021
7.	MTP2	System ask	All services are fully engaged in the development and implementation of the NHS Improvement Maternity and Neonatal Quality Improvement programme by March 2021
8.	MTP3	System ask	All women are able to make choices about their maternity care, during pregnancy, birth and postnatally by March 2021
9.	MTP4	Oversight	The LMS is engaging with Operational Delivery Networks to deliver safe and sustainable models of neonatal care across England by March 2021
10.	MTP5	Oversight	The LMS has a credible plan for how its financial allocation (Transformation funding) will be spent, and is it on track to spend in year.
11.	MTP6	Oversight	The LMS has sufficient core staffing, and clear governance and reporting processes in place by March 2021



Programme needs to:

1. Deliver the implementation plan for the Mental Health Forward View, ensure delivery of the mental health access and quality standards, increase baseline spend on mental health; work to eliminate out of area placements and reduce PICU spend
2. Improve access to psychological therapies and ensure at least 16.8% of the population access IAPT in 2018/19 rising to 19% in 19/20 and 25% by 20/21 a key milestone under 5YFV
3. Eradicate legacy issues in CAMHS around access, backlogs and reduce waiting lists whilst also providing specialist help to Looked After Children placed in the area and overall improve delivery and efficiency
4. Provide one stop coordinated service for Adult Autism and stepdown beds for Learning Disability patients from Tier 4

System Partners / Enablers need to:

1. Work across all systems to consider mental health needs of individuals
2. Ensure services all are trauma aware
3. Focus on prevention and early intervention
4. System has a clear understanding of reasonable adjustments for individuals with mental health or learning disabilities issues
5. Close gaps in provision of Autism services for adults as there is no commissioned pathway in Shropshire
6. Improve provision and support for out of area Looked After Children
7. Eliminate inappropriate access arrangements, improving multi-agency working and enhance understanding amongst other agencies of role of core CAMHS team and lead overall improvement of service
8. reduce treatment time in Early Intervention In Psychosis, reduce inequity in LD services
9. Have provision of both acute and PICU MH beds locally to avoid spot purchasing out of area based on competitive tariffs

The progress:

1. Extra Funding has been extended to current Provider to enable increase of Mental Health patients receiving employment support (IPS) under 5YFV
2. Scoping is now complete for the Commissioning of a clear integrated pathway for Adult Autism Disorder Spectrum, next stage will be moving into procurement process (April 2018)
3. Equity access to LD respite agreed with Local Authority
4. Scoping underway to reduce PICU bed use out of area and improve quality, QIPP benchmarking in progress
5. Delivery issues in CAMHS being addressed via a Remedial Action Plan with clear milestones and objectives. Operational Group in place monitoring progress
6. Dementia diagnosis rate for Shropshire is presently at 69.9% against the national benchmark of 66.7%.
7. CCGs meeting entry, recovery and waiting times targets for Access to Psychological services

Key Interventions / Milestones

Contractual talks pencilled for March 18 with aim to increase IAPT access

Implementation of Community Mental Health Hubs joining the Main Provider and Third Sector Organisations almost complete

Implementation of Community Mental Health Hubs joining the Main Provider and Third Sector Organisations almost complete

Development and delivery of new models of integrated care for MH and LD services

Benchmark and scope likelihood of having local PICU beds to reduce OOA placements

Risks to delivery

Risks

1. Legacy issues and backlogs in CAMHS require more resource in terms of workforce to eradicate. Provider currently running extensive recruitment process, Risks of serious incidents, safeguarding issues as a result of service problems with recruitment.
2. NHSE requirement that IAPT interventions be clustered and each treatment be tariff based will likely push contract prices up based on national reference costs which means there is a financial risk to the CCG to meet the required IAPT access targets mandated under the Five Year Forward View
3. Burden on financial resources due to spot purchasing of beds for female PICU
4. Gaps in provision, adult ASD (no LD), some patients might not receive required support.

Data

Mental health MDS (MHMDS) - difficult to manipulate
IAPTUS- IAPT service only



Elective Care Transformation – full details in next update

Exec Lead – Julie Davies

PMO Contact – Jill Barker

NHS
England

NHS
Improvement

Programme needs to:

8 workstreams identified

- Work Stream 1 – PLCV Policies
- Work Stream 2 – MSK
- Work Stream 3 – Ophthalmology
- Work Stream 4 – Diabetes
- Work Stream 5 – Outpatients
- Work Stream 6 – MRI
- Work Stream 7 – Neurology
- Work Stream 8 - Dermatology

System Partners / Enablers need to:

The progress:

- Initial draft submission to NHSE

Key Interventions / Milestones

Timely direct access to MSK therapies operating under a single specification (April 2018) and central booking (Sept 2018)

Shropshire Patients have access to services compliant with NICE OA Quality Standards , in Primary Care from September 2018

SOOS established as Countywide community based specialist MSK assessment and treatment service from March 2018 & providing MSK triage by April 2018

All routine MSK direct access to be coordinated through SOOS, the specialist access route April 2018

Aligned incentives contract in place with RJAH from 1st April 2018

Risks to delivery



Acute Reconfiguration - Future Fit

Executive Lead – Debbie Vogler

Programme Manager – Andrea Webster

Programme needs to:

- Ensure safe progress towards a formal public consultation, including developing effective relationships with scrutiny bodies
- Once approval received, deliver a formal public consultation, analysis of data, final report and decision making process
- Ensure implementation of the action plans arising from the Clinical Senate Review and NHSE Assurance Panel feedback
- Co-ordinate the development and delivery of a robust IIA Mitigation Plan before the end of the consultation period
- Ensure the completion of a ambulance and patient transport impact modelling exercise prior to the end of the consultation period
- At the end of the consultation period, ensure robust analysis and full report to inform next phase of decision making

System Partners / Enablers need to:

- Support the effective delivery of the consultation with relevant clinical and managerial support to key events
- Contribute to the development of the IIA Mitigation Plan
- Ensure delivery of actions to timescale arising from external review exercises where individual stakeholder organisations are nominated as lead officers
- Develop and implement robust out of hospital/neighbourhood models which will support the required reduction in demand on acute hospital services in line with the Future Fit Activity and Capacity modelling and which also delivery effective and seamless integrated pathways between acute and community
- The OOH and neighbourhood working models, and the Future Fit strategy, need to be aligned to primary care strategic planning when considering workforce mobilisation

The progress:

- The consultation process commenced on 30th May and will run until 11th September having been extended by one week to support additional requested engagement events.
- Public exhibition and Pop-up events have been held across Shropshire, Telford and Powys engaging with the public and raising awareness of the consultation.
- A mid point review took place in July to determine progress
- All key priorities and Leads to support development of the DMBC have been identified and working with the Programme Director to evidence plans and progress is being made.
- Ambulance modelling work being completed by ORH with all providers fully engaged supporting delivery of the work.
- Formal post consultation process is being formalised with advice from NHSE

Key Interventions / Milestones

Approval to proceed to formal consultation by NHSE and commenced on 4th May

Consultation exercise completed and results analysed and report available to inform DMBC (Consultation ends 4 September 2018). Date for analysis and report TBC

IIA Mitigation Plan and Ambulance Impact Modelling completed prior to the end of the consultation period in order to inform DMBC

All key actions arising from external reviews of the programme completed

Development of DMBC (date tbc)

Risks to delivery

Risks

FF Team capacity and resource needs to be maintained to support delivery of the programme – current capacity is at acceptable level. Significant political and campaign opposition to the proposals, impacting on programme reputation in the media with significant resource required to manage emails, letters and media responses – Additional resources have been identified and a media plan is in place to ensure factual and correct information and responses are readily in the public domain. The Care Closer to Home and Neighbourhood working models and the Future Fit strategy need to formally report on progress of alignment to primary care strategic planning when considering workforce mobilisation and out of hospital activity modelling.

Data



Urgent and Emergency Care

System Improvements

Plan on a Page

Mixed formats of plan on a page to reduce duplication



Urgent & Emergency Care – Transformation Programme

Implementation of UEC High Impact Changes

- Demand & Capacity Review
- Stranded Patients
- ED Systems & Processes
- Red2Green / SAFER
- Integrated Discharge Team
- IV Therapies in the Community
- Frailty
 - Frailty Team at ED front door
 - Reduce admissions / readmissions from care homes
 - Trusted Assessors

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- Further details around the Urgent & Emergency Care work programme are available by contacting maggie.durrant@nhs.net



High impact change model

Managing transfers of care between hospital and home





Stranded Patient Flash Report

Project Overview				Overall Project Status
Project Title:	Stranded patient	Deadline:	02/07/2018	<div>AMBER</div>
Exec Lead:	Edwin Borman	Project Lead:	Gemma McIver	
Clinical Lead:		Project Group:	Improving patient flow	
Date of Report:	21/08/2018	% improvement in admitted performance target 4%		

Progress, Issues/Risks, and Decisions Key Items completed this week/since the last report

Current Position	
<ul style="list-style-type: none">Monday 20/08/2018 – 233 lowest ‘Monday’ figure since the improvement work commenced on average same period as last year was 275 – August tends to be historically the lowest point we have de creased this to date however seasonal trend indicates that by September the stranded patient number does increaseWeekend figures fell below 200 for the third consecutive weekCOP Friday 17/08/2018 – number was 188Super Stranded 30/31st the Super Stranded went up to 66 however this has now reduced to 51 this week maintaining the 39% improvement against the NHSE 23% improvement target – this is in Summer so we need to continue to sustain efforts in order to still meet the target set for April.Model Hospital have released data up to May 2018 for patients with LOS over 6 days performance nationally shows that SaTH are in the first Quartile (this is positive) 4th against our ‘peers’For Super Stranded performance in Model Hospital- SaTH are again in the First Quartile showing over a 25% improvement and as such are ranked number 14 in the country.Model Hospital data reflects that LOS for >75’s is also below national average at 8 days across RSH and PRH this places SaTH as the best performers against our peers and ranked number 13 nationally.	
Progress	
<ul style="list-style-type: none">Production boards now in place across all USC wardsDrive to reduce days to hours has now commenced to support pre 12 dischargesContinued to lower the threshold for case management from 21 to 18 days for USCValue stream aligned to this work on-going focus on board round and afternoon huddleConsistent support from Shropshire council and CCG at Super Stranded however due to commitments across the system attendance at these meetings is continuing to dwindle which will put a risk on maintaining the NHSE improvement targetStroke Therapist now reporting 3 longest lengths of stay at Super StrandedWard 21 evaluation progressed with plan to present at execs for planning/ sign offDr Eardley has supported with drive for Clinical Criteria for Discharge across medicine going into the weekend	



Stranded Patient Flash Report

Project Overview				Overall Project Status
Project Title:	Stranded patient	Deadline:	02/07/2018	<div>AMBER</div>
Exec Lead:	Edwin Borman	Project Lead:	Gemma McIver	
Clinical Lead:		Project Group:	Improving patient flow	
Date of Report:	21/08/2018	% improvement in admitted performance target 4%		

Cont.

Key Issues/Risks

- Medical capacity to engage and support to challenge/ explore medical decisions is an area that is needed to fully achieve a reduction and sustained improvement
- Challenges with joint care arrangements peer to peer planning - speciality referrals – IT solution required
- Inconsistent use of PSAG on board rounds –delay in patients declared MFFD in medical notes being flagged on PSAG
- Therapy cover/ vacancies across all wards impacting on discharge planning and goal setting
- Discharge to Assess culture not supported for pathway 3 patients requiring EMI environment
- FFA completion and ownership remains a challenge
- Frequent discharge pathway changes due to gaps in community provision (example: patient waiting 5 days for rehab bed improving and then needing pw1)
- Powys engagement and support is limited
- Criteria for accessing Pathways is different across local authorities impacting on decision making and trusted assessor model
- CHC at Telford and Shrewsbury have built in a brokerage model to source care that adds multiple days to LOS for fast tracks and PW1 patients (mitigated by S2H)
- Lack of community IV pathways
- No pathway 2 bed forward view for Telford to plan weekend discharges
- Pathway 1, 2 and 3 delays continue for Telford patients impacting on LOS and flow
- Challenges for Frailty Team and nursing staff when referring to community hospitals from ED
- Frailty funding decision pending for workforce recruitment

Key Items for next week

- Progressing phase 2 of stranded patient plan – invite case managers to the Super Stranded hubs
- PDSA stranded at RSH now standing and takes place around the PSAG – roll out to PRH on going
- Share ward 21 evaluation
- COE and Cardiology continue with AEP audit – Cardiology scheduled for next week



Taskforce- Steering Group Report

Project Overview				Overall Project Status
Project Title:	Improving ED Processes	Deadline:	06.04.18	<div>AMBER</div>
Exec Lead:	Nigel Lee	Project Lead:	Rebecca Houlston	
Clinical Lead:	Dr Kumaran Subramanian	Project Group:	Urgent Care Improvement Programme	
Date of Report:	22nd August 2018	% improvement in admitted performance target		

3B. Progress, Issues/Risks, and Decisions

Key Items completed this week/since the last report

- Daily cross site huddles continue – circulated to Execs daily
- External Exec level huddles with external attendance
- ED summit internal clinical summit group and external risk summit group
- ED recovery document developed – inclusive of action plans (also revised to include recent NHSI visit)
- Weekly ED performance meeting to review further actions
- Weekly report describing minors performance for w/c 13/08/18
- Acute Medicine Workforce review
- Review of Medical Staffing deep dive with Katy Molland – job plan/DCC review of middle grade doctors and consultants
- Paediatric review of attendances
- Audit of patients that leave without being seen

Key Issues / Risks

- ED middle grade overnight gaps continue to be a significant issue – next gap from 27th August at RSH continuing through the rest of August/early September on both sites, solution to cover PRH with SHO's only overnight is not supported by Paeds, Anaesthetics or Radiology. Gaps during the day are occurring more often with some days left without any cover.
- Since April 2018 there have been 44 night shifts where there has been no overnight middle grade
- External reporting minors vs non admitted
- Data quality including ECDS acuity issues – Ongoing risk due to lack of changes on SEMA
- Data quality – ambulance breaches
- ED workforce status – impact upon ability to deliver required process changes
- Operational Team capacity to deliver required process changes
- Constant changes to medical rota to cover key shifts resulting in gaps 'within hours' is resulting in significant delays to be seen
- Financial impact of highly escalated salaries for overseas doctors and locums
- Additional physio clinics following the ED clinics no longer being in place – increased attendances under review and now added to the risk register
- Admin backlogs in both ED – quality and financial risk
- Nursing gaps – average of 44% agency used per week
- Await confirmation from Exec meeting as to funding for streaming nurse and if the service can continue

All risks mitigated where possible.



Taskforce- Steering Group Report

Project Overview				Overall Project Status
Project Title:	Improving ED Processes	Deadline:	06.04.18	AMBER
Exec Lead:	Nigel Lee	Project Lead:	Rebecca Houlston	
Clinical Lead:	Dr Kumaran Subramanian	Project Group:	Urgent Care Improvement Programme	
Date of Report:	22nd August 2018	% improvement in admitted performance target		

Cont.

Key Items for next week
<ul style="list-style-type: none">• Progress actions in recovery plan• Review key actions from medical deep dive• Deliver any changes to pathways following decision around business continuity• All patients to be managed against professional SOP's/ professional standards – circulation of SOP required to all clinicians• On-going recruitment drive and review of potential locums and nurses• Continue to push internal ED actions to improve non admitted and minors performance• Review next steps for business continuity



Red2Green/Safer

Project Overview – IMPROVING FLOW STEERING GROUP				Overall Project Status
Project Title:	Objective 3 - Red 2 Green/SAFER	Deadline:		AMBER
Exec Lead:	Deidre Fowler	Project Lead:	Rachael Brown	
Clinical Lead:	To be agreed for each site	Project Group:	Improving patient flow	
Date of Report:	22nd August 2018	% improvement in admitted performance target 4%		

3B. Progress, Issues/Risks, and Decisions

Key Items completed this week/since the last report

- Project / kaizen in place which incorporates SAFER principles under standard work. Task and finish group meeting fortnightly. First set of re-measures show improvements in some areas.
- Corporate nursing Nightingale project to be developed as part of standard work plan regarding safety huddles.
- Weekly data shows a slight dip against trajectory for this week. Currently at 14% against a trajectory of 16.4%
- As part of Kaizen plan board rounds and huddles established as priority areas, ward plans in place.
- Baseline metrics recorded for USC wards and in progress of collection SC wards.
- Buddy system of support in place and meetings held.
- SC engagement event to held 15.8.18. Good engagement from ward areas.
- Further masterclasses held this week for production boards / people link boards.
- Further Kaizen events identified / scheduled for September to address some issues that need further exploration e.g. FFA
- Super - stranded patient reviews continue to take place on a weekly basis for both care groups across both sites. LOS threshold reduced to 18 days
- Red2Green function and clinical reasoning for changes to EDD live on psag. Developing tolerance reporting in line professional standards, to be in place end of September
- Check, chase, challenge process in place across both sites, all care groups. Production board developed to provide visibility of daily metrics.

Key Issues / Risks

- Discharge planning process and med fit category, changing of pathways, and ability to 'flag' complex patients earlier in the patient journey.
- Internal blocks: doctor review / specialty referrals and FFA completion still highlighted as areas of concern
- Lack of red2green completion leading to insufficient and potentially misleading data on some wards. Weekend completion remains poor. About half of all wards consistently submit data.
- Dip in performance against baseline measure / trajectory
- Pace of change
- Medical engagement

Key Items for Next Week

- Continue to work with the identified wards to understand processes, key issues and effectiveness with a view to making further improvements
- Stranded patient reviews both care groups, with weekly metrics, and escalation.
- Check, chase, challenge approach and process.
- Ward manager meetings



Integrated Discharge Team

Exec Lead – Claire Old

Programme Leads – Sara Dillon & Tanya Miles

01 October 2018



SaTH needs to:

1. Increase the number of FFAs received by the discharging organisation before midday – target 80% before midday.
2. Increase the number of FFAs received per week to enable the LAs to meet their discharge trajectories (target: Shropshire 64 per week, Telford Wrekin 42) Through the demand and capacity work we will review the original figures for discharge to ensure that they are accurate as these have never been reached.
3. Nurse led discharge criteria embedded to improve earlier discharges
4. DLN's to be part of the discharge team- the case management approach to be embedded across both sites to ensure the correct approach toward discharges.
5. SaTH therapists to goal set for minimum 72 hours post discharge – this needs to be across all wards.
6. Transfer by relative/Red Cross should be default unless otherwise indicated
7. Anticipatory equipment planning and prescribed meds with person day before discharge
8. Need access to Senior Medical advice and diagnostics from SaTH for Admission Avoidance – to be considered at A and E group – Frailty at Front Door on both sites – decision needed re future funding needed.

System needs to:

1. System-wide Choice Policy in line with national guidance approved by all partners and implemented – need to ensure consistent application.
2. Trusted assessors for care homes in place to be extended in Telford.
3. Support the current demand and capacity modelling across the system.
4. Further develop the system wide assistive technology offer.
5. Continue to support the admission avoidance pathway provided by Rapid Response nursing and social care teams.

The progress:

1. ECIST review of IDT process and develop the SOP 15/16/10/18
2. RPIW event re FFA's 5/11/18

Overall status

Amber

Improvement in the A&E Quality Standard/Improve nt discharge practice

Interventions and process changes

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Set criteria met nurse discharge especially at weekends

Operational intermediate process and framework review and system wide agreement to new framework.

Training across all partners regarding new intermediate care process.

Red, amber, green process for all intermediate care pathways with twice weekly monitoring and MDT's. tracker post out to advert.

Point prevalence/audit to review progress against new framework

SaTH therapists to goal set for minimum 72 hours post discharge

Transfer by relative/Red Cross should be default unless otherwise indicated

Anticipatory equipment planning and prescribed meds with person day before discharge

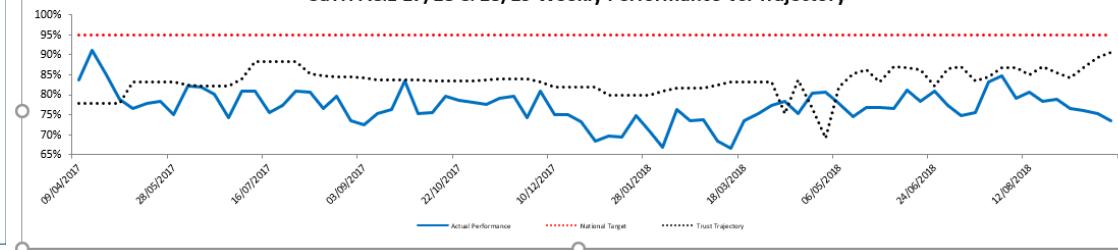
Risks to delivery

1. Insufficient patients ready for discharge to achieve the required FFA numbers per week for the LA to hit their discharge trajectories
2. Provider failure dom/bed based care. Mitigation plan in place
3. BCF sufficiency to meet demand. New governance structure to support BCF board to monitor performance.
4. PRH decision re closure and divert to other hospitals will have a huge impact upon the performance around DToC as patients are spread across the region.
5. Medication protocols for discharge are stretched with both in house and external providers being challenged by CQC on their processes around discharges.

Data

Shropshire A&E Dashboard

SaTH A&E 17/18 & 18/19 Weekly Performance Vs. Trajectory





Programme needs to:

- Develop a plan for delivery of IV therapy in community settings, with 4 phases;
- IV antibiotic therapy in MIU/DAART/Community Hospitals for patients on pathways for bronchiectasis, diabetic foot, UTI, cellulitis
- Patients on pathways as per phase 1 but requiring domiciliary delivery
- Non antibiotic IV therapy within community settings (eg iron)
- Self administration of IV antibiotics via pump therapy

System Partners / Enablers need to:

- Understand the potential need for funding to expand community capacity
- Support workforce development and competency
- Commit to review and consider commissioning additional service hours for DAART and MIU in key locations
- Support governance and accountability arrangements for medication and medical responsibility

The progress:

- Initial meeting held 30/4/18 to define scope of project and themes
- Good representation from SaTH and Shropcom
- Leadership and reporting arrangements defined
- High level output dates agreed

Key Interventions / Milestones

Phase 1;
Business case and plan to be presented July 2018

Phase 1;
Commence delivery October 2018

Phases 2,3,4
Dates to be determined

Risks to delivery

- Workforce – skills, competency and capacity
- Governance – medical responsibility, accountability, licencing
- Finance – redirection of resource to expand community provision, cost of medication
- Cultural change – to transfer patients to the community
- Limitations of currently commissioned opening hours of DAART and MIU centres

Data

Data is being collected to inform phase 1 of the delivery by Shropcom and SaTH and identify the following from April 2017-April 2018;

1. How many bed days occupancy in SaTH for patients only for antibiotic therapy for each of the 4 identified conditions
2. How many patients does this represent and their demographic
3. How many patients seen by Shropcom in DAART for antibiotic therapy for each of the 4 identified conditions and their demographic
4. How many patients seen by Shropcom in domiciliary settings for antibiotic therapy
5. Project group members are collating existing pathway information for the 4 initial therapies, for discussion and review of potential relevance or need for change.



Frailty Programme

Exec Lead – Fran Beck

Programme Lead – Michael Bennett / Emma Pyrah

Programme needs to:

- Implement Frailty Front Door at RSH in line with the AFN model
- Develop and implement Frailty Front Door at PRH by October at the latest
- Develop Inter-Disciplinary Teams to have robust MDT approach to complex discharge and achieve target of 136 complex discharges a week
- Support home First and achieving 60:30:10 for pathways 1/2/3
- IDTs support and wider ICS/ICT support SATH Red2Green/ SAFER through in-reach support
- Reduce admissions from Care Homes through specific dedicated Teams or focus
- Provide overview and scrutiny of the DTOC High Impact Changes progress across the economy in achieving Mature RAG rating by end of Quarter 4 reporting.
- Reduce and maintain DTOC target levels and reduce length of time of patients on the work list

System Partners / Enablers need to:

- Clinical and managerial support from all organisations to ensure prioritising programme of work
- Collaborate to maximise the effective utilisation of learning from PDSAs, and audit in order to create behaviour and system change
- Clearly define objectives, activity, resource, milestones within each program work stream to enable accurate assessment of progress
- Accessibility of clinical expertise to support programme development including ECIST and AFN

The progress:

- Frailty Front Door at RSH Evaluation Action Plan in place; monitored through the Frailty Task and Finish Group
- 6 As Audit completed highlighting potential for reduced admissions, reduced length of stay, improvements in clinical and care pathways
- PDSA for Frailty at Front Door at PRH completed 25-27th July to develop model and improve existing pathways. Evaluation highlighted need for additional medical and therapy capacity – within Winter Plan
- Inter-Disciplinary Teams (Clinical Hub) in place on both sites seeking to achieve target of 136 complex discharges/ week. IDTs engaged in weekly Stranded Patient reviews
- Trusted Assessors in place facilitating early discharge to care homes
- Care Home MDT in place in T&W. Commenced piloting Emergency Passports in six care homes in conjunction with WMAS. Preparing to launch Red Bag Scheme
- Shropshire Deep Dive of Care Homes including review of CHAS and potential for piloting Miralife
- Relaunch of NHS 111*6 clinical advice line for care homes
- Developed DTOC High Impact Changes Action Plan to achieve Mature by end of Quarter 4 RAG rating

Key Interventions / Milestones

Further develop Frailty at Front Door to maximise avoidable admissions and reduce length of stay on RSH site

Develop and implement Frailty at Front Door at PRH to maximise avoidable admissions and reduce length of stay on PRH

Implement DTOC High Impact Changes Action Plan to ensure achieving a Mature RAG rating by Q4

Care Homes actively utilising the NHS111 * 6 line for telephone clinical advice from the NHS111

Funding for Frailty team at Front Door at PRH to enable implementation and evaluation

Risks to delivery

- Current funding for Frailty at Front Door at RSH is based on local tariff Agreement. Risk that not agreed putting funding from April 2019 into question
- Current RSH infrastructure does not support working more upstream in ED to prevent admissions which limits to Service's impact on admission avoidance and potentially duplicates clinical input
- Additional capacity for Frailty at Front Door at PRH identified through PDSA. Needs approval through Winter Plan. Evaluation is needed to develop a Business Case for funding post April 2019
- Additional Domiciliary care capacity in both Boroughs to maximise complex discharges home for Pathway 1 and long term care at home supporting Home First and reduce length of time on the work list and recordable DTOCs

Data

- SATH reporting on Frailty at RSH highlighting impact on admissions and length of stay of Frail patient
- Need to develop methodology for monitoring impact at PRH
- Weekly reporting to A&E Delivery Group on performance related to complex discharge
- A Frailty dashboard is in place to monitor performance across both CCGs. This is being updated



Transformation Enablers

System Improvements

Plan on a Page



Digital Enabling Programme

Exec Lead –

Clinical Lead -

Programme Lead – Rob Gray



Programme needs to:

- developing the Local Digital Roadmap (LDR) - draft for NHS Digital Review October.
- Improve Connectivity : Provide seamless access networks and efficient procurement of new connections / wifi access for staff and citizens at all locations– close of financial year
- Populate Information sharing Gateway with agreements to allow sharing of information between organisations.
- Formulate an STP-wide plan for Cybersecurity: Ensure records and systems are secure.
- Improve Collaboration - Licensing future proof and cost efficient route for Microsoft and Office upgrades (towards O365 and CloudFirst)
- Identify & support digital requirements for all other programme groups
- Improve Digital Maturity Assessment scores to support programme success.
- Develop business cases as appropriate for possible future funding availability
- Analyse options for an Integrated care record across health and social care settings.
- Ensure and assist organisations within the STP to capture information electronically at point of care
- Identify the capability for Interoperability across the STP area.

System Partners / Enablers need to:

1. Ensure "Right Information available to the right person in the right time and location" enabling better outcomes for citizens.
2. Clarify the end vision and the level of commitment required from organisations.
3. Act as One! Agree the objectives of the enabling group with in the strategic governance process at exec level
4. Standardise on clinical coding (SNOMED-CT) for all organisations.
5. Provide resource (inc funding, project management etc) to define and plan programmes and projects
6. Involve digital solutions in all workstreams. Promote the modernisation and efficiency of paperless processes to increase efficiency through a digital programme
7. Conform to cyber-security requirements – and resource specialist support
8. Provide Strategic direction for an STP solution to enabling a system wide approach to an infrastructure that enables the use of all modern technologies to improve frontline patient care.

The Progress:

- Continue direct engagement with NHS England, and NHS Digital for strategic direction.
- New DEG chair, SRO and Exec Lead to meet to agree LDR direction.
- LDR refresh process nearing completion.
- HSLI bid completed phase 1 – refinement to be completed
- HSLI bid for 8/19 funding accepted by NHSE. £885k awarded.
 - Business cases to be created
- Project started - Enhance SCR for all active patients

Key Interventions / Milestones

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Oct-18. LDR refreshed and new Digital Programme defined. HSLI bid created and applied for.

Nov-18. Summary Care Record enhancement initiative started, and visible in secondary care, starting with A&E.

Dec-18. Network - shared procurement in place. Corporate Wifi access for all orgs planned for all sites

Jan-19. draw down funds for HSLI projects.

Jan-19. Defined Procurement process started for Electronic Patient Record systems for SaTH and RJAH to support shared access to Integrated care records

Risks to delivery

Resources – (lack of revenue funding to progress strategic planning, and availability. commitment from senior management to release or increase resources)

Lack of Technology standardisation - Action :Identify interoperable platforms and recommending their use across the STP

Licencing costs are set to increase with a requirement to migrate to a supported set of office applications with revenue costs instead of capital.

Executive Strategic Direction is unclear.

Lack of clear co-ordinated approval processes for schemes with a cross-organisation impact.

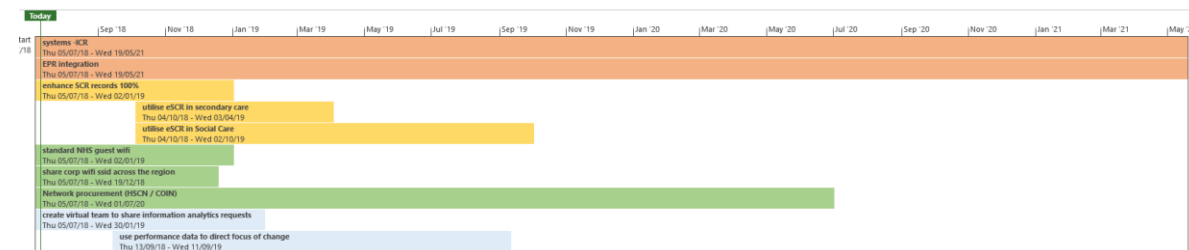
Complex governance arrangement (STP is not an executive group with delegated authority.)

Actions:

DEG SRO, Exec Lead and co-chairs appointed

Data

Outline programme plan.





Programme needs to:

- Use data in geographic layers at a very local level as evidence of emerging community need, & how or if they are being addressed
- Identify opportunities for developing community hubs, housing solutions or projects to support economic growth, where a local need is present.
- Inform the requirements for future service provision and ultimately guide the utilisation of the public estate
- Ensure estate is accessible, efficient and safe.
- Engage the expertise and knowledge of public sector delivery leads in developing community needs-based projects stemming from opportunities created by the One Public Estate work-stream.

System Partners / Enablers need to:

- Provide an integrated and co-ordinated healthcare estate relevant to redesigned patient /service user and staff pathways under the STP
- Deliver a reduction in estate
- Reduce / plan removal of backlog maintenance
- Support Estate aligning with and utilising the One Public Estate agenda
- Utilisation aligned with Carter review
- Deliver a Reduction in annual revenue costs
- Provide flexible estate that will enhanced a dynamic healthcare economy
- Develop local solutions drawing on all the assets and resources of an area
- Build resilience of communities.

The progress:

- Estates Workbook/Strategy completed and submitted on time and now a living document
- Capital bid for Shawburch submitted
- Project pipeline in early stages of development
- Joint OPE/STP Programme Delivery board established
- Whitchurch Project Board up and running and Shropshire Council Cabinet report approved. Continuing on road to delivery
- Asset Mapping & data layering work with Shropshire Council going well, producing evidence base & assisting to inform opportunities with regular meetings taking place to ensure co-ordination between Council and health future planning needs
- Early stages of planning for OPE 7 projects
- Engagement with Telford and Wrekin Council and aiming to continue engagement with Council and CCG to deliver joined up working opportunities

Key Interventions / Milestones

Circulate workshop outcomes , feedback through STP/Council/OPE partners/Local Councillors. Market Town specific Workshops to inform next steps

Run Telford & Wrekin Workshop, identify opportunities and then bring together all opportunities into one whole system approach

Overarching and adopted Estate Strategy aligning with the estate outcomes and key STP outcomes

Outline rationalisation plan, with better use of void space, shared/bookable space, joint utilisation, extended opening hours, energy efficient

Evidence using Geographical Intelligence Systems applied in layers ; to include Voluntary Sector services

Risks to delivery

- Risks**
- Timelines for funding bids vary across different organisations; aligning for cross-organisational estate projects difficult to achieve.
 - Aligning existing projects and agreement on potential future opportunities
 - Engagement not fully embraced
 - Rejection of future capital bids through omission of estate projects/concepts from STP Estates Strategy
- Actions:**
- Transparency and awareness of funding timelines between organisations
 - Agreed approach to partnership working
 - Identify and Plan for interim arrangements
 - Comprehensive links across all STP workstreams/enablers to include their known and anticipated estate implications

Data

- Validation and updates of SHAPE database (Health Service Estates) by all relevant organisations; ongoing requirement to maintain accuracy
- Property and Estates (Shropshire and Telford), Freehold land, Leasehold land, Leased land;
- Transport , Shropshire and Telford Bus routes 2016, Car and Van ownership (2011 Census);
- Demographic (covers Telford and Shropshire) (2016 MYE ONS) ,
- Deprivation (2015 IMD, DCLG)
- Community Facilities (e.g. libraries/schools)
- Older People,
- Health, including long-term illness & disability; health deprivation
- Planning Themes (Planning and Land Use Monitoring systems, Planning Policy Team
- Economy
- Housing Affordability





Strategic Estates Progress so far

The STP Estates Strategy has been a key piece of working with:

“ALL SYSTEM PARTNERS”

Through facilitated workshops, shared conversations recognising system interdependencies, increasing knowledge and understanding of Estates requirements across the system both now and in the future.

This strategy is facilitating system change through encouraging work to be done once by involving all partners in initial discussions, thus looking at the bigger picture and understanding the wider implications of organisational decisions....

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Programme needs to:

- Update the planning assumptions made in the 5 year STP financial plan and identifying a more robust view on the scale of savings in the following areas;
Corporate services savings in the health economy, using recent benchmarking data,
Shared recruitment processes (by the Workforce Work stream)
Procurement savings through model hospital and PPIB data
Estate rationalisation (developed by the STP Estates Work stream)
- Develop an over view that makes it clear what exists in plans already and whether the programme can stretch the thinking to gain more operational and financial value (e.g. target set to drive costs to the national median).
- IT foundations** to ensure the groundwork is most effectively procured to support the STP digital agenda.

System Partners / Enablers need to:

- Support a level of ambition proposed by the programme – ie. drive costs to the national median (where there is one or other agreed benchmark where there isn't),
- Sponsor and support the collaboration on key priorities, initially by sponsoring the CSU's diagnostic and option appraisal process.
- Have an 'open book' approach to data and information to enable opportunity assessment,
- Develop the relationship with other STP stakeholders to assess the opportunity for wider public sector benefits,
- Agree a change programme in due course.

The progress:

- The group, on behalf of the STP health partners have commissioned a piece of 'value added' work via Midlands and Lancs CSU to appraise the options for rationalising the 'back office' in health organisations. Time scales are now firmer and are outlined below. With a project plan developed to underpin the work.
- Back Office work stream meetings suspended until the initial reporting of the CSU diagnostic has reached a point where it is appropriate to review progress (meeting scheduled for 24th Sept).
- Individual STP work streams are working on discrete aspects of rationalisation or collaboration (estates and workforce)
- All providers are using benchmarking data to support decision making, with the most recent national submission for corporate benchmarking (Model Hospital) due to be submitted by STP health providers by the 17th July.

Key Interventions / Milestones

Commence CSU diagnostic – Summer 18

Data sharing to underpin the data analysis and diagnostic (Aug 18)

Initiate director/ senior team interviews (Sept 18)

Evaluate CSU diagnostic conclusions and agree programme of change – Autumn /Winter 18

Implement change programme – Winter 18 onwards

Risks to delivery

Risks

The scale of opportunity will not be realised due to;

- Lack of collaboration beyond health on procurement.
- Willingness to share data to support the CSU review.
- Capacity and will to drive ideas forward across organisations at pace
- Lack of willingness to collaborate on a joint agenda and give or pass on sovereignty by individual organisations.
- A Shropshire centric preference not accessing the opportunity where it is at its greatest on a wider footprint (ie out of STP boundaries)

Actions:

A review of the effectiveness of the existing county wide Procurement Group

Using the CSU diagnostic and option appraisal process to increase pace, draw conclusions and propose a change programme which will require tangible agreement.

Data

Model hospital (Carter)
Corporate services data (Model Hospital)
NHS Efficiency Map
Procurement data (PPIB)



Programme needs to:

1. Develop a system-wide **Strategic Transformation Workforce Plan** which supports Future Fit options linking acute and community models.
2. Develop and implement a system **Organisational Development Plan** to support new ways of working.
3. Develop **workforce sustainability** through the identification of learning and development, education and training needs and through supporting system programmes to implement change and support transformation.

System Partners / Enablers need to:

- **Work closely to share workforce intelligence**, undertake workforce modelling and strengthen system ownership of workforce strategies.
- **Work collaboratively** to attract, recruit and retain the current and future health and care workforce.
- **Agree system-wide requirements** in order to maximise the education, development and training opportunities for our workforce.
- Lead a **system programme** that delivers transformation and sustainability taking into account Future Fit options.
- Lead **cultural change** through health and care that supports **integrated working** which prioritises patients resulting in improved population health and wellbeing.
- Deliver **system-wide workforce solutions** and improvements in response to the system workforce challenges.

The progress:

- Agreement between STP partners on **priority areas** through the Strategic Workforce Group.
- **System-wide Workforce Strategy** – Baseline data being worked up via HEE.
- **Mental Health Workforce Plan** – Submitted with no requirement to resubmit. MH Delivery Plan now being addressed.
- **STP OD Group** - now set up with priorities being planned.
- **Local Maternity Services (LMS) Transformation Plan** developed. First draft of WFP taken to LMS Board and WF sub group meetings in progress. Leadership & Cultural Development Plan to follow in Autumn 2018.
- **GP Forward View Workforce Plan** has identified projects to address recruitment and retention targets and bids have been submitted to support GP recruitment, retention and resilience programmes.
- **2017/18 workforce investment programme** of £817,600 covering both primary care and acute services being delivered.
- **2018/19 workforce investment** scoping exercise in progress.
- **STP/LWAB** relaunched with priorities refreshed.
- **Education & Development Group** – Identification of priorities and development of Multidisciplinary Preceptorship Framework, Shared Learning Assets and Shared Statutory and Mandatory training projects.
- **Training Hub** – Re-establishment of the Shropshire and T&W Training Hub provision within the STP PMO.

Key Interventions / Milestones

Complete the **workforce profile data** gathering and individual specialist workforce plans. Aligning with Future Fit Programme.

Leadership and OD Programme with the King's Fund completed. NHSI (ACT Academy) **TCSL Programme** change management tools being used.

Development of **Shared Recruitment** project and **Collaborative Bank** – Project Briefs developed with partner engagement.

Implementation of a pilot **Rotational Apprenticeship Programme** with September 2018 start.

Delivery of **2018/19 STP/LWAB funded priority areas** and development of a **shared training/learning** offer to meet system needs and promote integrated working.

Risks to delivery

- Risks:**
- Planning without knowledge of future finances and service redesign/configuration. Future Fit Consultation ends in September 2018.
 - Varying levels of stakeholder engagement driven by different approaches to Workforce and access to data.
 - Ability to fund workforce development activities both in terms of finance and time.
 - Risk to quality of STP submissions due to a lack of clarity around requirements.
 - Timely decisions in respect of funding which affects education, development and recruitment.

- Actions:**
- Ensure strong workforce links with STP clinical /service priorities reporting into the Strategic Workforce Group.
 - Continue to build relations through working together on identified projects/ task & finish groups.
 - Identify priority development areas and align through STP PMO processes.
 - Collaborating with HEE to access support and align programmes.
 - Piloting areas of work to test outcomes.

Data

Shropshire Workforce Baseline:

STW system workforce baseline developed by HEE Workforce Intelligence Team utilising data from NHSI operational plans (workforce plan) for acute/community and mental health services, NHS Digital for primary care and NMDS for social care. Data presented at July meeting of Strategic Workforce Group and LWAB. The data provides demographic information, nurse to bed ratio and a comparison with the 17 LWABs across Midlands and East. A focused session with workforce planners to review the data and provide a response to HEE is currently being arranged.

Individual areas of workforce:

- **Mental Health Workforce** data included in the submission of the MH Workforce Plan in March.
- **Local Maternity Transformation Plan (LMS)** developed with workforce analysis being undertaken to inform WFP. Financial analysis underway with STP Finance Lead for LMS. WF risk register updated to include financial risks.
- **Primary Care workforce data** has been collated as part of the GPFV Workforce Plan.
- Cancer Alliance now linked into Collaborative Cancer Group to progress Cancer Workforce Plan.



Local Health Economy End of Life and Palliative Care Strategy

Caring, Responsive, Effective, Well-Led, Safe: A positive experience for patients, carers and families

The Shrewsbury and Telford Hospital NHS Trust



Shropshire Community Health NHS Trust

National Ambitions

Individual care

Fair access to care

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Comfort and Wellbeing

Coordinated care

All staff care

Caring Community

Living Well
HELPS --->
Dying Better

Facilitate effective personalised care planning and support of those important to the dying person

- Documentation provides clarity to all regarding patients' preferences/goals for living
- Important conversations
- Identify key worker
- Patient and carer access to documentation
- Shared electronic records

Ensure equal access to palliative and end of life care

- Develop systems with prognostication to identify patients in last year of life
- Co-ordinated processes for referral: clear Access criteria and Co-designed referral documents
- Establish a needs based model that identifies phase of illness and a system for prioritization
- Links with non-cancer specialists
- All supported by GSF and Frailty registers
- Support Transitional Care Initiatives

Establish 'Living Well' concept: support advanced & anticipatory care planning & timely access to services

- Culture of care is enablement
- Programs for palliative rehabilitation are established
- Expand homecare models to support a preference to die at home; further develop H@H service
- Provide necessary medication and associated documented administration authority

Work in partnership to ensure that care is coordinated between services

- Facilitated by Local Health Economy End of Life Group supported by CCGs
- Services compliment not replicate each other
- There is shared accessible documentation where possible (RESPECT, EOL care plan, PPC) and Flagging
- Integration of H@H with the Hospice Outreach Service

Ensure a competent workforce

- Identify education needs across services ; Establish education programmes
- Robust systems for appraisal and CPD across groups; System learning from Significant Adverse Events

Recognise compassionate communities voluntary support as an extension to services

- Severn Hospice continued roll out of coco
- Volunteering is seen as an arm to wider services
- Clinical services refer to established volunteer support
- Expand competencies in verification of death to facilitate this promptly and confidently

National Foundations

Personalised care planning

Shared records

Evidence and information

Those important to the dying person

Education and training

24/7 access

Co-design

Leadership





The programme needs to:

1. Develop our wider workforce to 'make every contact count' (MECC+) / proactive identification of people at risk of ill health and behaviour change conversations, brief interventions
2. Prevent harm due to alcohol, obesity and CVD
3. Support culture change and new working practices that help people at the earliest opportunity
4. Support active signposting and develop a good understanding of how communities support people – linking to Social Prescribing
5. Work across organisations (including the VCSE) to prioritise support for key population groups – address inequity and inequalities by connecting with the national and regional population health management support mechanisms
6. Support and embrace the role of the VCSE and communities to drive forward prevention activity
7. Focus on developing a good understanding of need – continual information provision for the JSNA
8. Improve communication between organisations

System Partners / Enablers need to:

1. Systematically raise awareness and deliver lifestyle advice, signposting and referral by healthcare and other professionals, e.g. through MECC +, PHE's One You, including for:
 - Stop Smoking Support
 - Weight management
 - Physical activity programmes
 - Immunisation opportunities, e.g. flu
2. Improve the prevention, detection and diagnosis of CVD, specifically diabetes and hypertension
3. Radically upgrade the role of the NHS in tackling harmful alcohol consumption, through screening, identification, brief advice and referral into treatment services
4. Deliver prevention expectations of the national Cancer Strategy
5. To ensure the systematic delivery of mental wellbeing services, including identification of mental ill health and prioritisation of emotional support

6. Work together to make best use of resource and expertise

The progress:

Mobilisation of the National Diabetes Prevention Programme March-May
Neighbourhood working to build community capacity- focus on Healthy places, Active and Creative communities
Delivery of Social Prescribing initiatives and infrastructure
Supporting Carers through all age strategies and Dementia Companions
Delivery of Fire Safe and Well Visits (since July 17)
Develop and deliver a system prevention framework for all pathways
Developing very positive joint working across health and care
Individual Placement Support Service for those in secondary MH services
Development and Deliver of MECC Plus for NHS providers, VCS, housing

Telford & Wrekin – Healthy Telford

Borough-wide lifestyle offer
Twitter and blog – using social media to inspire behaviour change
Developing and nurturing our community health champions
Public Health Midwife, stop smoking support and maternal health advice

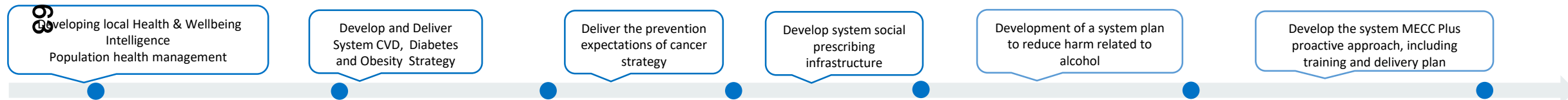
Shropshire – Healthy Lives

Development of an Integrated Care Navigation Programme
Delivery of Healthy Lives Programme and prevention services

Opportunities

- Smoke free hospital and brief interventions in hospital
- Connecting to workforce (and funding) to support development of staff (link to MECC plus)
- Mental health hubs, MH support in Local Maternity hubs, Early help for children and young people, link to Estates
- Healthy hubs and social care support/ advice and guidance in hospital
- Risky behaviour CQUIN - link to MECC Plus

Key interventions / Milestones



Risks to delivery

1. Lack of buy in by partner organisations
 - Risk to strategy delivery
 - Risk to culture change needed
2. Investment in prevention programmes (national and local)
 - Local Authority Public Health Grant challenges
 - Lack of NHS investment in prevention
3. Medical and nursing capacity
 - NHS Trusts (SaTH, SSSFT, ShropCom, RJA)
 - Primary Care

Outcomes – how do we know it's working? DRAFT

Public Health Outcomes Framework

- Healthy life expectancy
- Health Equity
 - Smoking rates
 - Obesity – children and adults
 - Physical activity
 - Wellbeing measures – Social Prescribing
 - Reduction in GP attendances
 - Reduction in unplanned hospital admissions
 - Cancer rates
 - Harm due to alcohol – alcohol admission rates

Connecting to other programmes

- Health and Wellbeing Boards Strategic Planning (both T&W and Shropshire)
- Better Care Fund (T&W and Shropshire)
- Rightcare
- STP Neighbourhoods and Out of Hospital Programmes – community development,
- GP 5 Year Forward View –
- Mental Health 5 Year Forward View – preventing
- Maternity Services Transformation
- Workforce – developing our
- Estates Partnership
- Musculoskeletal and Falls System Planning

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Shropshire Care Closer to Home

An Overview

Background

Unlike health systems in many other western countries, the past 40 years has seen relatively little change in the way in which the NHS delivers care. The way care is delivered (also known as the “model” of care delivery) is still heavily dependent upon the use of general hospitals. Whilst there is absolutely a need for general hospital services, it is important to remember that hospitals were built to provide care to people who could not be looked after safely at home.

Some aspects of our modern lives would have been considered science fiction 40 years ago, with huge changes seen in the way that we communicate, shop and manage our finances. However, despite advancements in technology, our dependence on general hospitals in the UK has altered very little. The pressure that the NHS is now faced with is unprecedented; people are living for longer with far higher and more complex levels of need than has ever been seen. This is particularly true for Shropshire whose population is older than most other counties in the UK.

In many parts of the country, changes in the model of care delivery are being made with a view to move the NHS towards a place that embraces technology, in order to meet the needs of the people it serves. Whilst this will be key to the health service being able to meet the long-term needs of the population, another crucial element is the way in which the organisations that make-up our local health systems, also known as “Health Economies”, work together. In order for the Health Economy of Shropshire to evolve successfully to meet the needs of Shropshire people, the organisations that belong to it need to agree to work towards a common goal, in other words they need to be “Strategically Aligned”.

To achieve this, senior representatives from the organisations which make up Shropshire’s Health Economy have set up a group where they share plans and ideas with each other. This group is called the Sustainability and Transformation Partnership, often referred to as the “STP”.

What is the role of Shropshire Clinical Commissioning Group?

Shropshire Clinical Commissioning Group (SCCG) is responsible for paying health service providers for the work they do to treat our population’s health needs, with a view to ensuring the population receives high-value care and treatment that is efficient, effective, safe, fit for purpose and economical. The same principles apply to the Local Authority (Shropshire Council) for the care services that it is responsible for purchasing on behalf of the population.

In order to make sure that best value treatment is provided, SCCG works with Public Health (a division of Shropshire Council), local people and GPs to understand the health and care needs of the population. SCCG considers these needs against the services being provided to decide whether they are providing the public with the highest value of care possible. If SCCG believes that providing services differently would result in higher-value provision for the population it serves, then it is usually SCCG's responsibility to coordinate the change process. A big part of this is "stakeholder engagement", this means working with the public, GPs, the Local Authority and service providers from the public, private and third sector (such as charities) to ensure that everyone's contribution is taken into account.

Once the change is complete, it is then SCCG's responsibility to keep the providers on-track and monitor the impact that the change is making. The process then begins again, working to understand the needs of the population and how they have changed. This is also known as the commissioning cycle and it is this process that has led to SCCG's ambition to work with stakeholders to bring *Shropshire Care Closer to Home*.

What is Shropshire Care Closer to Home?

When service change is required in order to attain a better value of provision for the population, the change must be organised and coordinated to ensure that the change takes place in a planned way. For small-scale changes, we call this process a "project". Some changes, such as achieving *Shropshire Care Closer to Home*, require a collection of projects to be managed simultaneously. This we call a "programme" of change. *Shropshire Care Closer to Home* is a programme of change that is being organised and coordinated by SCCG to achieve better value care for our population.

How does this fit with what is already happening?

As described earlier, the STP is tasked with job of making sure that the plans and ideas for change in Shropshire complement each other. Some readers will be aware that in addition to *Shropshire Care Closer to Home*, another programme of change called *Future Fit* is taking place. This work is aimed at making our outdated general hospitals suitable to meet the needs of the people accessing them. In order for *Future Fit* to work as is planned, *Shropshire Care Closer to Home* must also work as this will ensure that only those people who absolutely need to be in hospital are admitted. As other ideas for change are introduced, it is the STP's responsibility to make sure that they fit with what is already happening.

Why is change needed?

Care delivered in general hospitals often comes at a significant cost to the recipient. At worst it can result in the end of independent living, the development of additional health needs or a change in home address. Enabling people to receive treatment that allows them to live their day to day lives is a priority not only for SCCG, but for the NHS as a whole. If we were to bring *Shropshire Care Closer to Home* to our population, we would enable people to avoid the risks associated with being admitted to hospital and experience minimal levels of disruption to their lives while still receiving treatment.

As discussed earlier, we at SCCG absolutely believe that there is a need for general hospital services as some of the diagnostic testing and treatments delivered cannot safely be undertaken in another environment. However, in Shropshire just like many other parts of the UK, we have developed an unhealthy dependence upon our general hospital. We at the CCG have engaged with our stakeholders and have reached the conclusion that we have a duty to address this over-dependence, and bring *Shropshire Care Closer to Home*.

Who is Shropshire Care Closer to Home for?

Long-term health conditions are those that a person lives with for a long time, such as diabetes, coronary heart disease or dementia. When a person lives with a number of these conditions, their needs are known as complex. Information collected locally, tells us these people are particularly susceptible to being admitted to the general hospital and that, if there were suitable services in place, many of them could be treated closer to, or in some cases, at home. *Shropshire Care Closer to Home* is being aimed therefore at improving health outcomes for people with multiple long-term health conditions aged 65 and over. In order to achieve this, *Shropshire Care Closer to Home* will ensure that regardless of sexual orientation, gender, cognitive or physical ability, ethnicity or religion, services provided will be capable of meeting need in a dignified and respectful way.

Although it is recognised that targeting people over 65 with complex needs may exclude some patient groups, or “cohorts” as they are also known, moving *Shropshire Care Closer to Home* represents a big change for both Shropshire patients, and those delivering services. If we were to try to change everything that needs fixing all at once, we would be likely to fail, and fail we must not. It should however be recognised that once things are up and running smoothly, our future aspirations are to expand the principles of *Shropshire Care Closer to Home* across other cohorts.

What changes will we see?

SCCG often describe services at a “high level”, which means describing them in a non-detailed way. A reason for this is that local-level service provision may differ from place to place. For example people in Whitchurch may receive services differently to those in Craven Arms. When considering how we will implement *Shropshire Care Closer to Home*, it is important to understand that at this stage, this can only be described at a high level. With this in mind, *Shropshire Care Closer to Home* will initially be comprised of three high-level phases:-

Phase 1

Phase 1 is already in place. It is the Frailty Intervention Team (FIT) based at the A&E department at the Royal Shrewsbury Hospital. This team works to ensure that where possible people with complex needs (also referred to as frail) have their needs met quickly either to prevent a hospital admission from occurring, or to achieve a shorter stay in hospital than would otherwise have been expected by coordinating discharge requirements more effectively.

Phase 2

Phase 2 is about delivering a model of care called “Case Management”. This model has two parts. The first is about our community-based NHS workforce working closely with GP practices across Shropshire to get a clear understanding of how many people over the age of 65 have complex care needs. A crucial part of this process relates to categorising the people identified in terms of whether their need complexity is low, moderate or severe - a process known as “Risk Stratification”.

Once Risk Stratification is complete, those identified as being in severe need will be given the opportunity to work with a designated professional (also known as a “Case Manager”) who in turn will be responsible for a group of patients - also known as a “caseload”. The professional background of a Case Manager may vary dependent on what the most pressing needs of the recipient of support are. For example, for some patients a nurse would be best placed to provide support, whereas in others a social worker may be more suitable.

The Case Manager is responsible for developing and reviewing care plans with those in their caseload, and where required, coordinating services to meet their needs. Case Managers will promote recovery and identify when people under their supervision are deteriorating. This will enable them to put preventative measures in place to minimise the occurrence of acute and severe ill health, also known as a “health crisis”. This development of care plans and their delivery represents the second part of the Case Management model.

Phase 3

The third phase is made up of three high-level models:-

The first is called “Hospital at Home”. The aim of Hospital at Home is to provide diagnostic testing and treatment interventions that are traditionally associated with care in a hospital setting either in peoples own homes or from places close-by. Just as is the case in the local general hospital, this model would be delivered by a multi-disciplinary team made up of a range of health professionals including: GPs; Specialist Consultants; Social workers; Community Nurses; District Nurses; Advanced Nurse Practitioners; Mental Health Nurses; Pharmacists, Physio Therapists, Occupational Therapists and Dieticians to name but a few.

However, Hospital at Home is not a rapid-response model of care delivery. It functions in a planned fashion working alongside the Case Management model to prevent health crisis from happening. That said, we do not live in a perfect world and sometimes health crises do occur.

The second model of the third phase of *Shropshire Care Closer to Home* is about creating a Health Crisis Response Team. This would be set up to deliver both diagnostic testing and treatment interventions similar to those available from in the Hospital at Home model, but within a standardised 2 hour response window. This team would be made up of senior clinical staff, for example Advanced Nurse Practitioners who are capable of making clinical decisions and in most cases prescribing and administering medicines to manage acute health needs. However, if the Health Crisis Response Team should feel that the person is too unwell to be safely managed at home, there are two options which they can consider; they could admit the person to a “Step-up bed” or to the general hospital.

The provision of “Step-up beds” is the final model of the third phase of moving *Shropshire Care Closer to Home* and involves the provision of bed-based care in the localities in which people live, albeit away from their usual place of residence. These beds, which could be provided in community hospitals or nursing homes, will allow for high-intensity supervision of acutely unwell people whilst they undergo diagnostic testing and receive treatment. Should the Health Crisis Response Team decide to admit someone to a local Step-up bed, it may be that they continue to provide support to the recipient of care with a view to promoting safe discharge in as timely a way as is possible.

Are models going to be the same across the county?

As described earlier, this document provides a high-level overview of the models that are required to move *Shropshire Care Closer to Home*. The detail surrounding exactly how and who delivers them has not yet been agreed. There are a number of ways in which the models described above could be delivered, and this will vary across the county depending upon a number of local factors.

What is happening right now?

SCCG is working with the public and all stakeholders in the process of designing how we enable *Shropshire Care Closer to Home* on an ongoing basis. As this is a rapidly developing programme of work, things are changing all of the time. The SCCG communications team will be regularly posting updates on the SCCG website, so if you are interested in following this work, or would like to come along to one of our engagement events, please visit www.shropshireccg.nhs.uk (from 1st August, 2018) to find out more.

How will this be paid for?

SCCG has no additional money to pay for this way of working but the aim will be to redirect existing monies from services that are not fit for purpose and reinvest it into creating new services which would better meet the needs of our patients.

This means that to enable change to take place, some of the existing services may have to be stopped in order to provide the new ones. It is however expected that in doing things differently, we will provide the people of Shropshire with higher value care capable of reducing the dependence we as a county have upon general hospital services. In turn this will enable us to reduce the amount we spend on care based in this setting, allowing money to be redirected to community initiatives so that we may progressively build *Shropshire Care Closer to Home*.

It is also important to recognise that on the front-lines of care delivery, *Shropshire Care Closer to Home* will bring the Local Authority staff such as Social Workers, and those employed by the NHS closer together. This will inevitably strengthen the relationship that Shropshire CCG has with Shropshire Council, which may have future implications for how the respective organisations decide to fund *Shropshire Care Closer to Home*. This may become especially relevant should this new way of working enable Shropshire people to retain their independence for longer, thus reducing the financial commitment the Local Authority has for Care Home placements.

How long will this all take?

As with most successful large-scale change, things are not expected to happen straight away. In fact it is difficult to provide an exact time frame for how long this change will take, largely due to environmental factors outside of the control of SCCG. It is however planned that the first stage of Phase 2 (Risk Stratification) will begin to take place by the beginning of 2019. It is not agreed at this stage of the process where the change will begin in the county, although all progress in relation to this programme of work will be available on the SCCG website, www.shropshireccg.nhs.uk (from the 1st August, 2018).

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Programme Highlight Report

Project Name:	Shropshire Care Closer to Home		
Date:	18 th October 2018	Release:	Report #4
Author:	Barrie Reis-Seymour Commissioning & Redesign Lead, Out of Hospital		
Owner:	Lisa Wicks Deputy Director of Performance & Delivery/Head of Out of Hospital		
Reporting to:	Shropshire Care Closer to Home Programme Board		
Document Number:	04		

Note: This document includes updates and information that is true and accurate on the date detailed above.

Revision History

Date of next revision:

Revision Date	Previous Revision Date	Summary of Changes	Changes Marked
5/6/18	NA	First Draft	NA
5/7/18	5/6/18	Amended version and updated to include progress to date	NA
18/7/18	5/7/18	Final version agreed with inclusion of Vision, and RAG rated status updates	No

Approvals

This document requires the following approvals. A signed copy should be placed in the project files.

Name	Signature	Title	Date of Issue	Version
Lisa Wicks		Commissioning & Redesign Officer, Out of Hospital	18/10/18	02 - #4
Jessica Sokolov		Programme Chair and Clinical Lead	18/10/18	02 - #4

Distribution

This document has been distributed to:

Name	Title	Date of Issue	Version
Shropshire Clinical Commissioning Committee	Committee Members (ToR)	17/10/18	02 - #4
Shropshire Care Closer to Home Programme Board Members	Multiple members (ToR)	18/10/18	02 - #4

Overview

- Vision** Using all available resources to commission integrated health and care services that are clinically effective and cost-efficient and as close as possible to where people with the greatest need live.
- Purpose** A Highlight Report is used to provide the Shropshire Care Closer to Home Programme Board, and possibly other stakeholders, with a summary of progress and the stage status at intervals defined by them. The Programme Board shall use this report to monitor stage and project progress. The Project Management Team also uses it to advise the Programme Board of any potential problems or areas where the Programme Board could help.
- Contents**
- | | |
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| Status Summary | 3 |
| This Reporting Period | 5 |
| Next Reporting Period | 8 |
| Project and Stage Tolerance Status | 11 |
| Requests for Change | 12 |
| Key Issues and Risks | 12 |
- Advice**
- The Highlight Report is derived from the: Project Initiation Documentation; Project Management Plan, Risk Register, Issue Register, Quality Register, Communication & Engagement Strategy, and actual progress against plan.*
- The Highlight Report can take a number of formats, including: Presentation to the Programme Board and CCC (physical meeting or conference call); Document or email to the Programme Board; Entry in the project management tool.*
- The following quality criteria should be observed:*
- The level and frequency of progress reporting required by the Programme Board (monthly) is right for the stage and/or project
 - The Project Management Team provides the Highlight Report at the frequency, and with the content, required by the Programme Board
 - The information is timely, useful, accurate and objective
 - The report highlights any potential problem areas.
-

Date of Highlight Report	Thursday 18 th October 2018
Period Covered	20 th September 2018 – 18 th October 2018

Status Summary & Update

Phase 1 - Frailty Intervention Team in place at RSH with plans being developed to implement at PRH.

Phase 2 – Risk Stratification and Case Management model approved by the CCG Clinical Commissioning Committee on 15th August 2018. Additional resource now focusing on progressing the Alliance Agreement Partnership needed to enable subsequent operationalisation of the model through developing more detailed service delivery and workforce models that underpin demonstrator pilot sites. The overall delivery for Phase 2 remains as detailed on the original timeline although pace is required if any significant change is to be realised before December 2018 and the pressures that come with the core winter period. Next steps are currently reliant on the signed Alliance Agreement being in place to underpin the approach of integrated joint working.

Phase 3 – After the Programme Working Group and Board agreed to delay the design and modelling of Phase 3 to optimise availability and involvement of stakeholders, intensive design sessions for the three workstreams of Phase 3 (Rapid Response, Hospital at Home, Step Up/Down beds) have been arranged for end of October and into November; with a week dedicated to each of the workstreams. The approach is a series of focused collaborative co-design sessions co-ordinated from a central design room or hub, to which various stakeholders, patient representatives, GP colleagues and providers are invited. To date the design sessions have proved problematic with limited response to the invitations.

In order to maximise stakeholder involvement and engagement, a template has also been developed that allows comment, suggestions and feedback to be submitted for inclusion in the design process. This allows individuals who were unable to attend any of the design workshop sessions to still have the opportunity to contribute and be involved.

The information gathered from the design workshops and submitted written contributions will be consolidated in December 2018, before going out for further comment and input during the engagement process, stakeholder events and GP locality meetings in January 2019. In total, this structured approach provides three opportunities for everyone across the health and social care economy to be involved.

These additional steps in the design process, and involvement & engagement create a 4 month delay to the Phase 3 timeline against the original plan. Some of that is offset however by confirmation from NHS England that on any of the programme areas where it is required, no consultation can take place before May 2019 due to other another one happening at the same time, and possible purdah from T&W elections taking place.

On Thursday 20th September 2018 the Programme Board agreed to identify which areas of Phase 3 could be progressed without the need for formal consultation and separate out the timeline accordingly. Whilst the initial thinking was that only Step Up Beds could potentially require public consultation due to the nature of that change, it was agreed that formal consultation requirements would be determined once the models emerge; giving a clearer idea of any potential changes.

Some of the consultation requirements are also offset through comprehensive involvement and engagement in the earlier design and development stages.

The general consensus from all stakeholders is one of support, and a keenness to see these models developed and implemented as soon as possible.

The revised Phase 3 timeline incorporates the following key dates:

- October & November 2018
 - Design workshops
 - Present progress updated to GP localities
- December 2018
 - Additional contribution through template, and consolidation of all outputs
- January 2019
 - Public/patient and provider engagement
 - GP Locality workshops
- February 2019
 - Consolidate outputs and prepare longlist proposal
- March 2019
 - CCC option appraisal of longlist – to agree shortlist
- April 2019
 - Engagement and possible pre-consultation on shortlist
- May 2019
 - CCC option appraisal of shortlist – to agree preferred model(s)
- June 2019
 - Either commence mobilisation of agreed model if consultation is not required, or commence formal consultation on areas where it is deemed necessary.

The comprehensive programme communications and engagement strategy is in place, along with senior level communications and engagement resource supported & provided by the Community Trust to orchestrate the activities of the comms resources that were identified as being available in each of the providers.

SharePoint being further developed to become a shared platform and portal of communication through which all programme documentation will be shared and accessed in a controlled way. To be shared with other users over the next month. As at 1st October 2018 there are 17 users.

Dedicated IT Task & Finish Group working on all matters relating to IT and data infrastructure needed to support the programme, including shared data and the development of an electronic shared Care Plan.

Due to workforce gaps in the Shropshire Council team, it has been advised that the information for the JSNA will not be available until end of November 2018. Communication also received that the report being developed may not provide the level of detail expected and therefore discussions are underway to determine the impact of this delay on the programme, and whether the level of detail promised meets requirements. Both the delay in availability of a JSNA, and relevance of its contents is being logged as a Programme Risk.

This Reporting Period

Project Plan Areas

Project Plan Ref	Work Package Name	Status ¹	Notes ²
1	Programme Management	In place	As per overarching Project Plan
2	Vision & Model Design	In progress (Phase 3 delay)	As per plan according to each of the agreed phases, but with 4 month delay to Phase 3 timeline.
3	Impact Assessments	In progress – behind agreed timeline	Joint Strategic Needs Assessment under development by Shropshire Council. Full QIA, PIA and EQIA to be completed on agreed models. QIA on Phase 2 complete.
4	Phase 1	In place	FIT requirements in SaTH should diminish and reduce in time with the implementation of Phase 2. Positive impact reported with plans being developed to expand and rollout to PRH.
5	Phase 2	In progress	Final preferred model for risk stratification and case management agreed by the CCC. Developing operational and workforce models for implementation once Alliance agreement in place.
6	Phase 3	In progress (delay)	Scoping model options & possibilities. Design sessions planned for October & November.
7	Patient Involvement	Ongoing	Regular stakeholder workshops and ability to email queries. Further What Matters to Me events to be arranged.

¹ Either Pending Authorisation, In Execution or Completed (in the period)

² For example if Work Packages are being performed by external suppliers, this information may be accompanied by purchase order and invoicing data

Project Plan Ref	Work Package Name	Status ³	Notes ⁴
8	Comms & Engagement	Ongoing	Strategy and plan finalised. High level support in place to oversee strategy and orchestrate comms activities of various providers.
9	Quality & Safety	Pending	To be reviewed once shortlist of model options is being finalised. Phase 2 QIA complete.
10	Finance	Pending	To be modelled and reviewed once shortlist of model options is being finalised, and dependant on alliance working or not.
11	Workforce	Pending	To be reviewed once shortlist of model options is being finalised, and dependant on alliance working or not. Remit of provider(s).
12	IT	In progress	Dedicated IT Task & Finish Group addressing data and IT infrastructure requirements (data sharing, risk stratification tools and shared electronic Care Plan, emergency care plan and end of life plan).
13	Options Appraisal Process	Pending	Consultation not required for Phase 2, and will be planned in for Phase 3 – the formal requirements dependant on the models and potential changes that emerge.
14	Decommissioning	Pending	Decision depends on alliance working outcomes.
15	Procurement & Contracting	Pending	To commence once model is agreed and again, dependant on outcome of alliance discussions.
16	Commissioning	Pending	To commence once model is agreed, and again, dependant on outcome of alliance discussions.
17	Enhanced Commissioning	Pending	To commence once model is agreed.
18	Pilot Demonstrator Sites	Pending	To be developed, pending the outcome of alliance working discussions.
19	Full Mobilisation	Pending	To commence once model is agreed and/or following pilot of demonstrator sites.

³ Either Pending Authorisation, In Execution or Completed (in the period)

⁴ For example if Work Packages are being performed by external suppliers, this information may be accompanied by purchase order and invoicing data

Project Plan Ref	Work Package Name	Status ⁵	Notes ⁶
20	Monitoring and Evaluation	Pending	Independent clinical review of implemented models. Routine monitoring and reviews established following mobilisation, feeding back into a constant loop of improvements or changes if necessary (PDSA).

Products

Product Ref	Product name	Status ⁷	Notes ⁸
P1	Aristotle	In progress	Being utilised as the software to support and enable risk stratification. Meetings being planned to ascertain reporting criteria.
P2	Information Leaflet	Complete	Overview information leaflet ratified. Circulated widely to the media and public from, and uploaded to the CCG website 1 st August 2018.
P3	Generic Email	Complete	Generic programme email address established for public to make contact.
P4	Ideas Proforma	In progress	Template to be used for the submission of concepts to the Programme Board for consideration of inclusion within the Programme. Final changes to process being agreed.
P5	Staff Briefing	Complete	Provided and actioned by each provider organisation on 1 st August 2018.
P6	FIT evaluation	Complete	Evaluation of RSH pilot of frailty intervention team complete.
P7	Preferred Case Management Model	In Progress	Model identified through collaborative design process and approved by the Clinical Commissioning Committee making decision on 15 th August 2018.
P8	SharePoint	In Progress	SharePoint platform being developed which will provide one online forum to hold all papers, reports and documents relating to the programme; improving shared access and visibility of programme information
P9	Primary Care Networks	In Progress	NHSE initiative that reflects the intentions and aspirations of Case Management in the Care Closer to Home Programme. Work underway to map synergy to ensure integrated approach. SOP on case management and risk stratification operational compliance for GP colleagues also being developed for inclusion in a Primary Care Commissioning Framework.

⁵ Either Pending Authorisation, In Execution or Completed (in the period)

⁶ For example if Work Packages are being performed by external suppliers, this information may be accompanied by purchase order and invoicing data

⁷ Completed (in the period), Planned (but not started or completed) or Underway (as planned)

⁸ Indicate if any products are running behind schedule.

Corrective Actions Undertaken

- Overall Phase 3 timeline deferred by four months to allow for improved availability from stakeholders and thorough & inclusive design involvement and engagement process.
- Reminder involvement email issued 3/10/18 due to continued issues with stakeholder engagement in the design workshops.

Next Reporting Period**Project Plan Areas**

Project Plan Ref	Work Package Name	Status ⁹	Notes ¹⁰
1	Programme Management	In progress	Ongoing programme management, revisiting timeline phasing to reflect Phase 3 delays.
2	Model Design	In progress	Further shaping of Case Management, operational & workforce model. Design of Phase 3 options.
3	Impact Assessments	In progress	Risk assessment completed on impact on programme of JSNA not being available.
4	Phase 1	In Progress	Ensuring ongoing links to Phase 2. Ongoing evaluation. Plans being developed to expand, and rollout at PRH.
5	Phase 2	In progress	Focus on getting signed Alliance Agreement in place to enable collaborative development of operational service delivery and workforce plans for implementing demonstrator pilots, legal framework, outcomes and service specification.
6	Phase 3	In progress	Design and map a longlist of possible model options with further involvement and engagement in January 2019. Longlist of options by March 2019.
7	Patient Involvement	In place	Regular stakeholder workshops and ability to email queries. Planning further 'What Matters to Me' events.
8	Comms & Engagement	In progress	Ongoing maintenance of dedicated section of CCG website, replenishing and updating with new and additional information. Proactive media plan, and mobilisation of the comms & engagement strategy/plans.
9	Quality & Safety	Pending	To be reviewed once shortlist of model options is being finalised. Phase 2 QIA complete.

⁹ Either Pending Authorisation, In Execution or Completed (in the period)

¹⁰ For example if Work Packages are being performed by external suppliers, this information may be accompanied by purchase order and invoicing data

Project Plan Ref	Work Package Name	Status ¹¹	Notes ¹²
10	Finance	Pending	To be reviewed once shortlist of model options is being finalised, and dependant on alliance working or not.
11	Workforce	Pending	To be reviewed once shortlist of model options is being finalised, and dependant on alliance working or not.
12	IT	In progress	Ongoing dedicated IT Task & Finish Group meetings taking place and reporting into the Programme Working Group and Board.
13	Options Appraisal	Pending	Phase 2 complete and model agreed, with no required consultation. Option appraisal process for Phase 3 will take place between March and May 2019, with the need for formal consultation to be determined by the models that emerge from the design process. Confirmation given by NHSE that even where consultation is required, none can take place before May 2019 due to another consultation taking place.
14	Decommissioning	Pending	Decision depends on alliance working outcomes.
15	Procurement & Contracting	Pending	To commence once model is agreed and again, dependant on outcome of alliance discussions.
16	Commissioning	Pending	To commence once model is agreed, and again, dependant on outcome of alliance discussions.
17	Enhanced Commissioning	Pending	To commence once model is agreed.
18	Pilot Demonstrator Sites	Pending	To be developed, pending the outcome of alliance working discussions.
19	Full Mobilisation	Pending	To commence once model is agreed and/or following pilot of demonstrator sites.
20	Monitoring and Evaluation	Pending	Independent clinical review of implemented models. Routine monitoring and reviews established following mobilisation, feeding back into a constant loop of improvements or changes if necessary (PDSA).

¹¹ Either Pending Authorisation, In Execution or Completed (in the period)

¹² For example if Work Packages are being performed by external suppliers, this information may be accompanied by purchase order and invoicing data

Products to be completed

Product Ref	Product name	Notes
P1	Aristotle	Discussions underway with CSU and STP on capabilities of system, eligibility criteria, and primary care data sharing (via STP IT Group)
P3	Generic Email	In place. Process for monitoring, management and response to queries will sit within remit of newly identified comms resource.
P4	Ideas Proforma	Review process behind the proforma for submitting ideas to Programme Board for possible inclusion in Programme.
P8	SharePoint	Further development of SharePoint platform as the online forum that will hold all papers, reports and documents relating to the programme; improving shared access and visibility of programme information.
P9	Primary Care Networks	Alignment and synergy mapped to ensure integrated approach between Care Closer to Home Programme, clustering of GP Practices into networks, and this NHSE primary care initiative. SOP on case management and risk stratification operational compliance for GP colleagues also being developed for inclusion in a Primary Care Commissioning Framework.

Planned Programme Corrective Actions

- Refreshing timeline to incorporate Phase 3 delays and variability in consultation requirements.
- Ongoing analysis of other initiatives which may be addressing the same cohort of patients identified in this programme – added to risk log as potential overlap and duplication.
- Ensuring alignment with NHS England Primary Care Networks initiative.
- Revisiting resource and approach in order to optimise required involvement and engagement.

Project and Stage Tolerance Status

Scope

Phase 2 of the programme is on track within its agreed scope. Phase 3 will be delayed by a total of four months to the original timeline due to availability of required stakeholders in the design process, and additional levels of thorough and inclusive involvement and engagement of providers, GP's and practices, patients and public. Some of this delay however is offset by the fact that we cannot consult on the areas of Phase 3 where it may be required as originally intended due to other consultations taking place at that time. Clarity on what aspects require formal consultation will be ascertained as the models emerge from the design process, and the level of involvement & engagement at earlier stages in the design process. The overall timeline for Phase 3 based on these requirements is therefore delayed by four months, with a longlist now being available by March 2019, and the option appraisal process running to May 2019 when it is anticipated there will be identified preferred models.

Cost

No available funding and costs of remodelling services are yet to be identified through the design and option appraisal process. It is anticipated however that the same monies currently spent on community based services will be used differently, meaning no significant change on current funding and costs. Any costs will be offset by the eventual admission avoidance from secondary care of 4,586 patients per annum (not taking into account any potential impact from other initiatives that may reach the same cohort of patients, such as Frailty Intervention at the Front Door, follow up telephone care and support to enable timely discharge).

Timings

The actual against planned timings of the 3 agreed phases are as follows:

- *Phase 1* – in place with ongoing evaluation and plans to expand to PRH.
- *Phase 2* – on track. Collaboratively designed and formally approved Case Management model ready for next steps of shaping the more detailed operational service delivery and workforce models that would enable demonstrator pilot sites; before wider rollout across the county. Draft outcomes framework and service specs being reviewed and finalised. Enhanced focus in place on achieving the alliance agreement which is needed to ensure integrated joint working and commonality of aims and objectives.
- *Phase 3* – delayed by four months, intensive design sessions scheduled to take place late October and throughout November. Stakeholders also able to contribute in writing through a design input template mechanic. Further involvement and engagement workshops to take place January 2019. Working towards having a tangible longlist of model options for CCC consideration by March 2019 to commence the option appraisal process.

Requests for Change

Change Description	Raised	Pending	Approved	Rejected
Dementia to receive its own transformation programme	✓			✓*
Care and Voluntary Sector to be included in design workshops	✓		✓	
Bring Community Equipment Review into the Programme	✓	✓		
Provider organisations develop and implement their own staff briefings	✓		✓	

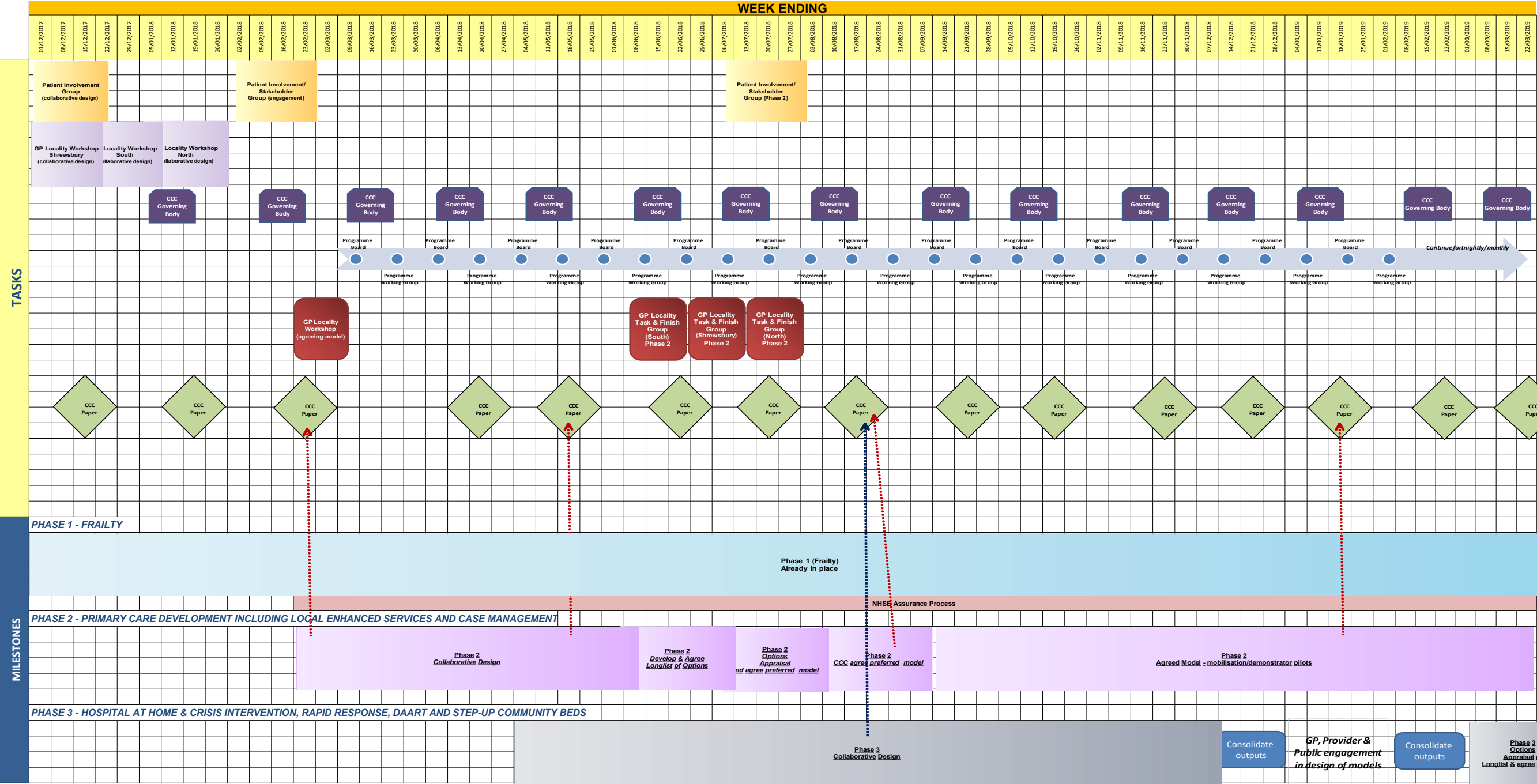
* Rejected on the proviso that dementia is factored into the wraparound care being developed through Case Management.

Key Issues and Risks

Risk or Issue	Potential	Actual	Mitigation
Inadequate comms and engagement resources to support programme		✓	Risk closed.
GP termination of LES could place stress on the health system leading to potential untoward consequences	✓		
Failure to align other programmes of work such as Future Fit, GP Out of Hours, Frailty and QIPP schemes which may result in double counting and reduced projected impact.		✓	Logged as a programme risk, and ongoing analysis to ensure alignment with other initiatives and identify areas of possible overlap.
Alliance working		✓	Discussions ongoing to help enable the development of a clear course of action.
Introduction of T&W Frailty unit could have a negative impact upon staffing FIT at RSH, and may destabilise the health economy in the absence of robust impact assessment	✓		
Delays in development of mapped out model options in Simul8		✓	Interim solution – mapped pathways created as images for use in locality task & finish groups.
Delays on implementation of Phase 3 due to NHSE consultation requirements and protocol.		✓	Actual delay being finalised before rephasing the programme timeline.
Possible delay to overall delivery of the programme, with subsequent impact on delivery of Future Fit as a result of not having a JSNA.	✓		Risk and potential impact escalated to Shropshire Council. Additional risk of delay in receiving JSNA, and whether the information will be fit for purpose.
Limited uptake and engagement by stakeholders in the Phase 3 design sessions.		✓	Would need to adopt a totally different approach to the design process.

-ends-

Shropshire Care Closer to Home Programme
High Level Timeline



		WEEK ENDING																																							
		29/03/2019	05/04/2019	12/04/2019	19/04/2019	26/04/2019	03/05/2019	10/05/2019	17/05/2019	24/05/2019	31/05/2019	07/06/2019	14/06/2019	21/06/2019	28/06/2019	05/07/2019	12/07/2019	19/07/2019	26/07/2019	02/08/2019	09/08/2019	16/08/2019	23/08/2019	30/08/2019	06/09/2019	13/09/2019	20/09/2019	27/09/2019	04/10/2019	11/10/2019	18/10/2019	25/10/2019	01/11/2019	08/11/2019	15/11/2019	22/11/2019	29/11/2019	06/12/2019	13/12/2019	20/12/2019	27/12/2019
TASKS																																									
MILESTONES		<p>PHASE 1 - FRAILTY</p> <p>Phase 1 (Frailty) Already in place</p> <p>PHASE 2 - PRIMARY CARE DEVELOPMENT INCLUDING LOCAL ENHANCED SERVICES AND CASE MANAGEMENT</p> <p>NHSE Assurance Process</p> <p>Phase 2 Evaluation of demonstrator pilots and expand to full rollout</p> <p>PHASE 3 - HOSPITAL AT HOME & CRISIS INTERVENTION, RAPID RESPONSE, DAART AND STEP-UP COMMUNITY BEDS</p> <p>Public engagement on shortlist of options</p> <p>Consolidate outputs</p> <p>Phase 3 Post-engagement Options Appraisal of Shortlist</p> <p>Phase 3 Either mobilisation or consultation commences on agreed models</p>																																							

	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th	13th	14th	15th	16th	17th	18th	19th	20th	21st	22nd	23rd	24th	25th	26th	27th	28th	29th	30th	31st		
2018	January	BANK HOLIDAY		South GP Locality Workshop						CCG Governing Body	North GP Locality Workshop						CCG Clinical Commissioning Committee																
	February													CCG Governing Body	Programme Working Group						CCG Clinical Commissioning Committee												
	March	Programme Working Group												CCG Governing Body	Programme Working Group						CCG Clinical Commissioning Committee	Programme Board							Programme Working Group	BANK HOLIDAY			
	April		BANK HOLIDAY								CCG Governing Body	Programme Working Group						CCG Clinical Commissioning Committee								Programme Working Group	Programme Board						
	May						BANK HOLIDAY		CCG Governing Body	Programme Working Group							CCG Clinical Commissioning Committee							Programme Board	Programme Working Group				BANK HOLIDAY				
	June						Programme Working Group	Programme Board					CCG Governing Body								CCG Clinical Commissioning Committee	Programme Working Group											
	July				Programme Working Group						CCG Governing Body							CCG Clinical Commissioning Committee	Programme Board	Programme Working Group													
	August		Programme Working Group						CCG Governing Body								CCG Clinical Commissioning Committee	Programme Working Group										BANK HOLIDAY					
	September												CCG Governing Body	Programme Working Group						CCG Clinical Commissioning Committee	Programme Board												
	October										CCG Governing Body	Programme Working Group						CCG Clinical Commissioning Committee	Programme Board														
	November														CCG Governing Body							CCG Clinical Commissioning Committee	Programme Board										
	December												CCG Governing Body	Programme Board							CCG Clinical Commissioning Committee					BANK HOLIDAY	BANK HOLIDAY						
2019	January	BANK HOLIDAY							CCG Governing Body								CCG Clinical Commissioning Committee																
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Shropshire Care Closer to Home

Decision & Key Action Record

COMPLETE			
Date	Group	Venue	Decision or Action
Monday 4th December 2017	Commissioning Team	William Farr House	High level scoping complete
Wednesday 20th December 2017	Clinical Commissioning Committee (CCC)	Room 2, Oak Lodge, William Farr House	Strategic intent of Programme formally noted
Friday 15th December 2017	Commissioning Team	William Farr House	Project Team and Programme Plan established
Friday 12th January 2018	Commissioning Team	William Farr House	Current and future state scoping complete (from GP and patient rep workshops)
Monday 15th January 2018	Commissioning Team	William Farr House	Programme governance established
Wednesday 17th January 2018	Clinical Commissioning Committee (CCC)	Room 2, Oak Lodge, William Farr House	Approach and phasing of Programme approved
Monday 29th January 2018	Commissioning Team	William Farr House	Programme Risk Log Established
Wednesday 15th February 2018	Programme Management Team	William Farr House	Programme Working Group and ToR established
Wednesday 21st February 2018	Clinical Commissioning Committee (CCC)	Room 2, Oak Lodge, William Farr House	Strategic intent and progress noted
Friday 9th March 2018	Programme Management Team	William Farr House	High level modelling complete
Thursday 22nd March 2018	Programme Management Team	Room 2, Oak Lodge, William Farr House	Programme Board and ToR established
Wednesday 25th April 2018	Programme Board	Room 2, Oak Lodge, William Farr House	Programme officially named 'Shropshire Care Closer to Home'
Friday 27th April 2018	Programme Management Team	William Farr House	High level scoping of other Case Management models complete
Wednesday 16th May 2018	Clinical Commissioning Committee (CCC)	Room 2, Oak Lodge, William Farr House	Strategic intent of Phase 2 (Case Management) and its links with Frailty formally noted
Thursday 7th June 2018	Programme Board	Room 2, Oak Lodge, William Farr House	Public-facing information leaflet, and provider staff briefing ratified for circulation
Friday 15th June 2018	Programme Management Team	William Farr House	Design outputs consolidated into Case Management model options
Monday 2nd July 2018	Programme Management Team	William Farr House	Agreement to utilise existing Aristotle system for risk stratification
Thursday 5th July 2018	Programme Working Group	Room G1, William Farr House	Emerging model and various options agreed
Wednesday 18th July 2018	Programme Board	Room G1, William Farr House	Agreed the Case Management core model and 9 areas of variability
Thursday 19th July 2018	Programme Working Group	Room G1, William Farr House	Explored the 9 areas of variability and agreed the final preferred Case Management model
Wednesday 16th August 2018	Clinical Commissioning Committee (CCC)	Room 2, Oak Lodge, William Farr House	Agreed the final Case Management model. Agreed strategic intent and approach to Phase 3.
Wednesday 4th October 2018	Programme Management Team	William Farr House	Invitations to Phase 3 design circulated, along with input template

PLANNED			
Date	Group	Venue	Decision or Action
Friday 26th October 2018	Design workshop stakeholders - various	Room B7, William Farr House	Complete high level design of Hospital at Home service (Phase 3)
Friday 16th November 2018	Design workshop stakeholders - various	Room B7, William Farr House	Complete high level design of Rapid Response service (Phase 3)
Friday 30th November 2018	Design workshop stakeholders - various	Room B7, William Farr House	Complete high level design of Hstep Up Beds service (Phase 3)
Friday 30th November 2018	Programme Management Team	William Farr House	Collate all written Phase 3 input templates received
Friday 28th December 2018	Programme Management Team	William Farr House	Consolidate design workshop outputs to summarise initial Phase 3 modelling
Jan-19	Programme Management Team	Various	Further testing of Phase 3 modelling at GP Locality Meetings
Jan-19	Programme Management Team	Various	Public, patient and provider stakeholder engagement in Phase 3 modelling
Feb-19	Programme Management Team	William Farr House	Consolidate all outputs & contributions and finalise longlist of Phase 3 model options
Mar-19	Clinical Commissioning Committee (CCC)	William Farr House	Option Appraisal of Phase 3 longlist - to agree a shortlist
Apr-19	Programme Management Team	Various	Public & patient engagement on shortlist of model options for Phase 3 (pre-consultation if necessary)
May-19	Clinical Commissioning Committee (CCC)	William Farr House	Option Appraisal of Phase 3 shortlist - to agree a preferred model
			Implement agreed model through demonstrator pilot or commence consultation
			PCBC

Involvement & Engagement Record

[illegible]



Health and Wellbeing Board 1st November, 2018

HWBB Joint Commissioning Report - Better Care Fund Update

Responsible Officer

Email: Penny.bason@shropshire.gov.uk

Tel:

Fax:

1. Summary

- 1.1 This report provides an update on the progress on the Better Care Fund (BCF). Appendix A highlights current BCF performance and Appendix B attached is the Q2 BCF return.
- 1.2 At the last HWBB (13th September 2018) the Board agreed to approve the BCF updated annex for 18/19 following the final approval of the BCF Section 75 Partnership Agreement by the Shropshire CCG. This was completed on 2nd October and the Partnership Agreement has now been agreed and signed by Shropshire CCG and Shropshire Council.
- 1.3 The Quarter 2 return highlights good performance against the national metrics for Delayed Transfers, Re-ablement, and Care Home Admissions (detailed in Appendix A below), however not all quarter 2 data is available. The non-elective admissions target is in danger of not being met when the September figures are available. The Quarter 2 return also highlights progress on the 8 High Impact Changes and notes joint working on Local Digital Road Map as an integration success story.
- 1.4 Key areas for development for the next quarter include focussing on the 8 High Impact Changes (detailed in the BCF Q2 Return), and will include proposals for developing a Red Bag Scheme in Shropshire.

2. Recommendations

- 2.1 The HWBB to note and discuss performance and the Q2 return.

REPORT

3. Risk Assessment and Opportunities Appraisal

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

- 3.2. The HWB Strategy requires that the health and care system work to reduce inequalities in Shropshire. All decisions and discussions by the Board must take into account reducing inequalities.
- 3.3. The schemes of the BCF and other system planning have been done by engaging with stakeholders, service users, and patients. This has been done in a variety of ways including through patient groups, focus groups, ethnographic research.
- 3.4. As the agreement is yet to receive final sign off from the CCG Governance process, this remains a risk, however joint working across Shropshire Council and Shropshire CCG is working closely to minimise this risk.

4. Background



4.1 The Better Care Fund progress is reported at every Health and Wellbeing Board through the Joint Commissioning Report to the HWBB.

<p>List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) For the final BCF plan please see HWBB paper here</p>
<p>Cabinet Member (Portfolio Holder) Cllr Lee Chapman</p>
<p>Local Member n/a</p>
<p>Appendices Appendix A: BCF Performance Appendix B: BCF Quarter 2 Return</p>

Appendix A

Better Care Fund Metrics 18/19

1. Non-elective Admissions



Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
8,509	8,259	8,920	8,661
8,262 	2 months 5,650 		

2. Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population.

Number of residential admissions is reducing




The following table shows the rate of admissions per 100,000 people

2018/19	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Profile (target)	150	300	450	600.3
Actual	83.5	185.5		
Performance				

Performance is better than the profiled target. The service reiterates that its priority is to ensure that the most appropriate care package is provided at the right time to meet people's needs.

3. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

This measure is reported in arrears.

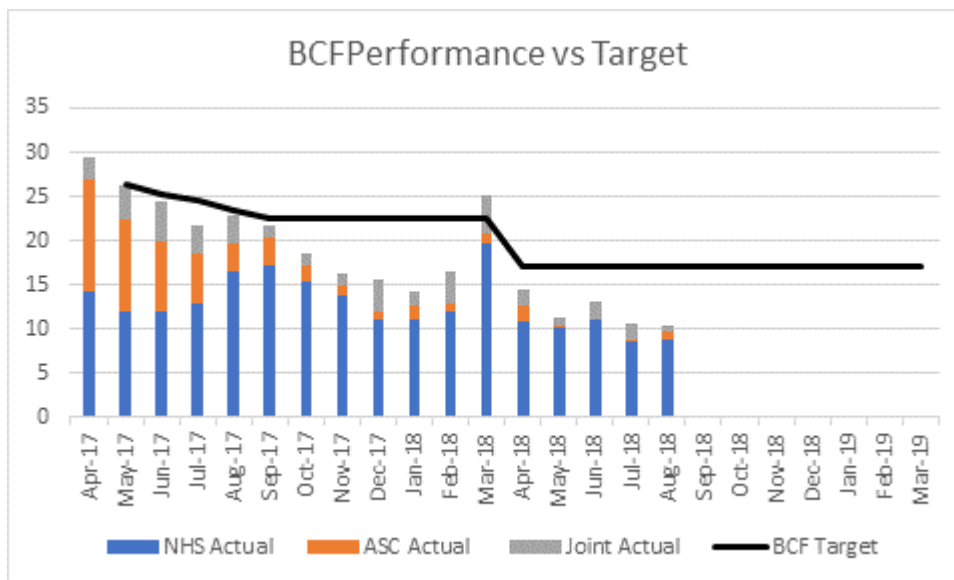
2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Target	82%	82%	82%	82%
Actual	83.4%	TBC		
Performance				

The reablement figure for q1 stands at 83.4%, better than the target of 82%. This covers those patients discharged into re-ablement during April – June with the 91 day follow-up occurring during July – September. Those discharged from hospital to reablement services in Q2 will be reviewed in quarter 3. This measure looks at the % of people who are still at home 91 days after their discharge, therefore always reported in arrears.

4. Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).

This is a joint measure with the NHS which records the combined number of patients who are delayed in their transfer of care from hospital.

The following chart shows the total monthly number of delayed days by organisation and demonstrates good progress with continued low DTOC numbers.



The final figure for Q1 was 13 against a target of 17, (better than target). After the first 2 months of quarter 2 we are currently better than target. The BCF target is for less than 17 patients a day to face a delayed transfer. For Q2 (July & August) we currently stand at a daily average of 12.9. Data for September is published on 8th November 2018 from which we will be able to calculate the final results for Q2.

Overview

The Better Care Fund (BCF) quarterly reporting requirement is set out in the BCF Planning Requirements for 2017-19 which supports the aims of the Integration and BCF Policy Framework and the BCF programme jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of the BCF quarterly reporting are:

- 1) To confirm the status of continued compliance against the requirements of the fund (BCF)
- 2) To provide information from local areas on challenges, achievements and support needs in progressing integration and the delivery of BCF plans
- 3) To foster shared learning from local practice on integration and delivery of BCF plans
- 4) To enable the use of this information for national partners to inform future direction and for local areas to inform delivery improvements

BCF quarterly reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including clinical commissioning groups, local authorities and service providers) for the purposes noted above.

BCF quarterly reports are submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally and these reports are therefore part of the official suite of HWB documents.

The BCF quarterly reports in aggregated form will be shared with local areas prior to publication in order to support the aforementioned purposes of BCF reporting. In relation to this, the Better Care Support Team (BCST) will make the aggregated BCF quarterly reporting information in entirety available to local areas in a closed forum on the Better Care Exchange (BCE) prior to publication.

For 2018-19, reporting on the additional iBCF Grant (funding announced in the 2017 Spring Budget) is included in the BCF quarterly reporting as a combined template to streamline the reporting requirements placed on local systems. The BCST along with NHSE hosted information infrastructure will be collecting and aggregating the iBCF information and providing it to MHCLG. Although collected together, BCF and iBCF information will be reported and published separately.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The details of each sheet within the template are outlined below.

Checklist

1. This sheet helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the Better Care Support Team.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference for the question and the 'checker' column which updates automatically as questions within each sheet are completed.
3. The checker column will appear "Red" and contain the word "No" if the information has not been completed. Clicking on the corresponding "Cell Reference" column will link to the incomplete cell for completion. Once completed the checker column will change to "Green" and
4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete Template'.
6. Please ensure that all boxes on the checklist tab are green before submission.

1. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. 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 cells are green should the template be sent to

2. National Conditions & s75 Pooled Budget

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Integration and Better Care Fund planning requirements for 2017-19 continue to be met through the delivery of your plan. Please confirm as at the time of <https://www.england.nhs.uk/wp-content/uploads/2017/07/integration-better-care-fund-planning-requirements.pdf>

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met within the quarter and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager.

In summary, the four national conditions are as below:

National condition 1: A jointly agreed plan

Please note: This also includes confirming the continued agreement on the jointly agreed plan for DFG spending

National condition 2: NHS contribution to social care is maintained in line with inflation

National condition 3: Agreement to invest in NHS-commissioned out-of-hospital services

National condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care

3. National Metrics

The BCF plan includes the following four metrics: Non-Elective Admissions, Delayed Transfers of Care, Residential Admissions and Reablement. As part of the BCF plan for 2017-19, planned targets have been agreed for these metrics.

This section captures a confidence assessment on meeting these BCF planned targets for each of the BCF metrics.

A brief commentary is requested for each metric outlining the challenges faced in meeting the BCF targets, any achievements realised and an opportunity to flag any Support Needs the local system may have recognised where assistance may be required to facilitate or accelerate the achievement of the BCF targets.

As a reminder, if the BCF planned targets should be referenced as below:

- Residential Admissions and Reablement: BCF plan targets were set out on the BCF Planning Template

- Non Elective Admissions (NEA): The BCF plan mirrors the CCG (Clinical Commissioning Groups) Operating Plans for Non Elective Admissions except where areas have put in additional reductions over and above these plans in the BCF planning template. Where areas have done so and require a confirmation of their BCF NEA plan targets, please write into england.bettercaresupport@nhs.net

Please note that while NEA activity is not currently being reported against CCG Operating Plans (due to comparability issues relating to specialised commissioning), HWBs can still use NEA activity to monitor progress for reducing NEAs.

- Delayed Transfers of Care (DToc): The BCF plan targets for DToc should be referenced against your current provisional trajectory. Further information on DToc trajectories for 2018-19 will be published shortly.

The progress narrative should be reported against this provisional monthly trajectory as part of the HWB's plan.

This sheet seeks a best estimate of confidence on progress against targets and the related narrative information and it is advised that:

- In making the confidence assessment on progress against targets, please utilise the available published metric data (which should be typically available for 2 of the 3 months) in conjunction with the interim/proxy metric information for the third month (which is eventually the source of the published data once agreed and validated) to provide a directional estimate.

- In providing the narrative on Challenges, Achievements and Support need, most areas have a sufficiently good perspective on these themes by the end of the quarter and the unavailability of published metric data for one of the three months of the quarter is not expected to hinder the ability to provide this very useful information. Please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any associated comments to explain.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

4. High Impact Change Model

The BCF National Condition 4 requires local areas to implement the High Impact Change Model (HICM) for Managing Transfers of Care. This section of the template captures a self-assessment on the current level of implementation, and anticipated trajectory in future quarters, of each of the eight HICM changes and the red-bag scheme along with the corresponding implementation challenges, achievements and support

The maturity levels utilised on the self assessment dropdown selections are based on the guidance available on the published High Impact Changes Model (link below). A distilled explanation of the levels for the purposes of this reporting is included in the key below:

Not yet established - The initiative has not been implemented within the HWB area

Planned - There is a viable plan to implement the initiative / has been partially implemented within some areas of the HWB

Established - The initiative has been established within the HWB area but has not yet provided proven benefits / outcomes

Mature - The initiative is well embedded within the HWB area and is meeting some of the objectives set for improvement

Exemplary - The initiative is fully functioning, sustainable and providing proven outcomes against the objectives set for

<https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change->

In line with the intent of the published HICM model self assessment, the self assessment captured via BCF reporting aims to foster local conversations to help identify actions and adjustments to progress implementation, to understand the area's ambition for progress and, to indicate where implementation progress across the eight changes in an area varies too widely which may constrain the extent of benefit derived from the implementation of the model. As this is a self assessment, the approaches adopted may diverge considerably from area to area and therefore the application of this information as a comparative indicator of progress between areas bears considerable limitations.

In making the self-assessment, please ensure that a representative range of stakeholders are involved to offer an assessment that is as near enough as possible to the operational reality of the area. The recommended stakeholders include but are not limited to Better Care Managers, BCF leads from CCGs and LAs, local Trusts, Care Sector Regional Leads, A&E Delivery Board representatives, CHIAs and regional

The HICM maturity assessment (particularly where there are multiple CCGs and A&E Delivery Boards (AEDBs)) may entail making a best judgment across the AEDB and CCG lenses to indicatively reflect an implementation maturity for the HWB. The AEDB lens is a more representative operational lens to reflect both health and social systems and where there are wide variations in implementation levels between them, making a conservative judgment is advised. Where there are clear disparities in the stage of implementation within an area, the narrative section should be used to briefly indicate this and the rationale for the recorded assessment agreed by local partners

Please use the 'Challenges' narrative section where your area would like to highlight a preferred approach proposed for making the HICM self-assessment, which could be useful in informing future design considerations.

Where the selected maturity levels for the reported quarter are 'Mature' or 'Exemplary', please provide supporting detail on the features of the initiatives and the actions implemented that have led to this assessment.

For each of the HICM changes please outline the challenges and issues in implementation, the milestone achievements that have been met in the reported quarter with any impact observed, and any support needs identified to facilitate or accelerate the implementation of the

To better understand the spread and impact of Trusted Assessor schemes, when providing the narrative for "Milestones met during the quarter / Observed impact" please consider including the proportion of care homes within the locality participating in Trusted Assessor schemes. Also, any evaluated impacts noted from active Trusted Assessor schemes (e.g. reduced hospital discharge delays, reduced hospital Length of Stay for patients awaiting care home placements, reduced care home vacancy rates) would be welcome.

Hospital Transfer Protocol (or the Red Bag Scheme):

- The template also collects updates on areas' implementation of the optional 'Red Bag' scheme. Delivery of this scheme is not a requirement of the Better Care Fund, but we have agreed to collect information on its implementation locally via the BCF quarterly reporting template.

- Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.

- Where there are no plans to implement such a scheme please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.

- Further information on the Red Bag / Hospital Transfer Protocol: A quick guide has been published:

<https://www.nhs.uk/NHSEngland/keogh-review/Pages/quick-guides.aspx>

Further guidance is available on the Kahootz system or on request from the NHS England Hospital to Home team through england.ohuc@nhs.net. The link to the Sutton Homes of Care Vanguard – Hospital Transfer Pathway (Red Bag) scheme is as below:

<https://www.youtube.com/watch?v=XoYZPXmULHE>

5. Narrative

This section captures information to provide the wider context around health and social integration.

Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.

Please tell us about an integration success story observed over reported quarter highlighting the nature of the service or scheme and the

6. Additional improved Better Care Fund

For 2018-19 the additional iBCF monitoring has been incorporated into the BCF form. Please fill this section in if you are responsible for the additional iBCF quarterly monitoring for your organisation, or geographic area.

To reflect this change, and to align with the BCF, data must now be entered on a HWB level.

For Quarter 2, the iBCF section of the form covers questions relating to external provider fees only. Specific guidance is provide on the iBCF

Better Care Fund Template Q2 2018/19

1. Cover

Version 1.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and are planned for publishing in an aggregated form on the NHSE website. **Narrative sections of the reports will not be published.** However as with all information collected and stored by public bodies, all BCF information including any narrative is subject to Freedom of Information requests.
- As noted already, the BCF national partners intend to publish the aggregated national quarterly reporting information on a quarterly basis. At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Shropshire
Completed by:	Penny Bason
E-mail:	Penny.bason@shropshire.gov.uk
Contact number:	01743 252767
Who signed off the report on behalf of the Health and Wellbeing Board:	Cllr Lee Chapman

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'

Complete

	Pending Fields
1. Cover	0
2. National Conditions & s75 Pooled Budget	0
3. National Metrics	0
4. High Impact Change Model	0
5. Narrative	0
6. iBCF	0



1. Cover

	Cell Reference	Checker
Health & Wellbeing Board	C8	Yes
Completed by:	C10	Yes
E-mail:	C12	Yes
Contact number:	C14	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	C16	Yes

Sheet Complete:	Yes
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2. National Conditions & s75 Pooled Budget

[^^ Link Back to top](#)

	Cell Reference	Checker
1) Plans to be jointly agreed?	C8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements?	C9	Yes
3) Agreement to invest in NHS commissioned out of hospital services?	C10	Yes
4) Managing transfers of care?	C11	Yes
1) Plans to be jointly agreed? If no please detail	D8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements? Detail	D9	Yes
3) Agreement to invest in NHS commissioned out of hospital services? If no please detail	D10	Yes
4) Managing transfers of care? If no please detail	D11	Yes
Have the funds been pooled via a s.75 pooled budget?	C15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please detail	D15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please indicate when	E15	Yes

Sheet Complete:	Yes
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3. Metrics

[^^ Link Back to top](#)

	Cell Reference	Checker
NEA Target performance	D11	Yes
Res Admissions Target performance	D12	Yes
Reablement Target performance	D13	Yes
DToc Target performance	D14	Yes
NEA Challenges	E11	Yes
Res Admissions Challenges	E12	Yes
Reablement Challenges	E13	Yes
DToc Challenges	E14	Yes
NEA Achievements	F11	Yes
Res Admissions Achievements	F12	Yes
Reablement Achievements	F13	Yes
DToc Achievements	F14	Yes
NEA Support Needs	G11	Yes
Res Admissions Support Needs	G12	Yes
Reablement Support Needs	G13	Yes
DToc Support Needs	G14	Yes

Sheet Complete:	Yes
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4. High Impact Change Model

[^^ Link Back to top](#)

	Cell Reference	Checker
Chg 1 - Early discharge planning Q2 18/19	F12	Yes
Chg 2 - Systems to monitor patient flow Q2 18/19	F13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q2 18/19	F14	Yes
Chg 4 - Home first/discharge to assess Q2 18/19	F15	Yes
Chg 5 - Seven-day service Q2 18/19	F16	Yes
Chg 6 - Trusted assessors Q2 18/19	F17	Yes
Chg 7 - Focus on choice Q2 18/19	F18	Yes
Chg 8 - Enhancing health in care homes Q2 18/19	F19	Yes
UEC - Red Bag scheme Q2 18/19	F23	Yes
Chg 1 - Early discharge planning Q3 18/19 Plan	G12	Yes
Chg 2 - Systems to monitor patient flow Q3 18/19 Plan	G13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q3 18/19 Plan	G14	Yes
Chg 4 - Home first/discharge to assess Q3 18/19 Plan	G15	Yes
Chg 5 - Seven-day service Q3 18/19 Plan	G16	Yes
Chg 6 - Trusted assessors Q3 18/19 Plan	G17	Yes
Chg 7 - Focus on choice Q3 18/19 Plan	G18	Yes
Chg 8 - Enhancing health in care homes Q3 18/19 Plan	G19	Yes
UEC - Red Bag scheme Q3 18/19 Plan	G23	Yes
Chg 1 - Early discharge planning Q4 18/19 Plan	H12	Yes
Chg 2 - Systems to monitor patient flow Q4 18/19 Plan	H13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q4 18/19 Plan	H14	Yes
Chg 4 - Home first/discharge to assess Q4 18/19 Plan	H15	Yes
Chg 5 - Seven-day service Q4 18/19 Plan	H16	Yes
Chg 6 - Trusted assessors Q4 18/19 Plan	H17	Yes
Chg 7 - Focus on choice Q4 18/19 Plan	H18	Yes
Chg 8 - Enhancing health in care homes Q4 18/19 Plan	H19	Yes
UEC - Red Bag scheme Q4 18/19 Plan	H23	Yes
Chg 1 - Early discharge planning, if Mature or Exemplary please explain	I12	Yes
Chg 2 - Systems to monitor patient flow, if Mature or Exemplary please explain	I13	Yes
Chg 3 - Multi-disciplinary/agency discharge teams, if Mature or Exemplary please explain	I14	Yes
Chg 4 - Home first/discharge to assess, if Mature or Exemplary please explain	I15	Yes
Chg 5 - Seven-day service, if Mature or Exemplary please explain	I16	Yes
Chg 6 - Trusted assessors, if Mature or Exemplary please explain	I17	Yes
Chg 7 - Focus on choice, if Mature or Exemplary please explain	I18	Yes
Chg 8 - Enhancing health in care homes, if Mature or Exemplary please explain	I19	Yes
UEC - Red Bag scheme, if Mature or Exemplary please explain	I23	Yes
Chg 1 - Early discharge planning Challenges	J12	Yes
Chg 2 - Systems to monitor patient flow Challenges	J13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Challenges	J14	Yes
Chg 4 - Home first/discharge to assess Challenges	J15	Yes
Chg 5 - Seven-day service Challenges	J16	Yes
Chg 6 - Trusted assessors Challenges	J17	Yes
Chg 7 - Focus on choice Challenges	J18	Yes
Chg 8 - Enhancing health in care homes Challenges	J19	Yes
UEC - Red Bag Scheme Challenges	J23	Yes
Chg 1 - Early discharge planning Additional achievements	K12	Yes
Chg 2 - Systems to monitor patient flow Additional achievements	K13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Additional achievements	K14	Yes
Chg 4 - Home first/discharge to assess Additional achievements	K15	Yes
Chg 5 - Seven-day service Additional achievements	K16	Yes
Chg 6 - Trusted assessors Additional achievements	K17	Yes
Chg 7 - Focus on choice Additional achievements	K18	Yes
Chg 8 - Enhancing health in care homes Additional achievements	K19	Yes
UEC - Red Bag Scheme Additional achievements	K23	Yes
Chg 1 - Early discharge planning Support needs	L12	Yes
Chg 2 - Systems to monitor patient flow Support needs	L13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Support needs	L14	Yes
Chg 4 - Home first/discharge to assess Support needs	L15	Yes
Chg 5 - Seven-day service Support needs	L16	Yes
Chg 6 - Trusted assessors Support needs	L17	Yes
Chg 7 - Focus on choice Support needs	L18	Yes
Chg 8 - Enhancing health in care homes Support needs	L19	Yes
UEC - Red Bag Scheme Support needs	L23	Yes

Sheet Complete:

Yes

5. Narrative[^^ Link Back to top](#)

	Cell Reference	Checker
Progress against local plan for integration of health and social care	B8	Yes
Integration success story highlight over the past quarter	B12	Yes

Sheet Complete:	Yes
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6. IBCF[^^ Link Back to top](#)

	Cell Reference	Checker
1. Average amount paid to external providers for home care in 2017/18	C19	Yes
1. Average amount expected to pay external providers for home care in 2018/19	D19	Yes
1. Uplift if rates not known	E19	Yes
2. Average amount paid for external provider care homes without nursing for clients aged 65+ in 17/18	C20	Yes
2. Average expected pay for external provider care homes without nursing clients aged 65+ in 2018/19	D20	Yes
2. Uplift if rates not known	E20	Yes
3. Average amount paid for external provider care homes with nursing for clients aged 65+ in 2017/18	C21	Yes
3. Average expected to pay for external provider care homes with nursing for clients aged 65+ in 18/19	D21	Yes
3. Uplift if rates not known	E21	Yes

Sheet Complete:	Yes
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[^^ Link Back to top](#)

Better Care Fund Template Q2 2018/19

2. National Conditions & s75 Pooled Budget

Selected Health and Wellbeing Board:

Shropshire

Confirmation of Nation Conditions

National Condition	Confirmation	If the answer is "No" 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? (This also includes agreement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes	
2) Planned contribution to social care from the CCG minimum contribution is agreed in line with the Planning Requirements?	Yes	
3) Agreement to invest in NHS commissioned out of hospital services?	Yes	
4) Managing transfers of care?	Yes	

Confirmation of s75 Pooled Budget

Statement	Response	If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:	If the answer to the above is 'No' please indicate when this will happen
Have the funds been pooled via a s.75 pooled budget?	Yes		

Better Care Fund Template Q2 2018/19

Metrics

Selected Health and Wellbeing Board:

Shropshire

Challenges Please describe any challenges faced in meeting the planned target

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metric

Support Needs Please highlight any support that may facilitate or ease the achievements of metric plans

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements	Support Needs
NEA	Reduction in non-elective admissions	Data not available to assess progress	This is a particular focus for neighbourhood/ out of hospital working and will need specific consideration regarding the nighttime closure of Princess Royal A&E. considering the previous months of data we may not meet this target	June - 2,684, July 2,804, August 2,766	none at this time
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	none	Residential Admissions to end of Q2 – the rate per 100,000 is 185.5 better than the target of 300	none at this time
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	On track to meet target	none	The reablement figure for q1 stands at 83.4%, better than the target of 82%. This covers those patients discharged into re-ablement during April – June with the 91 day follow-up occurring	none at this time
Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	On track to meet target	this remains a focus on health and care and will need specific consideration as part of the planned nighttime closure of Princess Royal A&E	The delayed transfer measure – the final figure for Q1 was 13 against a target of 17. (better than target) After the first 2 months of quarter 2 we are currently better than target.	none at this time

Better Care Fund Template Q2 2018/19

4. High Impact Change Model

Selected Health and Wellbeing Board:

Challenges

Please describe the key challenges faced by your system in the implementation of this change

Milestones met during the quarter / Observed Impact

Please describe the milestones met in the implementation of the change or describe any observed impact of the implemented change

Support Needs

Please indicate any support that may better facilitate or accelerate the implementation of this change

		Maturity Assessment					Narrative			
		Q4 17/18	Q1 18/19	Q2 18/19 (Current)	Q3 18/19 (Planned)	Q4 18/19 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	Early discharge planning	Established	Established	Established	Established	Mature		For planned care early discharge planning needs to be part of the GP 5 YFV and system planning - resource to support elements of planned care needs to be found to progress this element of the standard to achieve mature	Work continues in SATH and Shropcom to embed the SAFER/RED2GREEN work practices and to overcome the workforce challenges.	not at this time
Chg 2	Systems to monitor patient flow	Established	Established	Established	Established	Mature		Workforce challenges and heavy reliance on agency staff restricts provider ability to embed the required systems and processes to support early supported discharge sustainably.	Embedded case check challenge, SAFER bundle, RED2GREEN, End PJ paralysis, creating improvements	not at this time
Chg 3	Multi-disciplinary/multi-agency discharge teams	Mature	Mature	Mature	Mature	Mature	Multidisciplinary teams work together to through the discharge hubs, with morning and afternoon meetings to review the MFFD and allocate actions. Model now moving to the next phase of integrated discharge working with expansion of the membership to include community and achieving targets regarding discharge within 48 hours of completion of the FFA, working to audit 48 hour visit by specialist (social worker or therapist) in the community following discharge. Single assessment document reviewed and confirmed as fit for purpose. Trusted assessor roles in case homes established	out of hospital work needs to bed in and link to 7 day working, for further fulfilment of this high impact change - to move to exemplary	Embedded IDT implementation including daily and weekly targets of complex discharge cases; FFAs completed within 24 hours as required; Enhanced Integrated Discharge Team model implemented.	not at this time
Chg 4	Home first/discharge to assess	Mature	Mature	Mature	Mature	Mature		out of hospital work needs to bed in and link to 7 day working, for further fulfilment of this high impact change - to move to exemplary	consistent desired ratio splits of 60%P1, 30% P2, 10% P1	not at this time

Chg 5	Seven-day service	Not yet established	Not yet established	Not yet established	Plans in place	Plans in place		7 day availability of GP appointments has been established. However, workforce challenges, particularly in acute, make establishing 7 day working very challenging. For 7 day working to be effective and value for money all elements of the system need to be able to consistently commit the necessary resource over the 7 day period which is not possible at the present time, nor likely in 2018/19. All providers are committed through the STP Workforce Workstream to develop a sustainable workforce plan. The progression of the Future Fit acute hospitals reconfiguration	Future Fit consultation completed September 2018 and we are awaiting feedback. In the meantime the SaTH Board has agreed to close A&E overnight and plans are currently being developed to ensure this is done safely	not at this time
Chg 6	Trusted assessors	Established	Established	Mature	Mature	Mature	Integrated assessment teams work together appropriately; resources are accessed by a single assessment; confidence and trust increasing across	challenges are being overcome by working collaboratively, governance through the discharge to assess working group	Trusted Assessors for Care Homes continue to build the necessary relationships with care homes.	not at this time
Chg 7	Focus on choice	Established	Plans in place	Established	Established	Established		Challenges will be worked through the A&E delivery group	System wide Choice Policy agreed at A&E Delivery Board in early August 2018 for implementation by all providers. System training underway to implement the agreed policy	not at this time
Chg 8	Enhancing health in care homes	Established	Established	Established	Mature	Mature		Enhanced clinical input into care homes initiatives are in place but require review to determine if expected impact is being achieved and whether more or different is required, there is variation between care homes on flow to the hospital. Timeliness of progressing this work has been challenged due to capacity in the commissioning. Requires a deep dive analysis of care homes data to ensure future plans are targeted for maximum	Care Homes data deep dive analysis completed. Indicates that Shropshire is not an outlier for care home admissions. Has identified a cohort of patients from care homes who attend A&E but are discharged with little or no intervention which will be a key target cohort. The Shropshire Care Closer to Home Transformation Programme continues to gain momentum with plans for Phase 1 case management now nearing sign off	not at this time

Hospital Transfer Protocol (or the Red Bag scheme)

Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.

		Q4 17/18	Q1 18/19	Q2 18/19 (Planned)	Q3 18/19 (Planned)	Q4 18/19 (Planned)	If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.	Challenges	Achievements / Impact	Support needs
UEC	Red Bag scheme	Not yet established	Not yet established	Not yet established	Plans in place	Established	na	working collaboratively to investigate how we can implement this scheme. We are able to consider lessons learned from T&W	meetings scheduled during Q3	not at this time

Better Care Fund Template Q2 2018/19

5. Narrative

Selected Health and Wellbeing Board:

Shropshire

Remaining Characters:

17,006

Progress against local plan for integration of health and social care

Progress against local plan for integration

Programme office for the STP now supporting the Better Care Fund management in order to fully connect programmes across the area.

An updated Partnership Agreement (section 75) has been signed and will form the basis for more pooled arrangements between health and care. Key areas of development will include the risk sharing agreement as joint working progresses and pooling budgets supports system working.

Prevention:

- Connecting STP Population Health strategic planning (national tools and resources – flatpack) and the HWBB/ BCF prevention work.
- Good progress in developing care navigation including social prescribing, integrating delivery with social care Let's talk local, and primary care community care coordinators, and the voluntary sector. Key milestones include:
 - o Delivery in 14 GP practices (from summer 2018)
 - o Delivering system MECC Plus training that links system providers from prevention through to acute (autumn 2018)
 - o Developing children and young people's scheme (q3 18/19)
- Good progress in developing and delivering an improved IPS Enable service including:
 - o New advisors in post (from September 2018)

Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.

Integration success story highlight over the past quarter

The refreshed and coproduced Local Digital Roadmap (LDR) will support integration across the system and will be very important for supporting improvements for the BCF. This will include population health management and prevention (using business intelligence) and a shared care record as key areas of improvement.

The LDR is a vision of where the Shropshire, Telford and Wrekin STP aim to be over the coming years. The LDR has been completed by the Digital Enabling Group (DEG) which is a cornerstone of the STP.

Currently the Shropshire health community organisations each provide services in a focused way and have developed their technology to support what they do. This has meant that each organisation has its strengths and weaknesses when we move to having a common approach to delivering health care as a partnership.

Using our combined digital assets, such as data, infrastructure and technology, we can deliver solutions to some of the most complex problems facing our Health and Social Care system. These offerings, when added to the combined technical abilities of our IT staff, are capable of fundamentally changing the way we provide services – enabling better care for residents and more opportunities for our clinicians and care providers.

Please tell us about an integration success story observed over the past quarter highlighting the nature of the service or scheme and the related impact.

Better Care Fund Template Q2 2018/19

6. Additional improved Better Care Fund

Selected Health and Wellbeing Board:

Additional improved Better Care Fund Allocation for 2018/19:

Shropshire

£ 3,959,448

These questions cover average fees paid by your local authority (including client contributions) to external care providers.

We are interested only in the average fees actually received by external care providers from local authorities for their own supported clients (including client contributions). The averages should therefore exclude:

- Any amounts that you usually include in reported fee rates but are not paid to care providers e.g. the local authorities' own staff costs in managing the commissioning of places
- Any amounts that are paid from sources other than the local authorities' funding (including client contributions), i.e. you should exclude third party top-ups, NHS Funded Nursing Care and full cost paying clients.

The averages will likely need to be calculated from records of payments paid to social care providers and the number of client weeks they relate to, unless you already have suitable management information.

This single average should include fees paid under spot and block contracts, fees paid under a dynamic purchasing system, payments for travel time in home care, any allowances for external provider staff training, fees directly commissioned by your local authority and fees commissioned by your local authority as part of a Managed Personal Budget.

If you only have average fees at a more detailed breakdown level than the three service types of home care, 65+ residential and 65+ nursing (e.g. you have the more detailed categories of 65+ residential without dementia, 65+ residential with dementia) please calculate for each of the three service types an average weighted by the proportion of clients that receive each detailed category:

1. Take the number of clients receiving the service for each detailed category.
2. Divide the number of clients receiving the service for each detailed category (e.g. age 65+ residential without dementia, age 65+ residential with dementia) by the total number of clients receiving the relevant service (e.g. age 65+ residential).
3. Multiply the resultant proportions from Step 2 by the corresponding fee paid for each detailed category.
4. For each service type, sum the resultant detailed category figures from Step 3.

If you are unable to provide rates for both 2017/18 and 2018/19, please ensure that you provide the estimated percentage change between 2017/18 and 2018/19 in the table below.

Please leave any missing data cells as blank e.g. do not attempt to enter '0' or 'N/A'.

	2017/18	2018/19	If rates not yet known, please provide the estimated uplift as a percentage change between 2017/18 and 2018/19
1. Please provide the average amount that you paid to external providers for home care in 2017/18, and on the same basis, the average amount that you expect to pay in 2018/19. (£ per contact hour, following the exclusions as in the instructions above)	£ 16.94	£ 17.37	
2. Please provide the average amount that you paid for external provider care homes without nursing for clients aged 65+ in 2017/18, and on the same basis, the average amount that you expect to pay in 2018/19. (£ per client per week, following the exclusions as in the instructions above)	£ 521	£ 551	
3. Please provide the average amount that you paid for external provider care homes with nursing for clients aged 65+ in 2017/18, and on the same basis, the average amount that you expect to pay in 2018/19. (£ per client per week, following the exclusions in the instructions above)	£ 672	£ 705	
4. If you would like to provide any additional commentary on the fee information provided please do so. Please do not use more than 250 characters.			

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Agenda Item 8

Title of the report:	Children and Young People's Mental Health (BeeU) Service
Responsible Director:	Dr Julie Davies, Director of Performance & Delivery
Author of the report:	Steve Trenchard, Programme Director Mental Health
Presenter:	Steve Trenchard, Programme Director Mental Health

Purpose of the report:

The purpose of this paper is to inform the Health and Wellbeing Board of progress made in first 18 months of the Bee U Children and Young Peoples Service (CYP) jointly commissioned by both CCG's and the two local authorities in Shropshire, Telford and Wrekin. This includes the management of the waiting list backlog in the 0-25 Emotional Health and Wellbeing Service provided by Midlands Partnership Board (Previously SSSFT).

Key issues or points to note:

- The Intensive Support Team of NHS England visited the service in June 2018 and their findings have been shared with all partners and commissioners of the service.
- There continue to be improvements made in relation to the BeeU service
- Following the IST visit and final report an action plan has been developed which includes actions under six key areas:
 - Legacy Issues
 - Evidence Based Pathways
 - Service identity
 - Workforce
 - System wide governance
 - Data and information quality
- Health and care system leaders have met to discuss specific concerns highlighted through an audit of existing legacy cases.
- The proactive approach taken to managing the waiting list has seen steady progress in the reduction of waiting times and the refreshed standard operating policy (SOP) continues to be refined to ensure the team remains on top of the waiting times.
- The problem experienced with Rio (the Patient Administration System) continues to mean that data quality is not fully resolved, and the service has identified additional support from the Rio team to address this.
- Following an announcement that the Managing Director for Children's Services, Kieran Murphy has resigned, the Trust has incorporated the Children's Services into the Shropshire Division of MPFT under the leadership of Cathy Riley, Managing Director. There is also a new Service Manager in post replacing the previous.
- MPFT report that the service as it is being managed continues to over-perform and is creating a financial cost pressure, which is being discussed through contract meetings.

Actions required by Health & Well Being Board Members:

The Health and Wellbeing Board members are asked to note the contents of this update and discuss its contents.

Children and Young People's Mental health (BeeU) Service

Author: Steve Trenchard

Background

- 1 As a result of ongoing quality and safety concerns the Intensive Support Team (NHS Improvement) were invited to undertake a 'deep dive' to provide expert advice and support to enable the delivery of the improvements required at pace. The background to their visit was that both CCGs had missed the 30% access target for 17/18, there had been concerns about waiting times and inappropriate treatment since taking over from the previous provider and, a significant number of 'legacy' CYP being treated for a conduct disorder or ASD/ADHD being treated with medication only approaches.

Intensive Support Team (IST) Findings and Response

- 2 The IST highlighted areas of improvement in the following:
 - a. Legacy issues – a major problem that is slowing down the development of the new model and has ongoing serious patient safety. An audit of current cases is underway to identify and risk stratify the current treatment needs of all CYP within the service. This will be completed by 19th October 2018 and discussed with senior leaders at a meeting on 31st October.
 - b. Commissioner issues - need a coordinated plan across the whole of Shropshire and Telford and Wrekin area with strong governance framework to hold all partners and commissioners to account. The plan will form part of the refreshed system wide Local Transformation Plan for Children and Young People.
 - c. Provider issues – resolve pathway development, access and waiting times and ensure data flows are in place to measure access and outcome.
 - d. Pathway issues - the development of evidenced needs based pathways with outcomes measures.
- 3 An action plan to respond to all of the actions contained within the IST report with specific dates for expected improvements is under development at the time of this report being prepared. This will be overseen by the CYP Partnership Group and the CCG's Clinical Quality and Reporting Meeting. Additionally, oversight of the progress made (and the LTP Implementation Plan) will be through the STP Mental health Group.
- 4 The Action Plan is organised under the following headings:
 - a. Data and information quality (relates to data returns, outcomes, service utilisation)
 - b. Legacy Issues (relates to review of care and treatment of existing CYP in service)
 - c. Evidence Based Pathways (transformation of existing service to the specification that was commissioned)
 - d. Service identity (strengthening service 'brand' and partnership arrangements, and addressing system wide cultural changes required across primary care in understanding CYP mental health)

- e. Workforce (recruitment, training and skills or workforce)
- f. System wide governance (arrangements to hold to account and escalate if improvements not seen at pace).

- 5 The waiting list for 'core services' has reduced but there remain delays in access to appropriate treatments for CYP with experiences of Autistic Spectrum Disorders (ASD). There are no delays in treatment for partner organisations (i.e. Kooth and Healios) at the 'front door' to the 0-25 Health and Wellbeing Service.
- 6 The Board of MPFT are fully aware of the improvements required to the service and the Managing Director for Shropshire Division (which now includes the 0-25 Service) is fully engaged in the work programme.

Summary

- 7 This paper has outlined the progress made following the IST visit in June 2018. At the last meeting of the CCG Governing Body limited assurance was given until further significant improvements are made against the action plan.

Recommendations

- 8 The Health and Wellbeing Board is asked to note the contents of this update and discuss progress made.
- 9 The Health and Wellbeing Board is asked to maintain CYP Mental Health as an issue of shared system concern, and to keep the 0-25 Service under close review and take a further report on progress at a future meeting.

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Health and Wellbeing Board Meeting Date 1st November 2018

Item Title Healthy Lives update

Responsible Officer Val Cross, Health & Wellbeing Officer and Healthy Lives Coordinator,
Shropshire Council
Email: val.cross@shropshire.gov.uk

1. Summary

This report provides updates for 'Healthy Lives' the partnership prevention programme of the Health and Wellbeing Board. This includes information about; the 'Challenge Fund' bid, carers work, operational meetings, Healthy Lives publicity and specific programme updates.

2. Recommendations

That the Board notes these updates for information.

REPORT

3.0 This report provides updates for 'Healthy Lives' - the partnership prevention programme of the Health and Wellbeing Board.

3.1 Challenge Fund

This is funding being offered by the Department of Health and Social Care and the Department for Work and Pensions. A joint bid has been submitted, which links the Community physiotherapists at Robert Jones and Agnes Hunt Hospital, Enable, Shropshire Council and IAPT to social prescribing. It also facilitates a cross referral process between these services. All partners have been enthused by submitting this bid, and it is hoped we are successful. The outcome will be known mid-October.

3.2 Carers

Ongoing work to implement the All-Age Carers Strategy and Action Plan continues;

- Carer developed and led 'Taking the pressure out of caring' workshops have taken place during September and October across Shropshire, Telford & Wrekin. This has been funded by NHS England following a successful bid for funding between Shropshire and Telford & Wrekin Local Authorities. A bespoke young carers workshop will be planned and delivered later in the year.
- Young carers from Shropshire, Telford & Wrekin came together for a creative workshop in April 2018, again funded by NHS England, and a positive example of partnership working

between both local authorities and the respective commissioned carer centres. The artwork and messages created are powerful, and will be used in a printed leaflet to raise young carer awareness in schools and educational settings.

- The Action Plan is progressing, but there is still more work to be done. Gaps identified include been awareness in the workplace, and this will be progressed.

3.3 Operational meetings

The steering group meets every two weeks, and consists of partners across the whole system involved with the Healthy Lives Programme to progress actions and identify opportunities. The format has evolved, and different organisations have been attending which has enabled connectivity to Healthy Lives. For example; the Food Poverty Action Group, GP Physical activity lead and Citizens Advice have attended recently, and opportunities to link together have been identified and have been progressed. This also enables other conversations to take place between organisations.

The Healthy Lives Programme Leads meetings have been more challenging to organise, due to work pressures from all parties. An alternative has been to exchange information electronically, so everyone has knowledge of what is happening in each other's programme areas. Following agreement as to the best way forward, a workshop is being held in November, which will bring all leads together. This will enable everyone to update on each other's work areas, look at challenges and successes, and see how we can link the different programme work closer together.

3.4 Healthy Lives branding and publicity

Excellent work has taken place with and by the Council Communications Team, to develop a brand for Healthy Lives, and build the communications messages. This has resulted in;

- 'Pop-up' stands for Healthy Lives and for social prescribing. These are being used at events and in GP Practices where Social prescribing is new
- Production and printing of leaflets for referrers and stakeholders wanting to know more about social prescribing
- PowerPoint template with graphics added
- Examples of the images are below.



Next steps are production and printing of explanatory leaflets for people referred to social prescribing, case studies and website information.

3.5 Social prescribing

Many developments are taking place, and a specific paper will be presented at this meeting by Jo Robins, Healthy Lives Lead.

4.0 Conclusions

The Healthy Lives Programme is progressing well and work continues to ensure this.

5.0 Risk Assessment and Opportunities Appraisal

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

There are no Human Rights, Environmental Consequences, Community or Equality issues identified with the provision of these updates.

6.0 Financial Implications

There are no financial implications that need to be considered with this update.

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) Cllr Lee Chapman Portfolio Holder for Adult Services, Health and Housing
Local Member
Appendices
None

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Health and Wellbeing Board Meeting Date 1st November 2018

Item Title Social Prescribing – Progress Update and Future Ambitions

Responsible Officer Jo Robins
Consultant in Public Health
Shropshire Council

1. Summary

2. The H&WBB have previously received and endorsed the social prescribing model for Shropshire, supported the business case, and proposals for expansion. This paper provides an update on progress and outlines our ambitions for the future.

A report is attached for information

3. Recommendations

4. To seek endorsement for a system wide approach to social prescribing which builds on the good practice in place, and expands the model as part of the Healthy Lives Programme.
5. To identify a joint partnership funding stream to achieve the expansion of the existing social prescribing model

REPORT

6. Risk Assessment and Opportunities Appraisal

There are no Human Rights, Environmental Consequences, Community or Equality issues identified with the provision of these updates.

7. Financial Implications

Funding Implications for the Better Care Fund

8. Background

The report is attached and a presentation will be given at the Board meeting

9. Additional Information

A business case has been presented previously to the Health and Wellbeing Board

Conclusions

That

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)
Lee Chapman Portfolio Holder for Housing, Health and Adult Social Care
Local Member
Appendices None

Progress Update - Social Prescribing

There is considerable interest nationally, and regionally in the development of social prescribing especially within some of the integrated care systems. The impact and evidence for social prescribing is increasing and it has gained a profile amongst many different parts of the system as a way of combining traditional health and care services to be able to reach and help people with a range of social issues.

The case for working with primary care is compelling with an estimated 30% of people seeing their GP for a non medical reason. ***RCGP chair Professor Clare Gerada said she had referred more people to food banks than A&E in one week.***

In addition adult social care and other parts of the NHS are under pressure with staff reporting less time for people, and an increasing backlog of complex cases. Many of the conditions that are currently prevalent in the community or within an ageing population are preventable.

The H&WBB have previously received and endorsed the social prescribing model for Shropshire, supported the business case, and proposals for expansion. This paper provides an update on progress and outlines our ambitions for the future.

What is Social Prescribing and What Does it Offer?

Social Prescribing can be the **key to** identifying those people at risk of poor health whether that be due to a medical condition or a social issue relating to housing, loneliness, debt., unemployment, low level mental health. Social prescribing is an **intervention in it's own right** offering a non-clinical solution to support change in people through access to activities or interventions in their local communities.

The current Shropshire Social Prescribing model concentrates on referrals of people with:

- One or more long term conditions
- Pre-Diabetes
- Frequent attenders at GP practices
- Social isolation and loneliness
- Mild to moderate mental health issues
- Cardio-vascular risks
- Joint pain (linked to musculoskeletal health)
- Significant behavioural risks, e.g. smoking

The model is proactive as it identifies those most at risk through audit of at risk groups and through opportunistic referrals from primary care, adult social care, job centres, voluntary sector, mental health teams.

Delivery of Key actions

- Continuation of programme management approach with clear governance and accountability
- Learning from the demonstrator site in the Oswestry/Ellesmere locality systematically applied as the programme has scaled up.

- Step by step methodology for implementation
- An approach for working with the voluntary and community sector
- Quality assurance process for groups receiving referrals from the SP Adviser
- Systematic use of measurement tools and collection of data on outcomes
- Dedicated social prescribing advisor time for primary care practices signed up
- Project implementation teams in each practice with GP champions
- Range of marketing information and promotional materials for professionals being developed and regular media communication.

Social Prescribing Delivery Sites

Practices referring include:-

South Shropshire	Central	North Shropshire
Bishops Castle Bridgnorth Albrighton Brown Clee*	Severnfields Claremont Bank Marden Radbrook Green	Plas Fynonn Cambrian Caxton Ellesmere

- No social prescribing advisor but working with us on a community health improvement model

In development – Market Drayton and Whitchurch with interest from other GP's and primary care practices in different parts of the county..

Asset Based Model of Development and New Partnerships

Working with each locality has been central to the work, with partners from the voluntary sector, community groups, the GP practice and staff from local organisations such as Fire and Rescue, Lifestyle Services, Let's Talk Local. This brings together a new relationship and stronger connection between community and primary care creating an environment that provides people with the connections, support and advice they need to get well and stay well.

New and stronger partnerships have evolved with the voluntary sector, (both in terms of taking referrals and offering interventions to individuals but also through two posts hosted by the voluntary sector and now working with the established delivery team) . The delivery team are drawn from Community Enablement, Help2Change, adult social care, and public health.

To support phase two of the programme a stronger alliance has been formed between Healthy Lives and existing local networks to support the expansion of the model, and includes, Compassionate Communities, (the hospice led network of support) the Creative Wellbeing Network (led by Jane Povey), Healthwatch and Community Pharmacies. Their individual actions create a wider network of support which underpins and is essential to the

Phase Recent Developments Include:-

Patient Activation Measures Licences

Shropshire has secured from NHS England a number of licences which will enable us to continue to use Patient Activation Measures. This beneficial tool assesses how activated a patient is as well as identifying what to do with that information gathered at assessment. PAM uses a series of 13 statements about beliefs and patient confidence around the management of their individual condition (linked to health behaviours, clinical outcomes and costs for delivering care). Beneficial for identifying people who are able to change but also useful to enable a practitioner to choose the correct intervention.

Workforce Transformation

Development of a hybrid model which supports a multi-team approach in the three localities and sub-localities to look at how the unique assets, skills and expertise of the Social Prescribing Advisers and staff in Let's Talk Local can work alongside each other in a more complementary way to create a model of prevention that reaches people at risk, and supports those people to improve through behaviour change and motivational support.

The cross-skilling between LTL practitioners and social prescribing advisors will enhance behaviour change skills, motivational interviewing with a renewed focus on What Matters to Me to support self-management. Cross-fertilisation of measures and outcomes will be mutually beneficial to teams and people using services ultimately as well as helping to reduce pressure in primary care and the need for social care assessments.

Development of a Social Prescribing proposal to work with Children and Young People

Specific focus on 16-24 year olds with poor employment prospects, isolated not in higher education. A social prescribing advisor trained in working with young people, with behaviour change and motivational coaching skills to support. We have looked at other social prescribing programmes; however, there is limited evidence on a model for working with young adults specifically so we would draw on examples of work in other sectors such as the Citizens Board and Wellbeing Enterprises in Halton who have supported an entrepreneurial approach. However, we believe we are filling a gap in good practice. Links young farmers groups and other local sources of support such as a local community leader supportive of young adults (sports based, cycling, music, art, practical).

Westminster University – Interim Report and Local Analysis

The external research team recently presented an interim report on the model (within the demonstrator site). They are also analysing data using three validated tools (measuring patient activation, people's concerns and loneliness) as well as patient satisfaction, the experience of professional and service users and system data including attendance at GP's A&E, unplanned hospital admissions. The interim report provided positive feedback on the model and changes in behaviour with a reduction in people's concerns.

A fuller report containing the final analysis of all patients in the evaluation will be completed by December 2018. Local data analysis has also been completed on some aspects and is demonstrating improvements in well being and other indicators.

Shropshire's Regional Role

Shropshire leads the Midlands Social Prescribing Network and chairs the regional steering group, and provides support to individual areas to develop local programmes, organise the annual Midlands wide conference, disseminate information across the network, work with the steering group to develop an offer of support to organisations across the Midlands. As the profile of the work has evolved Shropshire has been asked to participate in regional and national workshops invited to offer a local govt. on the future of social prescribing and its links to personalisation within the NHS England Ten Year Forward Plan.

Funding and Sustainability

The CEO of the council and the other directors have given their backing to the model as has the accountable officer for the CCG. The current programme has been funded by existing resources with no external monies and scaling up will require additional funds to ensure long term sustainability

We believe however that the social prescribing model can reap real rewards for our local population and is a way of reaching people at risk of health conditions or with existing health problems (often exacerbated by social risks) placing considerable demand on overstretched services such as primary care and adult social care. Social Prescribing offers something different which seeks to address these.

Our Ambitions for the Future

- Shropshire wide social prescribing programme in all primary care practices and other community venues
- Expand referrals from across the wider system as the programme is scaled up- job centres, community support officers, children's social care, schools
- Let's Talk Local Teams and Social Prescribing Advisors working in an integrated team
- Working with the mental health trust and acute sector
- Self referrals
- Expansion of training for frontline health and care staff – Healthy Conversations
- Population health approach supporting the system at STP level



Health and Wellbeing Board Meeting Date

Item Title

Responsible Officer

Email: Michelle.Davies@shropshire.gov.uk Tel: 01743 255807 Fax: _____

1. Summary

This paper is to advise the Board on Adult Social Care's procurement of a Wellbeing and Independence service for adults. This service is to amalgamate and replace funding arrangements for a range of existing grants and contracts within the preventative sector. The Council's aim is to procure a single contract encompassing a range of solutions and activities for all adults using funding currently allocated by Adult Services.

The headline outcomes required of all preventative services commissioned by the Council are:

1. People's need for long-term formal care and support is delayed and/or reduced
2. People are enabled to live in a healthy and resilient community and are supported to build strong community networks
3. People are able to access appropriate information, advice and support regardless of their 'entry point' and location
4. Services are enabled to support complementary programmes such as Social Prescribing and 'out of hospital' support, such as the Shropshire Care Closer to Home programme

In support of these outcomes and of particular relevance to the Health & Wellbeing Board are the activities undertaken by preventative services providers in support of health and wellbeing outcomes which include (but aren't limited to):

- a. Helping people to address loneliness through befriending schemes and encouraging participation in social activities, leading to improved mental health and wellbeing
- b. Helping people to improve and maintain their mobility, gait and balance, thus reducing risk of falls and associated hospital admissions through participation in walking groups, exercise classes and other physical activity
- c. Helping people to continue carrying out their activities of daily living, for example cooking skills and dietary choices, in order to prevent deterioration in a range of health conditions.

Shropshire Council-funded preventative services can be broadly described by the type of activity or target group. These are general prevention; information, advice and advocacy; carers services; equipment, assistive technology and telecare; and housing-related services. Whilst it is essential that links are made and maintained across all types of activity, this procurement exercise will concentrate on 3 key themes:

1. Practical help to remain independent (wellbeing and independence)

2. Advice, advocacy and benefits
3. Housing-related support

The first on these 3 themes to be procured is the Wellbeing and Independence Service. It is unlikely that any one organisation would have the breadth of experience and range of activity to deliver this, so the Council is looking to commission a solution which brings together a number of organisations. This may be a formal or informal partnership, a consortium, a lead provider / sub-contractors arrangement or similar. Additionally, the Council recognises the importance of a strong brand, identity and recognition that various organisations have, and a solution which retains choice for people within the contracting arrangement is required.

The Wellbeing and Independence service will continue to help people to remain in their own home with access to opportunities to socialise and to stay healthy with the aim of reducing the likelihood of becoming unwell, using health services and/or needing to receive long term formal care and support. The service will improve people's sense of wellbeing and help to improve their confidence in dealing with everyday life.

Support will be practical and will have a primary focus on providing enough support for people to be able to live as independently as possible within their own home and to get out and about within their community. These services will include practical support aimed at helping people to develop or maintain daily living skills, manage health conditions, reduce vulnerability and enabling people to develop the confidence to engage with their local community and social, physical activity and creative activities.

This procurement is also linked to the re-procurement of Housing Support services and Advice, Advocacy and Benefits Support, as mentioned above theme 2 and 3. However, they will remain 3 separate contracts.

2. Recommendations

That the Board notes this update for information

REPORT

3. Risk Assessment and Opportunities Appraisal

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

Identified risks and mitigating factors:

Highlighted below are the possible risks that have been identified and the measures put in place to mitigate these risks:

- a. Structure of tender drives out smaller organisations leading to reduction in choice for customers.

This is mitigated by retention of a small grants fund with the potential opportunity for the lead provider to provide the small grants from year 2. During year 1, there will be a piece of engagement work carried out with these smaller organisations to ensure that the transferring of the grants to the new provider is in the best interests of those organisations and to identify measures to be put in place through the contract to support those organisations. It will also provide the time to enable Shropshire Council to ensure that all audit requirements can be met going forward.

Access to preventative services will continue to be available at any physical contact point or through a range of media so existing signposting arrangements should continue. There will be an expectation with the contract for the lead provider to demonstrate how they are working closely with these smaller organisations

- b. Inability of potential tenderers to form consortiums / partnerships within required timescales.

This has been mitigated by the commissioning process involving the provider market and has encouraged collaboration across the sector through regular consultation engagement events and additional meetings with those organisations directly affected. A process of detailed information gathering from the sector to identify the strengths of their organisations and challenges they face, including the gaps in service delivery and any possible duplication, has been completed and this information has been used to inform the development of the service specification.

- c. Consortium / lead contractor structure builds in additional cost and bureaucracy.

To address this reporting requirements will be based on established validated models and further work will be done with the council's Intelligence and Insight team to develop reporting. Work with FPOC and digital transformation will help to develop the approach. This will also be mitigated by holding quarterly contract review meetings to address any concerns and allow for any contract amendments to support future service delivery

- d. Challenge from the public as a result of any changes in the services they receive.

This has been mitigated by detailed engagement in both the design and delivery of the Wellbeing and Independence Service with all stake holders including: Service users, carers, providers, social care staff, Clinical commissioning Group, Health and other Shropshire Council Colleagues.

Opportunities Appraisal

Options for procuring preventative services have been considered by Adult Services DMT. It was agreed to procure the Wellbeing and Independence service in the format described in this paper.

Throughout the engagement process with all stake holders a number of themes were identified along with a variety of procurement options. The 3 themes described in this paper were arrived at collectively and have been developed as they are the most effective to deliver the required outcomes for Adult Social Care preventative services and meet the health needs of individuals preventing or reducing their reliance on health services.

4. Financial Implications

The council currently funds a number of organisations to deliver the types of activity which will be incorporated in this procurement.

The current budget has been set based on the current funding arrangements and it is proposed that this budget remains unchanged. The 'core' contract will be for £816,300 per annum. With effect from 1st April 2020 we propose that these small grants may be provided by the lead contractor, potentially adding a further £32,200 to the contract value in year 2 following further engagement with those organisations directly affected.

In total, over the proposed maximum 5 years of the contract the contract value will be £4,210,300

5. Background

‘Preventative Services’ can be described as those which help to delay or reduce the need for unplanned or crisis (and more expensive) health and care interventions later on. Additionally, the types of interventions delivered as Preventative Services can also have a positive impact on the quality of life, health and wellbeing of individuals and communities.

Prevention can happen at any stage in a person’s involvement with services and can be tailored to current and expected future circumstances. Preventative services should aim to achieve the following:

- Preventing and delaying ill health
- Keeping people fit and active
- Developing personal resilience
- Allowing people to maintain independence
- Reducing inequalities
- Improving wellbeing and quality of life
- Reducing the need for acute services including A&E, hospital admissions, residential care, etc
- Reducing isolation
- Allowing for more informed lifestyle choices and decision making
- Preventing homelessness

An impact assessment undertaken by the VCS in Shropshire identified the high volume of support that is provided through the voluntary sector and a significant proportion of this advice and support is provided by volunteers. If funding for these services is lost or reduced around one third of organisations are at risk of total closure if one funding stream (e.g. grant / contract) is lost with the subsequent reduction in volunteer numbers. The assessment also identified a combination of changes to eligibility, reduced opening hours, reduction in the range of activities and loss of community venues which would significantly reduce the preventative support offered by the VCS.

Preventative service providers utilise large numbers of volunteers to deliver services. Prevention saves money - for example research shows that befriending services save £3.75 for every £1 spent and benefits advice saves £8.80 for every £1 spent. By offering security in the provision of longer term preventative services Adult Social Care (ASC) and health are avoiding the increased costs that would be associated with a significant number of those individuals if they were no longer supported in this way by these organisations for a fraction of the cost. This prevents significant pressure to the ASC future purchasing budget, and potential demand placed on health service, reducing pressure on NHS as a result of reduced hospital admissions and reduced primary care interventions.

Preventative services can be defined at three ‘levels’ of prevention. Taking the example of helping people to avoid problems associated with falls in later life the preventative response could include:

Level 1 Universal / primary prevention – information, social marketing aimed at the whole population giving advice on how keeping active reduces risk in later life

Level 2 Secondary prevention – targeted at those people who are more at risk of falling, e.g. older people, and provide access to exercise classes, etc

Level 3 Tertiary prevention – where someone has fallen already provide additional interventions to reduce the risk of falling again

This project is focussed on commissioning prevention at levels 2 and 3, whilst heeding the overarching need to provide access to good quality information for the population.

The Council has a responsibility under the Care Act to provide or arrange for services, facilities or resources which would prevent, delay or reduce individuals' needs for care and support. Local and national research has shown that investment in preventative services and housing support clearly helps to avoid much higher costs further 'downstream' in areas such as social care, admissions to hospital and homelessness.

Current Position

Shropshire Council's Adult Services commissions a number of different organisations to deliver preventative services, many of which are Voluntary, Community or Social Enterprises (VCSEs). Providers range in nature and size from very small, very local groups formed in response to a particular local need or specialist type of provision through to local housing providers and branches of national VCSEs. Providers are funded through a mixture of grants and/or contracts, a number of which have been in place for some time, although they have all been regularly reviewed through annual grant reviews or periodic procurement activity.

Some providers have formed themselves into consortia with the aim of delivering a consistent and joined-up response to a particular set of issues. Two examples of these are the CAAN consortium delivering information, advice and advocacy and the Sustain consortium delivering housing-related support.

In addition, and highly important to the range of choice available to people in need of support, there are many more VCSEs operating in Shropshire which provide preventative outcomes for people in need and which are not funded through the Council's Adult Services. It is important that these organisations have the right conditions to be able to continue to be sustainable and be given every opportunity to make mutually beneficial and complementary links with Adult Services-funded providers.

As described earlier in this document a significant amount of work has been done with the sector and a range of other stakeholders to identify a way of offering sustainability to the Voluntary and Community Sector whilst carrying out Shropshire Council's duties under the Care Act and continuing to develop resilient communities, increasing the independence of local people and preventing and reducing the amount of long term care and supported required as set out in Shropshire Council's Adult Social Care Strategy. As a result of this work and these priorities it has been decided to commission a Wellbeing and Independence service to meet the requirements of theme 1.

6. Additional Information

Please see additional papers for further information. Copies of the service specification can be made available to members of the HWBB on request.

7. Conclusions

The model of delivery for Adult Social Care is predicated on early intervention and prevention. By offering sustainability to the voluntary sector and providing a longer-term contract, this

activity will continue to prevent an increase in required package costs and demand placed on health services.

Therefore, we will procure a Wellbeing and Independence service based on the model described above.

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

- | |
|--|
| <ul style="list-style-type: none">- Preventative services Commissioning Intentions document- Shropshire Council Equality and Social Inclusion Impact Assessment (ESIIA) |
|--|

Cabinet Member (Portfolio Holder)
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Lee chapman

Local Member

Appendices

Appendix 1 Preventative Services Commissioning Intentions document

Appendix 2 Shropshire Council Equality and Social Inclusion Impact Assessment
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Preventative Services in Shropshire Commissioning Intentions 2019 – 2024

Background

‘Preventative Services’ can be described as those which help to delay or reduce the need for unplanned or crisis (and more expensive) health and care interventions later on.

Additionally the types of interventions delivered as Preventative Services can also have a positive impact on the quality of life, health and wellbeing of individuals and communities. Prevention can happen at any stage in a person’s involvement with services and can be tailored to current and expected future circumstances. Preventative services should aim to achieve the following:

- Preventing and delaying ill health
- Keeping people fit and active
- Developing personal resilience
- Allowing people to maintain independence
- Reducing inequalities
- Improving wellbeing and quality of life
- Reducing the need for acute services including A&E, hospital admissions, residential care, etc
- Reducing isolation
- Allowing for more informed lifestyle choices and decision making
- Preventing homelessness

Preventative services can be defined at three ‘levels’ of prevention. Taking the example of helping people to avoid problems associated with falls in later life the preventative response could include:

Level 1 Universal / primary prevention – information, social marketing aimed at the whole population giving advice on how keeping active reduces risk in later life

Level 2 Secondary prevention – targeted at those people who are more at risk of falling, eg older people, and provide access to exercise classes, etc

Level 3 Tertiary prevention – where someone has fallen already provide additional interventions to reduce the risk of falling again

This project is focussed on commissioning prevention at levels 2 and 3, whilst heeding the overarching need to provide access to good quality information for the population as a whole. This project incorporates the preventative outcomes provided through housing-related floating support.

Preventative services funding is an area of discretionary spend by the Council, although the Council does have a responsibility under the Care Act to provide or arrange for services, facilities or resources which would prevent, delay or reduce individuals’ needs for care and

support. In any event, local and national research has shown that investment in preventative services and housing support clearly helps to avoid much higher costs further 'downstream' in areas such as social care, admissions to hospital and homelessness.

Many statutory services and many programmes depend on a sustainable and effective suite of preventative services. For example, the Social Prescribing programme in Shropshire relies on the availability of preventative solutions to be able to 'prescribe' for their clients.

Preventative services are valued by customers, partners, stakeholders and the Council itself. Services achieve this through focussing on those things which have an impact on an individual's ability to be able to live independently in a home of their own and then helping those individuals to overcome them.

Current Position

Shropshire Council's Adult Services commissions a number of different organisations to deliver preventative services, many of which are Voluntary, Community or Social Enterprises (VCSEs). Providers range in nature and size from very small, very local groups formed in response to a particular local need or specialist type of provision through to local housing providers and branches of national VCSEs. Providers are funded through a mixture of grants and/or contracts, a number of which have been in place for some time, although they have all been regularly reviewed through annual grant reviews or periodic procurement activity.

Some providers have formed themselves into consortia with the aim of delivering a consistent and joined-up response to a particular set of issues. Two examples of these are the CAAN consortium delivering information, advice and advocacy and the Sustain consortium delivering housing-related support.

In addition, and highly important to the range of choice available to people in need of support, there are many more VCSEs operating in Shropshire which provide preventative outcomes for people in need and which are not funded through the Council's Adult Services. It is important that these organisations have the right conditions to be able to continue to be sustainable and be given every opportunity to make mutually beneficial and complementary links with Adult Services-funded providers.

People needing support are able to access preventative services through a number of routes. These include:

- Signposting – from the Council's First Point of Contact (FPOC) team, Let's Talk Local sessions, other public sector partners or other VCSEs
- Referral – where direct referral arrangements have been put in place
- Direct access by contacting the appropriate organisation either in person, by phone, by email or online

Shropshire Council-funded preventative services can be broadly described by the type of activity or target group. These are general prevention; information, advice and advocacy; carers services; equipment, assistive technology and telecare; and housing-related services.

Whilst it is essential that links are made and maintained across all types of activity, this project will concentrate on 3 key themes:

1. Practical help to remain independent (wellbeing and independence)
2. Advice, advocacy and benefits
3. Housing-related support

The provision of good quality information is a common requirement across all services, as is the aim to help people to develop or sustain their own networks of friendships and/or support. There are also a small number of specialist preventative services in place.

Practical Help to Remain Independent

Commissioned services under this theme have a primary focus on providing enough support for people to be able to live as independently as possible within their own home and to get out and about within their community. These services may include, for example, help with cleaning, laundry and vacuuming, gardening, shopping, collecting prescriptions, befriending and social and creative activities.

Advice, Advocacy and Benefits

The primary aim of these services is to give people the tools and the confidence to make their own choices based on good advice. Linked very closely to this is the support available to help people to navigate the benefits system and to ensure that they are accessing the correct benefits.

By far the largest single area that people seek advice about is around benefits and tax credits. In terms of advocacy, the most frequent issues people are seeking the support of an advocate for are around social care and health & community care, followed by financial capability, housing and benefits.

Advice and advocacy services bring in a lot of additional money to the Shropshire economy through helping people to access the correct benefits. For example, in 2016/17 the CAAN partners secured financial assistance for their clients of nearly £2.5m.

Housing Support

Housing support is preventative in nature. It provides support to people with a number of issues, all of which may compromise or inhibit their ability to be able to maintain a tenancy or a home of their own. There are many reasons why somebody may struggle to continue to live independently in a house of their choice. If these are left unaddressed, they may result in the need to move into residential or higher cost care, hospital admission or eviction or loss of home for other reasons.

The main reasons why people are referred, or refer themselves, to housing support are:

- Deteriorating financial position (all age ranges but particularly under-65s)
- Risk of tenancy failure (all age ranges) – for a variety of reasons
- Risk of statutory homelessness (particularly, but not exclusively, under 65s)
- Long-term worklessness (under 65s with a focus on under 25s)

- Risk of unplanned hospital admissions (older people in particular)
- Risk of Accident & Emergency visits, for example through falls (older people in particular)
- Risk of residential care or increased care costs (older people)

Housing support is very successful in helping people to avoid these risks and services are currently configured to provide a flexible mix of time-limited crisis support, time-limited higher-level support and low-intensity occasional support.

In addition, housing support services, particularly the support hubs around sheltered housing, provide significant benefit to the wider communities they operate in and to other voluntary and community organisations making use of these facilities. These hubs provide a physical venue for activities to take place, without which those activities would cease. Activities include lunch clubs, bingo, day centres, leisure and exercise and information & advice sessions such as falls avoidance and home safety. These help to tackle social isolation that many older and vulnerable people experience, promote health & wellbeing and reduce demand on other services. Around 3,000 people attend activities at support hubs.

Context for Commissioning Preventative Services

The Financial Challenge

The Council has been dealing with a sustained period of financial challenge due to a combination of inflationary pressures and ongoing cuts in government grants. The significant financial savings the Council has made, and will continue to make over the next 3 years, coupled with income generated through commercial activity, will put the Council's finances onto a sustainable footing.

The impact of austerity on preventative services in Shropshire can be seen in a number of different ways. Funding reductions or ending of funding for programmes or services does not mean that the need for that support goes away. The need may be displaced and create additional demand on remaining services; or people cope without support for a while before seeking support again or reach a point of crisis resulting in a more intensive period of assistance to resolve issues that have built up.

Examples include the ending of Legal Aid funding for support at benefits tribunals which means that it is difficult or impossible for people to be supported to make their case; and the ending of funding for benefits advisors within mental health teams which has resulted in increased demand on advice agencies with the added effect of advisors and volunteers having to respond to the presenting individual's mental health issues as well as the benefits issue.

The Population Challenge

The population of Shropshire is projected to increase over the coming years and, more importantly, the make-up of the population is set to change. Shropshire (excluding Telford & Wrekin) had a population of 306,129 at the 2011 census (an increase of 8.1% from the 2001 census).

Projections made in 2016 point to a population of 337,800 by 2041. There are currently 76,000 people living in Shropshire aged 65 or more. This is projected to increase by over 50% to 114,600 by 2041, equivalent to 33.5% of the county's population (against a projected national average of 24%). In addition the number of people aged 85 and over is projected to increase by 137% (13,300 people) from 9,700 in 2016 to 23,000 in 2041.

There are currently 56,826 people who have long-term sickness, of whom 29,000 are aged 65+. Around 15,200 people aged 18-64 have a moderate physical disability and around 28,700 people are estimated to have a common mental health disorder.

Therefore the inflationary pressures referred to above take into account not only cost of living / cost of operating expenses, but also the cost pressures of accommodating, supporting and caring for those who need it and of an increasingly ageing population.

Legislation

Of particular relevance to preventative and housing support services, the **Care Act 2014** is the key piece of legislation covering social care services for adults. Particular parts of the legislation to note include:

- Introduction of the wellbeing principle. Section 1 of the Care Act sets out the 'wellbeing principle'. Local authorities will be under a general duty to promote an individual's wellbeing; this applies when they are making any decisions under the Care Act and will relate in part to the suitability of an individual's living accommodation. The well-being principle should be imbedded in all aspects of the local authority's decision making, and applies equally to people who are not eligible for care and support. For example, the local authority must have regard to the well-being principle through the provision of universal services.
- Prevention. Under section 2 of the Care Act, a local authority must provide services or take steps which it considers will contribute towards preventing or delaying the development by adults or carers of the need for care or support, and it must try to reduce the need for care and support by adults or carers in its area. This duty applies to all adults in the local authority's area. This includes access to good quality information, reducing loneliness or isolation and a range of early interventions such as fall prevention clinics, adaptations to housing, handyperson services, and short-term provision of wheelchairs or telecare services.
- Integration of care and support
- Information and advice – including all aspects relating to individuals' wellbeing such as Housing

The **Homelessness Reduction Act 2017** places additional duties on the Council in respect of people who are, or are at risk of, homelessness. These include:

- an extension of the period when someone is considered to be threatened with homelessness from 28 days to 56 days
- a duty to provide advisory services for anyone who is threatened with homelessness, regardless of whether they might be considered to be in priority need
- a requirement to issue a personalised plan for each eligible applicant
- a new duty to relieve homelessness by supporting the applicant to find alternative accommodation

The government is committed to a programme of **Welfare Reforms** which seeks to reduce the total welfare bill. Older and vulnerable people and people on low incomes, who have most contact with the welfare benefits system, will experience the most change. As these reforms roll out, the impacts of these changes will become clearer. Feedback from the Shropshire Housing Support Group indicates that vulnerable people increasingly need more help with navigating the system and that these changes are causing 'much stress'. Additionally, feedback from providers engaged in supporting, advising and advocating for people in contact with the welfare benefits system are reporting that the changes are resulting in increased pressure on advice and advocacy services.

The Public Services (**Social Value**) Act 2012 requires the Council to ensure that it considers how it can maximise social, economic and environmental benefits in the way that it commissions. Shropshire Council has a Social Value framework and Charter which it has developed with partners from Shropshire Clinical Commissioning Group (CCG), the Voluntary & Community Sector, Police & Crime Commissioner and Housing.

Strategic

Shropshire Council's Corporate Plan 2018/19 sets out four high-level outcomes which provide the focus of the work of the Council and underpin what we are trying to achieve over the coming years. These outcomes are:

- Healthy People – supporting people to take responsibility to look after themselves, increasing their quality of life and reducing ill health to minimise demand and dependency on public services.
- Resilient Communities – communities which are self-sufficient and have the resources and capabilities to meet their collective needs and to flourish. Communities which are safe, sustainable and help each other and supporting vulnerable adults to remain in their communities.
- Prosperous Economy – for example working with our older population profile and promoting Shropshire as a place to develop technologies that enable people's independence, improve health outcomes and contribute to health and social care..
- A Commercial Council – being innovative and resourceful; being as efficient as we can be and identifying and pursuing opportunities to generate income which can be invested into services. We will operate in a way that promotes the best use of local resources.

The four key priorities set out in our Vision and Strategy for Adult Social Care 2018/19 – 2020/21 are:

- Creating resilient communities and helping you to continue to live independently. This will be achieved through ensuring that everyone has access to information and advice that supports their wellbeing, either through the council's First Point of Contact team, Shropshire Choices portal or through the VCSE.
- Helping you to prevent or reduce needs. Working with partners, including the VCSE, we can identify, target and intervene with people who are at risk of developing needs.

- Delaying the impact of your needs. Services will be aimed at enabling people to gain or regain skills to help them live as independently as possible. This means that we will aim to support people in the short-term whilst expecting that, wherever possible, they support themselves long-term.
- Meeting your needs through a creative approach to care that is value for money. Support will be easy to access and services will be flexible and open to change.

The priorities for Shropshire's Health and Wellbeing Strategy are focused on Prevention (Health Promotion and Resilience) and Sustainability (Promoting Independence at Home).

The Better Care Fund Plan for Shropshire identifies its main areas of focus as:

- Prevention
- Early Intervention
- Supporting People in Crisis
- Supporting people to live independently for longer

Identification of need / Gaps in Provision

Survey of people who use preventative services

People who use services have been asked to contribute their experiences of preventative services through a combination of feedback from meetings (Making it Real), an online questionnaire and supported questionnaires. Over 160 responses were received. Findings from the survey include:

1. **How people benefit** – improved wellbeing; more confident; help with benefits; help with debt, money; social interaction / meeting others with similar issues; practical assistance – cleaning, gardening
2. **What keeps people independent** – regular contact / ongoing support; access to information / knowing how to find it – important; good transport; social contact; help with paperwork and form-filling; adequate capacity at high demand services
3. **How people find out about services** – support worker; Citizens Advice; current provider; libraries and information points; GP / surgery
4. **What helps people to decide whether or not to use a service** – the most common factor which helps people to decide is whether the service is easy to get to or access. This is followed by what others say about the service and recommendation from a professional. A smaller proportion said they use the internet, although some actively said they wouldn't
5. **What people would like to access but can't** – help with PIP / appeals; transport; household help; help with IT; finding friends; social contact outside of people with similar issues
6. **What are the blockers to accessing support (from the customer's point of view):**
 - a. unaware of services
 - b. not knowing who to talk to
 - c. cost / affordability
 - d. transport - availability
 - e. waiting times
 - f. service cuts / lack of funding

- g. not enough coordination between services
- h. personal issues /condition
- i. finding it difficult to ask
- j. IT – either not having access or not comfortable using it

Survey / Feedback from providers

Commissioned providers and other providers of preventative services who are not funded by the Council have been involved since the beginning of this review and have contributed through provider events, subject-specific working groups and a survey. Feedback includes:

- More customers are presenting with more acute, multiple and complex issues which require more support. This can be challenging for volunteers
- Reductions in services elsewhere have increased demand on remaining services
- People don't know how to navigate the system in order to self-refer or to support signposting
- People have difficulty in accessing the right service at the right time due to:
 - Availability
 - Difficulty in arranging transport
- Waiting times for support are increasing
- People with mental health issues accessing advice and advocacy present a challenge in terms of capability of dealing with the individual (not the issue)
- Form filling – online and paper – is becoming more complex and takes longer

Stakeholders

Stakeholders, particularly colleagues in mental health teams, safeguarding teams and the Healthy Lives programme have been involved and kept informed of this review. Stakeholder feedback includes:

- It can be difficult for professionals to access advice and advocacy for their clients
- Difficult to access services immediately when required
- Reductions in services elsewhere have increased demand on their services
- No support for people who need to attend a benefits tribunal (following the ending of Legal Aid funding)

In summary of this section there are some general issues which will need to be addressed as well as specific issues for particular areas of need.

Commissioning Principles

In commissioning preventative services we want to ensure that the following principles are understood and adopted:

- Preventative services help people to keep well, live well and to feel enabled to do things for themselves
- The services that are available to people should feel joined-up, with multiple access points, and all providing good quality information about how the 'system' works

- Preventative services will support complementary programmes such as Social Prescribing and 'out of hospital' initiatives
- Shropshire is a large and rural county with a dispersed population. Approaches that work in one part of the county may not necessarily work as well in others. Providers will understand the importance of 'Place' and the Shropshire 'landscape' as it relates to support and care in communities and will apply a locally tailored approach to the work they do with vulnerable people.
- In these challenging financial times it is vital that prevention is targeted at those areas which make the biggest difference. Providers will therefore work very closely with the Council to ensure that resources and support are allocated according to priority.
- Providers will aim to maximise income from alternative funding streams to complement Shropshire Council funding
- Providers will need to be able to maximise the value of all available resources in the communities in which they operate. This will include their own staff, buildings, technology, expertise, volunteer capability and other infrastructure as well as all of these owned or operated by other partners and stakeholders. This will make best use of resources without unnecessary duplication of effort.
- Meaningful and productive partnerships will be developed and sustained between commissioned services and non-commissioned activity as well as the public and private sectors.
- Providers will adopt the principles of 'Making Every Contact Count' which is an approach to behaviour change that utilises the millions of day to day interactions that organisations and people have with other people to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations.
- Providers will need to be flexible and able to adapt to changing priorities
- Providers will need to demonstrate that they are committed to maximising the social, economic and environmental benefits gained through the way that they organise themselves. Providers will work with the Council to develop and deliver Social Value outcomes as described in the Council's Social Value Framework

Outcomes

The key outcomes from preventative services in Shropshire will be:

1. People's need for long-term formal care and support is delayed and/or reduced
2. People are enabled to live in a healthy and resilient community and are supported to build strong community networks
3. People are able to access appropriate information, advice and support regardless of their 'entry point' and location
4. Services are enabled to support complementary programmes such as Social Prescribing and 'out of hospital' support

In support of these outcomes are the activities undertaken by preventative services providers in support of health and wellbeing outcomes which include (but aren't limited to):

- a. Helping people to address loneliness through befriending schemes and encouraging participation in social activities, leading to improved mental health and wellbeing
- b. Helping people to improve and maintain their mobility, gait and balance, thus reducing risk of falls through participation in walking groups, exercise classes and other physical activity
- c. Helping people to continue carrying out their activities of daily living, for example cooking skills and dietary choices, in order to prevent deterioration in a range of health conditions

More detailed outcomes will be developed for each of the commissioned themes and incorporated in service specifications.

Social Value

In addition, VCSEs are able to generate significant Social Value through the way that they operate. The following Social Value outcomes will be delivered:

1. Employment opportunities for local people through:
 - a. The number of local people (FTE) employed on the contract for at least one year
 - b. The number of employees (FTE) taken on who are long-term unemployed
 - c. The number of employees (FTE) taken on who are NEET
 - d. The number of jobs (FTE) created for people with disabilities
2. Developing education, skills and training opportunities within Shropshire through:
 - a. The number of apprenticeships that have been completed or will continue to be supported
 - b. The number of weeks spent on meaningful work placements
 - c. The number of hours dedicated to supporting people into work by providing career mentoring, mock interviews, CV advice, etc
 - d. The number of volunteers supported
3. Supporting the local supply chain through:
 - a. Total amount spent in the local supply chain
 - b. In-kind expert support to small enterprises / community organisations, eg legal, financial expertise
4. A green and sustainable county through:
 - a. A reduction in car miles spent on delivering services
 - b. Use of clean transport technologies, eg low- or no-emission vehicles

Financial

Investment in preventative services provides financial benefits to the statutory sector and to the wider economy. Helping someone to remain in their own home with access to opportunities to socialise and to stay healthy reduces the likelihood of becoming unwell, using health services and / or needing to move into funded residential care. Helping someone to better manage their finances or debts will reduce the likelihood of a deterioration in mental health and of putting their tenancy at risk. Helping someone to

maintain a tenancy helps to avoid a presentation for homelessness which is distressing for the individual and expensive for the Council. Providing someone with the means to get out and about and spend money in local shops supports the local economy.

For example, an impact assessment on 1,750 current housing support customers was undertaken by providers during summer 2016. An estimate of the financial impact of identified risks using locally available figures and data from New Economy Manchester found that current housing support funding of £1.8m per annum in Shropshire results in:

1. Overall – avoidance of costs to the public purse of £12.5m, including:
 - a. Avoided additional costs to Shropshire Council of £8.6m, made up of:
 - i. £6.0m to Adult Services
 - ii. £2.5m to Housing Services
 - iii. £91,000 to Leaving Care Team (this ignores longer term costs of children becoming looked after)
 - b. Avoided additional costs to Health of £2.6m
 - c. Avoided additional costs to DWP £850k
 - d. Avoided additional Costs to Criminal Justice £400k

The financial constraints on the Council mean that there will continue to be uncertainty over future levels of funding for preventative services, so there is therefore a need for services wherever possible to be increasingly sustainable beyond core public funding. Providers should aim to maximise revenue from a range of sources to complement the funding provided by Shropshire Council. Providers will also need to establish whether there are elements of their current services or developments of them which may provide a commercial income in future which will sustain some level of service.

Proposed Commissioning Model

Having taken account of feedback from users of preventative services, providers and stakeholders it is proposed that services are commissioned under three main themes:

1. Wellbeing and independence
2. Advice, advocacy and benefits
3. Housing-related support

Key to the success of this approach, however, and taking into account feedback from users of services, will be that services are of a consistent quality, 'joined-up', easy to access and easy to find out about. Good, accurate information will be available to people, regardless of their entry point, whether that is to a Shropshire Council information point or to a local provider organisation and all points in between. Additionally, all providers will aim to support people to make connections and links within their communities so that they are self-reliant as far as possible. Commissioned services should aim to provide just enough support to enable or maintain independence.

In commissioning these three themes the Council wishes to simplify the funding arrangements and, wherever possible, commission a single contract for each theme. However, the council does recognise the strong brand, identity and recognition that many

local organisations have and solutions will be sought which retains choice for people within these contracting arrangements.

There are also a small number of specific grant funding arrangements which would not benefit from being incorporated into any one of the themes above. These will be reviewed prior to determining the funding arrangements.

Theme 1 – Wellbeing and independence

This theme will deliver a range of practical solutions for people to help them stay healthy and well at home and also to be able to access other activities. Support will be practical and will have a primary focus on providing enough support for people to be able to live as independently as possible within their own home and to get out and about within their community. These services may include, for example, help with cleaning, laundry and vacuuming, gardening, shopping, collecting prescriptions, befriending and social and creative activities.

By its nature a lot of this support will be on a one-to-one basis but it will also incorporate organised group activities and the development of self-reliant peer networks. Support is not envisaged to be long-term in nature, but is about enabling people to do things for themselves. However, people have told us that they value the ability to be able to contact a trusted individual or organisation from time to time so services will need to be flexible enough to cater for this.

Our aim is to have a single contract encompassing a range of solutions and activities for all adults. It is unlikely that any one organisation would have the breadth of experience and range of activity to deliver this, so we are looking to commission a solution which brings together a number of organisations. This may be a formal or informal partnership, a consortium, a lead provider / sub-contractors arrangement or similar.

We recognise that this is likely to take time to achieve so would be interested in hearing from the provider market how this could happen smoothly and with little or no disruption to service delivery and the end users. We would, for example, be happy to consider a two-stage approach which secures provision from day one and sets out the plan to move towards a single contract.

Theme 2 – Advice, advocacy and benefits

This theme will deliver advice and advocacy across a range of issues which impact on people's wellbeing and will incorporate support for people engaged with the welfare benefits system. The theme acknowledges that whilst advice and advocacy are distinct disciplines they are closely linked and should remain so. Additionally, as advice around welfare benefits accounts for approximately 50% of all advice issues dealt with through the CAAN consortium it makes good sense to link benefits support into this theme.

This commissioned service is one part of a network of advice and benefits support which is delivered across the statutory and voluntary sectors and will complement all other activity in this area. This will require close working with commissioners, the statutory sector and other community organisations operating in this area. For example, Shropshire Council's

First Point of Contact and Customer Services will provide advice and support for customers and will refer or signpost people to more specialist provision where necessary.

General (non-statutory) advocacy and advocacy under the Care Act will be commissioned together as part of this theme as it will allow providers to flex their resources according to need. Consideration will be given to other statutory advocacy (eg IMCA) being commissioned as part of this theme as well although that is yet to be finalised.

Access to advice, advocacy and benefits support can be through one of two routes:

1. For the general public either by direct access to the commissioned service, or
2. For professionals, eg social work teams, mental health teams, by a referral system giving quicker access

It is important that a balance is maintained between professional referrals and general access so that people are still able to access advice directly.

As it has been demonstrated through the CAAN consortium in Shropshire, a consortium approach to delivery can be very successful and we aim to commission a single contract incorporating advice, advocacy and specialist benefits support.

Theme 3 – Housing-related support

This theme will support people whose needs are such that their ability to maintain a tenancy or remain independent in their home would be compromised without that support. The focus of housing-related support will be on ensuring that people have access to appropriate and settled accommodation according to their circumstances and have the support networks in place to help them sustain that accommodation. This theme will incorporate 'floating' support as currently commissioned but not the separately commissioned supported housing schemes.

Housing-related support will have two principal areas of focus:

1. Helping people to prevent, delay or reduce the need for long-term formal care and support, including healthcare services
2. Helping to prevent homelessness and/or to support people who have been homeless into settled accommodation

Housing-related support will therefore help the council to meet its statutory prevention duties under the Homelessness Reduction Act and will also help to prevent or delay the need for people to progress into residential or nursing care.

Housing-related support complements other activity through, for example, making resources available to other agencies to run activities or providing drop-ins and 'surgeries' at other agencies' premises.

Where eligible we will expect social landlords to maximise other income streams, such as the Intensive Housing Management charge for additional tenancy-related assistance for vulnerable clients. This will ensure that housing-related support funding is targeted at the support needs of vulnerable clients and will help to cushion the planned reduction in

funding for housing-related support as set out in the Council's Financial Strategy 2018/19 – 2022/23 (Shropshire Council Cabinet 14th Feb 2018).

As has been demonstrated by the success of the Sustain consortium in Shropshire, a consortium approach to delivery of housing-related support works well and we aim to commission a single contract.

Small grants

The council currently funds a number of organisations to support their delivery of specific or specialist activities through a programme of small grants. Given their nature, we propose to continue provision of these small grants, subject to regular reviews of need and effectiveness. Given that these small grants complement and enhance the overall effectiveness of the Theme 1 Wellbeing and Independence service we propose that the responsibility for making and reviewing the small grant payments sits with Theme 1, with the budget transferred accordingly.

Procurement / Timescales

This is a complex commissioning programme and will be done in 3 main stages. The outline / provisional timescales are as follows:

Theme	Actions	By when
Wellbeing and independence	Commence procurement	End-October 2018
	Tenders returned	Early December 2018
	Contract Award	Early January 2019
	Contract commences	April 2019
Small grants	Awarded	TBC – in accordance with the Wellbeing and Independence theme
Advice, advocacy and benefits	Commence procurement	April 2019
	Tenders returned	June 2019
	Contract Award	July 2019
	Contract commences	October 2019
Housing-related support	Commence procurement	December 2018
	Tenders returned	January 2019
	Contract Award	February 2019
	Contract commences	April 2019

**APPENDIX 1 – CURRENT CONTRACT AND GRANTS BY COMMISSIONING THEME –
PROPOSED – UPDATED 18th October 2018**

Theme 1 – Wellbeing and Independence

Organisation Name	Name of Service / Description
Age UK	Core Services including day centres
Age UK	Help at Home (partial)
Qube	Core Grant
Royal Voluntary Service	Good Neighbour Service
Shropshire RCC	Universal Prevention
North Shrewsbury Friendly Neighbours	Friendly Neighbour Service

Small Grants – Administered by Theme 1

Organisation Name	Name of Service / Description
A4U	Autism Hub additional grant
Alzheimers Society	Dementia support groups
Designs in Mind	Creative and practical skills
Move On Club	Social club – learning disabilities
Remap Shropshire	One-off engineering solutions
Shifnal Live at Home	Bathing and support services in Shifnal
Working Together (Ludlow)	Community café in Ludlow

Theme 2 – Advice, Advocacy and Benefits

Organisation Name	Name of Service / Description
A4U (as part of the CAAN Consortium)	Autism Hub (element of CAAN contract)
Age UK	Help at Home (part)
CAAN	General Advocacy
CAAN	Information & Advice
CAAN	Care Act Advocacy

Theme 3 – Housing-Related Support

Organisation Name	Name of Service / Description
Sevenside Housing (Housing Plus)	Central Shropshire Floating Support
Shropshire Housing Group (Connexus)	South West Shropshire Floating Support
Shropshire Housing Group (Connexus)	North East Shropshire Floating Support
STaR Housing	South East Shropshire Floating Support
STaR Housing	North West Shropshire Floating Support
Bromford Housing	Acquired Brain Injury Floating Support

Specialist / Standalone Funding – NB Sight Loss Services to be reviewed separately

Pohwer	IMCA – consider incorporating in Theme 2
Shropshire RCC	Sight and Hearing Loss Service
Shropshire Mind	Mental health centre & drop-in – aim to include in Theme 1/small grants after yr 1
SIAS	IMHA

Sight Loss Shropshire	Mobile van, info etc
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Shropshire Council Equality and Social Inclusion Impact Assessment (ESIIA)

Name of service change: Commissioning Preventative Services for Adults

Contextual Notes

The What and the Why:

The Shropshire Council Equality and Social Inclusion Impact Assessment (ESIIA) approach helps to identify whether or not any new or significant changes to services, including policies, procedures, functions or projects, may have an adverse impact on a particular group of people, and whether the human rights of individuals may be affected.

This assessment encompasses consideration of social inclusion. This is so that we are thinking as carefully and completely as possible about all Shropshire groups and communities, including people in rural areas and people we may describe as vulnerable, for example due to low income or to safeguarding concerns, as well as people in what are described as the nine 'protected characteristics' of groups of people in our population, eg Age. We demonstrate equal treatment to people who are in these groups and to people who are not, through having what is termed 'due regard' to their needs and views when developing and implementing policy and strategy and when commissioning, procuring, arranging or delivering services.

It is a legal requirement for local authorities to assess the equality and human rights impact of changes proposed or made to services. Carrying out ESIIAs helps us as a public authority to ensure that, as far as possible, we are taking actions to meet the general equality duty placed on us by the Equality Act 2010, and to thus demonstrate that the three equality aims are integral to our decision making processes. These are: eliminating discrimination, harassment and victimisation; advancing equality of opportunity; and fostering good relations.

The How:

The guidance and the evidence template are combined into one document for ease of access and usage, including questions that set out to act as useful prompts to service areas at each stage. The assessment comprises two parts: a screening part, and a full report part.

Screening (Part One) enables energies to be focussed on the service changes for which there are potentially important equalities and human rights implications. If screening indicates that the impact is likely to be positive overall, or is likely to have a medium or low negative or positive impact on certain groups of people, a full report is not required. Energies should instead focus on review and monitoring and ongoing evidence collection, enabling incremental improvements and adjustments that will lead to overall positive impacts for all groups in Shropshire.

A **full report (Part Two)** needs to be carried out where screening indicates that there are considered to be or likely to be significant negative impacts for certain groups of people, and/or where there are human rights implications. Where there is some uncertainty as to what decision to reach based on the evidence available, a full report is recommended, as it enables more evidence to be collected that will help the service area to reach an informed opinion.

Shropshire Council Part 1 ESIIA: initial screening and assessment

Please note: prompt questions and guidance within boxes are in italics. You are welcome to type over them when completing this form. Please extend the boxes if you need more space for your commentary.

Name of service change

Commissioning preventative services for adults in Shropshire

Aims of the service change and description

'Preventative Services' can be described as those which help to delay or reduce the need for unplanned or crisis (and more expensive) health and care interventions later on. Additionally Preventative Services can have a positive impact on the quality of life, health and wellbeing of individuals and communities.

Prevention can happen at any stage in a person's involvement with services and can be tailored to current and expected future circumstances. Preventative services should aim to achieve the following:

- Preventing and delaying ill health
- Keeping people fit and active
- Developing personal resilience
- Allowing people to maintain independence
- Reducing inequalities
- Improving wellbeing and quality of life
- Reducing the need for acute services including A&E, hospital admissions, residential care, etc
- Reducing isolation
- Allowing for more informed lifestyle choices and decision making
- Preventing homelessness

Preventative services can be defined at three 'levels' of prevention. Taking the example of helping people to avoid problems associated with falls in later life the preventative response could include:

Level 1 Universal / primary prevention – information, social marketing aimed at the whole population giving advice on how keeping active reduces risk in later life

Level 2 Secondary prevention – targeted at those people who are more at risk of falling, eg older people, and provide access to exercise classes, etc

Level 3 Tertiary prevention – where someone has fallen already provide additional interventions to reduce the risk of falling again

This project is focussed on commissioning prevention at levels 2 and 3, whilst heeding the overarching need to provide access to good quality information for the population as a whole.

Preventative services funding is an area of discretionary spend by the Council, although the Council does have a responsibility under the Care Act to provide or arrange for services, facilities or resources which would prevent, delay or reduce individuals' needs for care and support. In any event, local and national research has shown that investment in preventative services and housing support clearly helps to avoid much higher costs further 'downstream' in areas such as social care, admissions to hospital and homelessness.

Many statutory services and many programmes depend on a sustainable and effective suite of preventative services. For example, the Social Prescribing programme in Shropshire relies on the availability of preventative solutions to be able to 'prescribe' for their clients.

Preventative services are valued by customers, partners, stakeholders and the Council itself. Services achieve this through focussing on those things which have an impact on an individual's ability to be able to live independently in a home of their own and then helping those individuals to overcome them.

Currently Shropshire Council's Adult Services commissions a number of different organisations to deliver preventative services, many of which are Voluntary, Community or Social Enterprises (VCSEs). Providers range in nature and size from very small, very local groups formed in response to a particular local need or specialist type of provision through to local housing providers and branches of national VCSEs. Providers are funded through a mixture of grants and/or contracts, a number of which have been in place for some time, although they have all been regularly reviewed through annual grant reviews or periodic procurement activity.

Some providers have formed themselves into consortia with the aim of delivering a consistent and joined-up response to a particular set of issues. Two examples of these are the CAAN consortium delivering information, advice and advocacy and the Sustain consortium delivering housing-related support.

Feedback from engagement with people who use services, providers of preventative services and stakeholders has identified a number of issues which this project aims to try and address. People who use services have told us:

- They find it difficult to access services which help with:
 - PIP / appeals
 - Transport
 - household help
 - help with IT
 - finding friends
 - social contact outside of people with similar issues
- They don't (or won't) access support due to:
 - unaware of services
 - not knowing who to talk to
 - cost / affordability
 - transport - availability
 - waiting times
 - service cuts / lack of funding
 - not enough coordination between services
 - personal issues /condition
 - finding it difficult to ask
 - IT – either not having access or not comfortable using it

Preventative service providers have told us:

- More customers are presenting with more acute, multiple and complex issues which require more support. This can be challenging for volunteers
- Reductions in services elsewhere have increased demand on remaining services
- People don't know how to navigate the system in order to self-refer or to support signposting
- People have difficulty in accessing the right service at the right time due to:

- Availability
- Difficulty in arranging transport
- Waiting times for support are increasing
- People with mental health issues accessing advice and advocacy present a challenge in terms of capability of dealing with the individual (not the issue)
- Form filling – online and paper – is becoming more complex and takes longer

Stakeholders have told us:

- It can be difficult for professionals to access advice and advocacy for their clients
- Difficult to access services immediately when required
- Reductions in services elsewhere have increased demand on their services
- No support for people who need to attend a benefits tribunal (following the ending of Legal Aid funding)

In light of the outcomes from this engagement work we have developed a set of principles on which preventative services are to be commissioned. These include:

- Preventative services help people to keep well, live well and to feel enabled to do things for themselves
- The services that are available to people should feel joined-up, with multiple access points, and all providing good quality information about how the 'system' works
- Preventative services will support complementary programmes such as Social Prescribing and 'out of hospital' initiatives
- Shropshire is a large and rural county with a dispersed population. Approaches that work in one part of the county may not necessarily work as well in others. Providers will can apply a locally tailored approach to the work they do with vulnerable people.
- Prevention is targeted at those areas which make the biggest difference.
- Providers will aim to maximise income from alternative funding streams to complement Shropshire Council funding
- Providers will need to be able to maximise the value of all available resources in the communities in which they operate. This will include their own staff, buildings, technology, expertise, volunteer capability and other infrastructure as well as all of these owned or operated by other partners and stakeholders.
- Meaningful and productive partnerships will be developed and sustained between commissioned services and non-commissioned activity as well as the public and private sectors.
- Providers will adopt the principles of ['Making Every Contact Count'](#)
- Providers will need to demonstrate that they are committed to maximising the social, economic and environmental benefits gained through the way that they organise themselves.

Given that there have been successful examples of consortium and partnership working in the county, and the requirement for services to be coordinated and feel joined-up we are proposing to procure 3 services, each aimed at a particular area of prevention, on the principles above. Organisations bidding to deliver the work will need to set out who else they plan to work with and demonstrate how they will retain choice and multiple access points for people who use services. The services will be for:

1. Wellbeing and Independence – practical support for people in the home and enabling people to get out and about and be active in their communities
2. Housing support - to support people whose needs are such that their ability to maintain a tenancy or remain independent in their home would be compromised without that

support. The focus of housing-related support will be on ensuring that people have access to appropriate and settled accommodation according to their circumstances and have the support networks in place to help them sustain that accommodation.

3. Advice, Advocacy & Benefits - to deliver advice and advocacy across a range of issues which impact on people's wellbeing and will incorporate support for people engaged with the welfare benefits system.

Intended audiences and target groups for the service change

This service change is relevant to the following:

- People who currently use preventative services
- People who would use preventative services in future
- Families, carers and advocates of people who use or may use preventative services
- Providers of preventative services
- Adult social care teams
- Health services including community health teams
- The council's First Point of Contact team
- Other Shropshire Council customer access points
- Councillors as community leaders
- MPs
- Neighbouring authorities
- Strategic partnerships including the Marches LEP and the West Midlands Combined Authority

Evidence used for screening of the service change

Analysis has been undertaken on signposting data from the council to preventative service providers in order to understand signposting patterns. Demographic data and data from provider reporting has been reviewed and contributed to our understanding of the current position and potential future demand. Customer engagement which was undertaken during the development of the Adult Social Care Strategy 2018/19 – 2020/21 has identified a number of principles which can be applied to this specific review of preventative services including retention of specialist service providers, early intervention, making every conversation count, invest in lower level prevention, maximise use of resources and partnership work between health, social care, housing and the voluntary sector. In addition, evidence and feedback received from people who use services, service providers and stakeholders, as detailed below, has informed the Council's approach.

Specific consultation and engagement with intended audiences and target groups for the service change

The council has engaged with people who use preventative services, providers (whether funded by Shropshire Council or not), internal teams and other stakeholders. Engagement has been through a number of methods:

- **People who use services** – proposals were raised and discussed at an early stage through existing meeting groups attended by people who use services, eg Making it Real. Council Officers attended 3 x Making it Real area groups to discuss preventative services and to ask members of the groups whether services were effective, how people access services and what people would like help with but can't seem to find.

Providers of preventative services, whether commissioned and funded by the Council or not, were asked to engage with people who use their services using a questionnaire on which to base their discussions and provide feedback. Over 30 organisations commissioned by the Council were invited to engage their clients and 18 organisations which are not commissioned by the Council were asked as well.

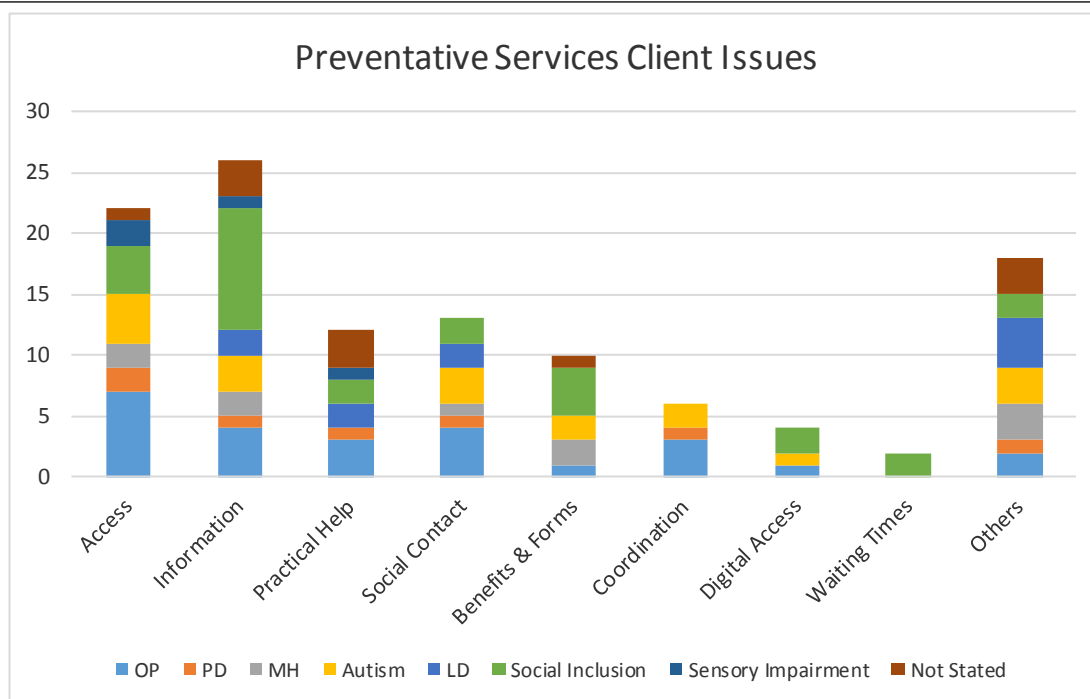
A questionnaire was also made available online.

In total over 150 responses from people were received of which 22 came from the online questionnaire and the remainder from clients of service providers.

It isn't possible to ascertain the personal characteristics of all people who provided responses, but of those who have self-identified or whose characteristics can be drawn from their responses:

- 33 people have 'social inclusion' needs
- 25 people have a learning disability or difficulties
- 24 are older people
- 19 have a physical disability
- 15 have autism or related
- 14 have mental health issues
- 8 have a sensory impairment

Analysis of the issues raised by people as being important in terms of the help they need or that people feel could be improved show that overall access to good quality information is most important, followed by accessibility (including good transport), social contact, practical help and benefits & form-filling. The chart below shows how these issues are broken down by personal characteristics.



Finally, in addition a smaller number of people asked to be kept informed on progress of this project and the key points in the service specifications have been shared with these people for further comment.

- **Service providers** – Preventative service providers have been fully engaged throughout this project. 3 events have been held to introduce the project, develop proposals, discuss progress and share findings. Around 30 providers have been represented at these events. In addition, 6 smaller focus groups looking at particular aspects of commissioning for prevention have been held with providers. These smaller focus groups covered the following topics:
 - Data, reporting and outcomes
 - Networks between public, business and community sectors
 - Review of current preventative activity
 - Independently-funded prevention
 - Commissioning priorities
 - Commissioning structures

Providers have also contributed to a questionnaire aimed at understanding the nature of their clients, referrals and emerging issues or gaps. 19 providers responded in total.

- **Council teams and other stakeholders** – have also attended the provider events and focus groups

Potential impact on Protected Characteristic groups and on social inclusion

Using the results of evidence gathering and specific consultation and engagement, please consider how the service change as proposed may affect people within the nine Protected Characteristic groups and people at risk of social exclusion.

1. Have the intended audiences and target groups been consulted about:

- their current needs and aspirations and what is important to them;
 - the potential impact of this service change on them, whether positive or negative, intended or unintended;
 - the potential barriers they may face.
2. If the intended audience and target groups have not been consulted directly, have their representatives or people with specialist knowledge been consulted, or has research been explored?
 3. Have other stakeholder groups and secondary groups, for example carers of service users, been explored in terms of potential unintended impacts?
 4. Are there systems set up to:
 - monitor the impact, positive or negative, intended or intended, for different groups;
 - enable open feedback and suggestions from a variety of audiences through a variety of methods.
 5. Are there any Human Rights implications? For example, is there a breach of one or more of the human rights of an individual or group?
 6. Will the service change as proposed have a positive or negative impact on:
 - fostering good relations?
 - social inclusion?

Initial assessment for each group

Please rate the impact that you perceive the service change is likely to have on a group, through inserting a tick in the relevant column. Please add any extra notes that you think might be helpful for readers.

Protected Characteristic groups and other groups in Shropshire	High negative impact <i>Part Two ESIIA required</i>	High positive impact <i>Part One ESIIA required</i>	Medium positive or negative impact <i>Part One ESIIA required</i>	Low positive or negative impact <i>Part One ESIIA required</i>
Age (please include children, young people, people of working age, older people. Some people may belong to more than one group eg child for whom there are safeguarding concerns eg older person with disability)			Yes – positive impact aimed at ensuring that all adults are able to access	
Disability (please include: mental health conditions and syndromes including autism; physical disabilities or impairments; learning disabilities; Multiple Sclerosis; cancer; HIV)			Yes – positive impact aimed at ensuring that all adults are able to access	
Gender re-assignment (please include associated aspects: safety, caring responsibility, potential for bullying and harassment)				X
Marriage and Civil Partnership (please include associated aspects: caring responsibility, potential for bullying and harassment)				X
Pregnancy & Maternity (please include associated aspects: safety, caring responsibility, potential for bullying and harassment)				X

Race (please include: ethnicity, nationality, culture, language, gypsy, traveller)			X	
Religion and belief (please include: Buddhism, Christianity, Hinduism, Islam, Judaism, Non conformists; Rastafarianism; Sikhism, Shinto, Taoism, Zoroastrianism, and any others)			X	
Sex (please include associated aspects: safety, caring responsibility, potential for bullying and harassment)				X
Sexual Orientation (please include associated aspects: safety; caring responsibility; potential for bullying and harassment)				X
Other: Social Inclusion (please include families and friends with caring responsibilities; people with health inequalities; households in poverty; refugees and asylum seekers; rural communities; people for whom there are safeguarding concerns; people you consider to be vulnerable)			Yes – positive impact. Services are required to focus on social inclusion	

Guidance on what a negative impact might look like

High Negative	Significant potential impact, risk of exposure, history of complaints, no mitigating measures in place or no evidence available: urgent need for consultation with customers, general public, workforce
Medium Negative	Some potential impact, some mitigating measures in place but no evidence available how effective they are: would be beneficial to consult with customers, general public, workforce
Low Negative	Almost bordering on non-relevance to the ESIA process (heavily legislation led, very little discretion can be exercised, limited public facing aspect, national policy affecting degree of local impact possible)

Decision, review and monitoring

Decision	Yes	No
Part One ESIA Only?	Yes	
Proceed to Part Two Full Report?		No

If Part One, please now use the boxes below and sign off at the foot of the page. If Part Two, please move on to the full report stage.

Actions to mitigate negative impact or enhance positive impact of the service change

Services will be commissioned based on a set of principles developed with people who use services, providers and other stakeholders. Stakeholders will be critical to the success of services through good quality signposting and support for providers.

As the engagement exercise has not identified race, religion or belief we will need to ensure that providers are inclusive and are culturally appropriate and accessible in the way that services are delivered. This will need to form part of monitoring arrangements.

The engagement exercise has not identified people in rural and isolated areas so we will need to ensure that services are available across the county, with effective links made with other organisations who can assist with accessibility including transport, digital access, support provision and physical locations. This approach will go some way towards mitigation of the higher costs of service delivery across rural Shropshire. This will form part of monitoring arrangements.

Actions to review and monitor the impact of the service change

We are developing reporting arrangements to evaluate the effectiveness of preventative services across all 3 commissioned themes. This will involve the council's First Point of Contact monitoring and will also require providers to use validated assessment tools to report on outcomes. There will be quarterly review of progress with all 3 commissioned theme leads, council leads and other stakeholders.

As part of the ongoing review of preventative services, commissioners will keep up to date with commissioning practice elsewhere and take opportunities to learn from good practice and share with local providers.

The Health and Wellbeing Board is being kept informed of commissioning proposals and will be updated with progress as services develop.

Scrutiny at Part One screening stage

People involved	Signatures	Date
<i>Lead officer carrying out the screening</i>		
<i>Any internal support*</i>		
<i>Any external support**</i>		

<i>Head of service</i>		

**This refers to other officers within the service area*

***This refers either to support external to the service but within the Council, eg from the Rurality and Equalities Specialist, or support external to the Council, eg from a peer authority*

Sign off at Part One screening stage

Name	Signatures	Date
<i>Lead officer's name</i>		
<i>Head of service's name</i>		

Shropshire Council Part 2 ESIIA: full report

Guidance notes on how to carry out the full report

The decision that you are seeking to make, as a result of carrying out this full report, will take one of four routes:

1. To make changes to satisfy any concerns raised through the specific consultation and engagement process and through your further analysis of the evidence to hand;
2. To make changes that will remove or reduce the potential of the service change to adversely affect any of the Protected Characteristic groups and those who may be at risk of social exclusion;
3. To adopt the service change as it stands, with evidence to justify your decision even though it could adversely affect some groups;
4. To find alternative means to achieve the aims of the service change.

The Part Two Full Report therefore starts with a forensic scrutiny of the evidence and consultation results considered during Part One Screening, and identification of gaps in data for people in any of the nine Protected Characteristic groups and people who may be at risk of social exclusion, eg rural communities. There may also be gaps identified to you independently of this process, from sources including the intended audiences and target groups themselves.

The forensic scrutiny stage enables you to assess:

- **Which gaps need to be filled right now, to help you to make a decision about the likely impact of the proposed service change?**

This could involve methods such as: one off service area focus groups; use of customer records; examination of data held elsewhere in the organisation, such as corporate customer complaints; and reference to data held by similar authorities or at national level from which reliable comparisons might be drawn, including via the Rural Services Network. Quantitative evidence could include data from NHS Foundation Trusts, community and voluntary sector bodies, and partnerships including the Local Enterprise Partnership and the Health and Well Being Board. Qualitative evidence could include commentary from stakeholders.

- **Which gaps could be filled within a timeframe that will enable you to monitor potential barriers and any positive or negative impacts on groups and individuals further along into the process?**

This could potentially be as part of wider corporate and partnership efforts to strengthen the evidence base on equalities. Examples would be: joint information sharing protocols about victims of hate crime incidents; the collection of data that will fill gaps across a number of service areas, eg needs of young people with learning disabilities as they progress through into independent living; and publicity awareness campaigns that encourage open feedback and suggestions from a variety of audiences.

Once you have identified your evidence gaps, and decided on the actions you will take right now and further into the process, please record your activity in the following boxes. Please extend the boxes as needed.

Evidence used for assessment of the service change: activity record

How did you carry out further research into the nine Protected Characteristic groups and those who may be at risk of social exclusion, about their current needs and aspirations and about the likely impacts and barriers that they face in day to day living?

And what did it tell you?

Specific consultation and engagement with intended audiences and target groups for the service change: activity record

How did you carry out further specific consultation and engagement activity with the intended audiences and with other stakeholders who may be affected by the service change?

And what did it tell you?

Further and ongoing research and consultation with intended audiences and target groups for the service change: activity record

What further research, consultation and engagement activity do you think is required to help fill gaps in our understanding about the potential or known affect that this proposed service change may have on any of the ten groupings and on the intended audiences and target groups? This could be by your service area and/or at corporate and partnership level.

Full report assessment for each group

Please rate the impact as you now perceive it, by inserting a tick. Please give brief comments for each group, to give context to your decision, including what barriers these groups or individuals may face.

Protected Characteristic groups and other groups in Shropshire	High negative impact	High positive impact	Medium positive or negative impact	Low positive or negative impact
Age (please include children, young people, people of working age, older people. Some people may belong to more than one group eg child for whom there are safeguarding concerns eg older person with disability)				
Disability (please include: mental health conditions and syndromes including autism; physical disabilities or impairments; learning disabilities; Multiple Sclerosis; cancer; HIV)				
Gender re-assignment (please include associated aspects: safety, caring responsibility, potential for bullying and harassment)				
Marriage and Civil Partnership (please include associated aspects: caring responsibility, potential for bullying and harassment)				
Pregnancy & Maternity (please include associated aspects: safety, caring responsibility, potential for bullying and harassment)				
Race (please include: ethnicity, nationality, culture, language, gypsy, traveller)				
Religion and belief (please include: Buddhism, Christianity, Hinduism, Islam, Judaism, Non conformists; Rastafarianism; Sikhism, Shinto, Taoism, Zoroastrianism, and any others)				
Sex (please include associated aspects: safety, caring responsibility, potential for bullying and harassment)				
Sexual Orientation (please include associated aspects: safety; caring responsibility; potential for bullying and harassment)				
Other: Social Inclusion (please include families and friends with caring responsibilities; people with health inequalities; households in poverty; refugees and asylum seekers; rural communities; people for whom there are safeguarding concerns; people you consider to be vulnerable)				

ESIIA Full Report decision, review and monitoring

Summary of findings and analysis - ESIIA decision

You should now be in a position to record your decision. Please highlight in bold the route that you have decided to take.

1. To make changes to satisfy any concerns raised through the specific consultation and engagement process and through your further analysis of the evidence to hand;
2. To make changes that will remove or reduce the potential of the service change to adversely affect any of the Protected Characteristic groups and those who may be at risk of social exclusion;
3. To adopt the service change as it stands, with evidence to justify your decision even though it could adversely affect some groups;
4. To find alternative means to achieve the aims of the service change.

Please add any brief overall comments to explain your choice.

You will then need to create an action plan and attach it to this report, to set out what further activity is taking place or is programmed that will:

- *mitigate negative impact or enhance positive impact of the service change,*
- AND*
- *review and monitor the impact of the service change*

Please try to ensure that:

- *Your decision is based on the aims of the service change, the evidence collected, consultation and engagement results, relative merits of alternative approaches and compliance with legislation, and that records are kept;*
- *The action plan shows clear links to corporate actions the Council is taking to meet the general equality duty placed on us by the Equality Act 2010, to have due regard to the three equality aims in our decision making processes.*

Scrutiny at Part Two full report stage

People involved	Signatures	Date
<i>Lead officer</i>		
<i>Any internal support</i>		
<i>Any external support</i>		
<i>Head of service</i>		

Sign off at Part Two full report stage

Signature (Lead Officer)	Signature (Head of Service)
Date:	Date:

Appendix: ESIIA Part Two Full Report: Guidance Notes on Action Plan

Please base your action plan on the evidence you find to support your decisions, and the challenges and opportunities you have identified. It could include arrangements for:

- continuing engagement and involvement with intended audiences, target groups and stakeholders;
- monitoring and evaluating the service change for its impact on different groups throughout the process and as the service change is carried out;
- ensuring that any pilot projects are evaluated and take account of issues described in the assessment, and that they are assessed to make sure they are having intended impact;
- ensuring that relevant colleagues are made aware of the assessment;
- disseminating information about the assessment to all relevant stakeholders who will be implementing the service change;
- strengthening the evidence base on equalities.

Please also consider:

- resource implications for in-house and external delivery of the service;
- arrangements for ensuring that external providers of the service are monitored for compliance with the Council's commitments to equality, diversity and social inclusion, and legal requirements including duties under the Equality Act 2010.

And finally, please also ensure that the action plan shows clear links to corporate actions the Council is taking to meet the general equality duty placed on us by the Equality Act 2010, to have due regard to the three equality aims in our decision making processes.

These are:

- Eliminating discrimination, harassment and victimisation
- Advancing equality of opportunity
- Fostering good relations

Note: Shropshire Council has referred to good practice elsewhere in refreshing previous equality impact assessment material in 2014 and replacing it with this ESIIA material. The Council is grateful in particular to Leicestershire County Council, for graciously allowing use to be made of their Equality and Human Rights Impact Assessments (EHRIAs) material and associated documentation.

For further information on the use of ESIIAs: please contact your head of service or contact Mrs Lois Dale, Rurality and Equalities Specialist and Council policy support on equality, via telephone 01743 255684, or email lois.dale@shropshire.gov.uk.

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