Shropshire Council

Date: Thursday, 23 May 2019

Time: 9.30 am

Venue: Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND

Contact: Michelle Dulson, Committee Officer
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Email: michelle.dulson@shropshire.gov.uk

HEALTH AND WELLBEING BOARD

TO FOLLOW REPORT (S)

7 System Update (Pages 1 - 128)

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

Shropshire Care Closer to Home
Report attached.

Contact: Barrie Reis-Seymour, Shropshire CCG

System Update:

The Sustainability and Transformation Plan for Shropshire, Telford & Wrekin
Report attached.

Contact: Martin Harris, Telford and Wrekin CCG

Better Care Fund, Performance
Report to follow.

Contact: Penny Bason, Shropshire Council / Shropshire STP/Tanya Miles

Healthy Lives Update
Report to follow.

Contact: Val Cross, Health and Wellbeing Officer

9 **Public Health Financial Changes** (Pages 129 - 132)

Report to follow.

Contact: Andy Begley, Director of Adult Services, Shropshire Council

Shropshire Council | NHS Shropshire Clinical Commissioning Group | Shropshire together

Health and Wellbeing Board
Meeting Date: 23rd May 2019

Item Title Shropshire Care Closer to Home – Update Report

Responsible Officer Lisa Wicks Shropshire Clinical Commissioning Group
Email: Lisa.Wicks@nhs.net

1. Summary

This paper provides an update on the Shropshire Care Closer to Home programme.

2. Recommendations

The Health and Wellbeing Board is recommended to note the information and progress outlined in the report.

REPORT

Programme Phases & Progress Updates

Phase 1
Phase 1 is presently operational in the form of the Frailty Intervention team (FIT) who are based within the A&E Department of Royal Shrewsbury Hospital providing rapid frailty assessments and transferring to more appropriate care settings; with the aim of minimising unnecessary hospital admissions and ensuring the person is in the right place for their care and support. A phased launch has now commenced at the A&E Department of Princess Royal Hospital in Telford.
A short film on the work of the Shropshire Frailty Team commissioned by NHS England has also been finalised and launched.

Phase 2
The Phase 2 model of earlier identification of people's needs and proactive integrated health and social care delivered by a community based Case Management team was approved by the Governing Body in August 2018. A Pilot Implementation Group was established, made up of stakeholders spanning the whole health and social care system including CCG, Shropshire Council, GP's, SaTH NHS Trust, Midlands Partnership Foundation Trust, Shropshire Community Trust, patient and public representatives, and the voluntary & care sector; with the remit of collectively planning and implementing pilot demonstrator sites that will test the model prior to robust evaluation and wider rollout across the county. The service specifications, model, demonstrator site criteria and required outcomes were all agreed, and the providers are now taking this forward by co-ordinating the developing and shaping of the more detailed operational functionality of the pilots including locations, workforce, governance and ways of working.

The commitment is that the pilot demonstrator sites will be functional from June 2019 and will run for 9 months, including at the latter stages a 3 month robust evaluation against control sites and required outcomes.

The 8 locations for the pilot demonstrator sites of this service are:

- Albrighton Medical Practice
- Belvidere Medical Practice
- Plas Ffynnon Medical Practice
- Wem & Prees Medical Centre
- Bridgnorth Medical Practice
- Bishops Castle Medical Practice
- The Meadows Medical Practice
- Pontesbury Medical Practice

Work is still underway to develop the required IT and data elements including flow of data between providers, data sharing agreements, GDPR requirements, risk stratification or case finding using merged data, and shared electronic Care Plan meaning everyone involved in the care of that person has all of the required information and that the person has to only ever tell their story once. This will also be added to with an emergency care plan, end of life plan, and links to vital information such as allergies and DNAR notes.
While this enormous piece of work continues, automated risk stratification and data sharing agreements will be in place for the 8 named GP practices for the pilots to commence on 1st June 2019. A manual workaround process is currently being developed and agreed for the shared Care Plan as that technical development will not be in place by June.
All of this IT and data work us also fully aligned with the agenda of the STP Digital Enabling Group.

Phase 3
The design process for Phase 3, which is acute and semi-acute services but still in the community, commenced with extensive scoping and research of other similar national and international models at the end of 2018. The first draft concepts of these new models of care were then shared with stakeholders across the whole health and social care system for critique, comment and feedback.

The draft models were then also shared with the Programme Working Group, Programme Board, GP's and primary care colleagues, and a large-scale patient/public and provider stakeholder event. This ensured ongoing collaborative do-design of the new models and services by enabling us to gather as much feedback and input as possible.

The programme team then spent April consolidating all of the comments and feedback harnessed from all workshops and meetings, before undertaking thematic analysis of the core themes. This condensed feedback is now being considered and reviewed by the Programme Board in order to make any final adjustments to the model designs as part of refining and finessing them, and ensuring they are fit for purpose and sustainable.

If endorsed by the Programme Board in May 2019, the proposed models will then be taken to an extraordinary Shropshire Clinical Commissioning Committee on 11th June 2019 for consideration and approval. If agreed, planning will then commence for the implementation of pilot demonstrator sites following the same process as Phase 2.

The modelling and design has included the development of not only high level model and pathway descriptions, but also detailed robust service specifications that sets out the criteria for using the service or being discharged from it, location, conditions treated, governance, quality and safety, outcomes, and workforce.

The Phase 3 models can be summarised as follows:

Hospital at Home A model for an episode of specialist care delivered for a limited time period in person's home, or at the person's care/residential home, as an alternative to being treated in an acute hospital setting.	**DAART** A designated space that provides timely access to assessment, diagnostics, and short term intervention without the need for hospital admission; before being referred to an ongoing care setting or discharged.
Rapid Response A model that provides a Rapid Response Team of professionals who respond to a person with early signs of deterioration, or heading towards a crisis, and provide a rapid intervention and assessment that stabilises, before triaging to the appropriate setting and then departing.	**Crisis** A service that provides an emergency responsive team of professionals who respond to a person with unmanageable signs of deterioration, or who has tipped into a crisis, and provide assessment, stabilisation, similar to the Rapid Response team but also provide short term high level intensive treatment and monitoring for up to 72 hours before referring to a more appropriate care setting; whether that is stepping down if the person's condition has improved or escalating as a hospital admission of the person deteriorates.

The fifth element of Phase 3 (Step Up beds) will be revisited now that local population disease profiling and prediction information has been received and once the full written report is received.

It will be the implementation and embedding of Phase 3, along with Phase 2, that will see the full benefits realisation of Shropshire Care Closer to Home in vastly improved patient experience, whole system functionality and flow, transformed community services, enabling Future Fit, and reduction of non-elective admissions into secondary care; reflecting the recommendations also set out in the National 5 Year Forward View and the NHS 10 Year Plan.

It is worth noting that whilst these are described as individual services, they will function collectively as one cohesive model of care where the individual moves seamlessly from one service to another without handoffs, co-ordinated by the Case Manager who provides the sole consistent point of contact for the patient and their family. A high level service map of the overarching Shropshire Care Closer to Home models demonstrating these interdependencies is enclosed for information as ***Appendix A*** and ***Appendix B***.

Enablers

A dedicated Care Closer to Home Communications and Engagement Group was established to support delivery across the whole system of the communications and engagement strategy required to support the programme.

A dedicated IT Lead has now been identified within Shropshire CCG who has established a dedicated Care Closer to Home IT Group, with the remit of driving through development and delivery of the necessary IT and data work; essential for the running of the Care Closer to Home services. This includes two-way flow of data between providers, data sharing agreements, GDPR

requirements, risk stratification or case finding using merged data, and shared electronic Care Plans. This is aligned with the work underway in the background of the STP Digital Group on achieving the same agenda of work but on a broader whole system scale.

A software tool purchased by Shropshire Council is now in place which provides a wealth of information into the local population disease prevalence, profiling and predictions. Work is underway to convert this information into a written Joint Strategic Needs Analysis (JSNA) which will enable work to start on developing the fifth strand of Phase 3, Step Up Community Beds.

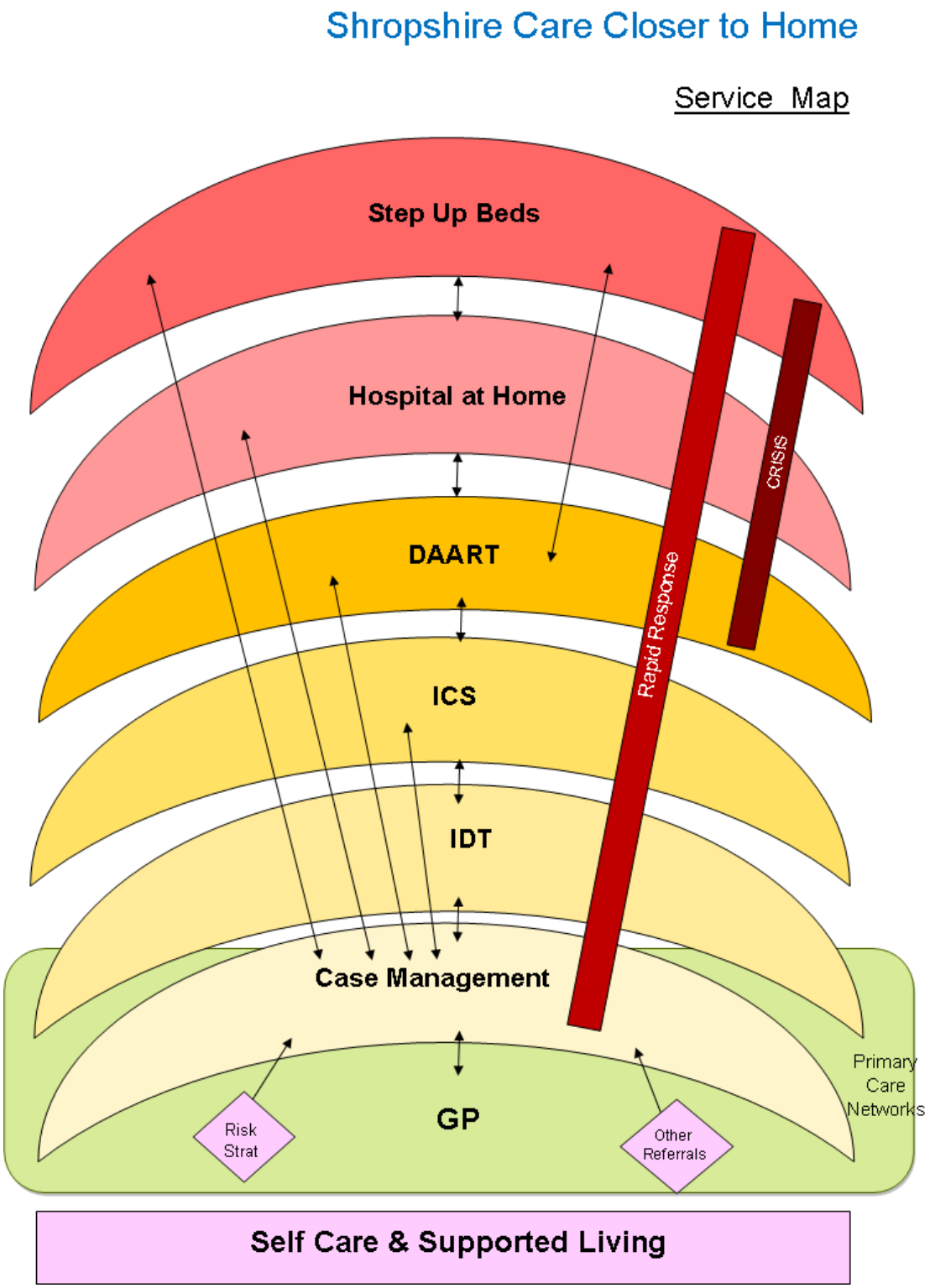
Once these phases are fully embedded and functional, there is a Phase 4 that will see an expansion to include all ages, and not just those aged 65 and over. The reason for starting with 65 plus and frailty is this group being the predominant proportion of population in the Shropshire demographic.

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

-ends-

Appendix A

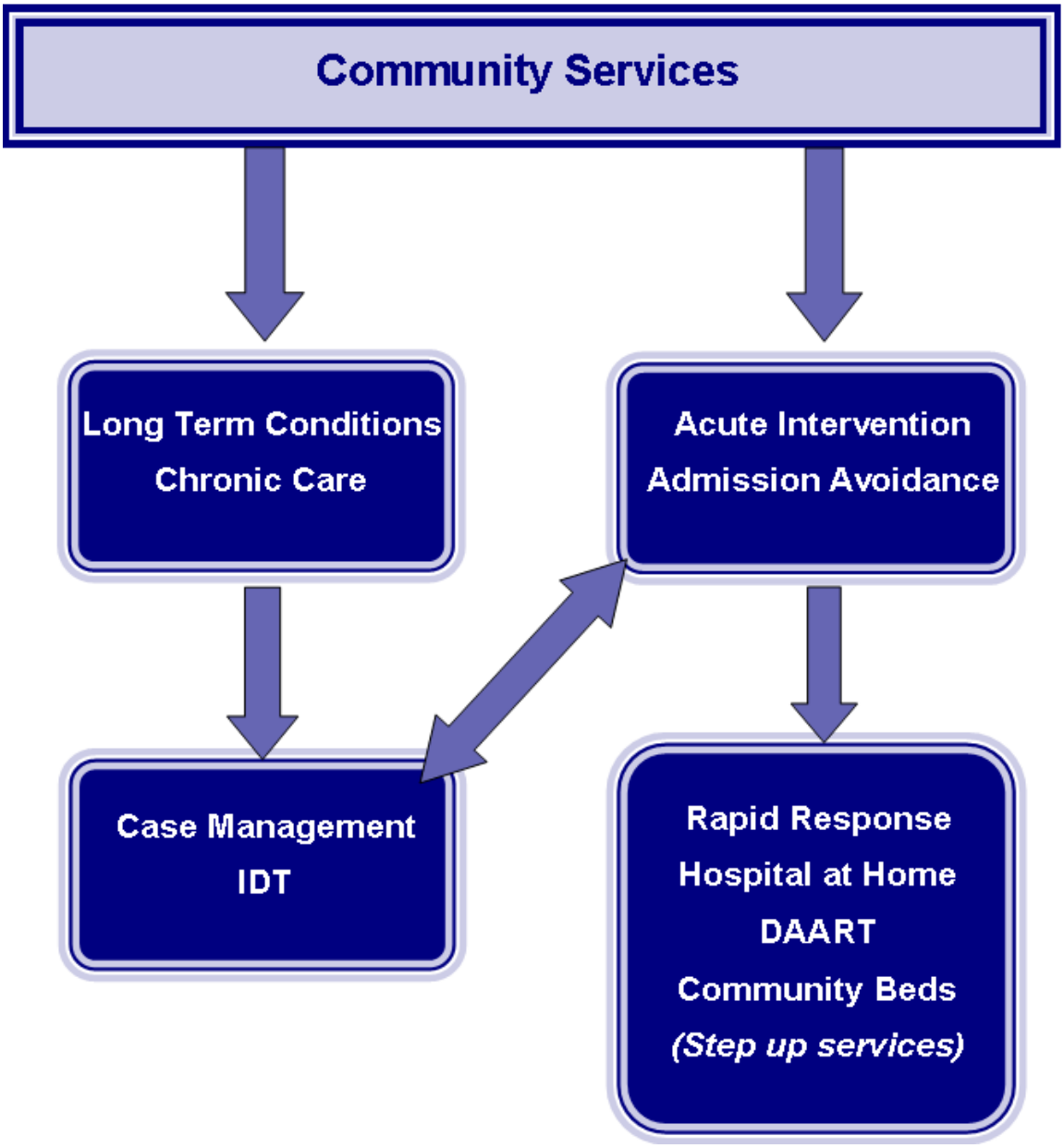
High Level Services Map



Appendix B

Shropshire Care Closer to Home

Pathways



Health and Wellbeing Board
23rd May 2019

STP Update: April 2019 19/20 System Operating Plan Narrative submission

Responsible Officer
Email: Martin.Harris7@nhs.net Tel:

1. Summary

The attached report provides the Board with an update on the progress of the Sustainability & Transformation Programme for Shropshire, Telford and Wrekin, in relation to the recently submitted NHSE & I System Operating Submission. Extensive work has been undertaken to ensure this is a collaborative submission reflecting a "system" overview of the 19/20 individual organisations operating plans. This submission is not yet signed off by NHSE & I, the STP is awaiting feedback, particularly around our predicted financial position, so some data in the attached is subject to change.
We are confident that this submission reflects a system view and would like to take this opportunity to thank Local Authority colleagues for their ongoing contribution and support.

2. For Information

The Board is invited to:

a) Note the system narrative submission, that has been developed collaboratively with all system partners

b) Note current context, challenges, system structure, governance and performance – all of which are subject to change as we as a system work towards becoming and Integrated Care System by 2011

c) Note system ambition and priorities

"The ambition of Shropshire, Telford & Wrekin STP is to deliver joined-up, transformed health and care services for local people"

d) Note timeline, delivery and enablement programmes, approach to activity and capacity planning and overall system financial position.

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

Cabinet Member (Portfolio Holder)
Local Member
Appendices STP Update: April 2019 19/20 System Operating Plan Narrative submission
Further information Please contact jo.harding1@nhs.net for any further clarification following the meeting

System Operational Plan April 2019

Shropshire, Telford & Wrekin STP

Board Version of submitted STP Plan

Our system plan has input from the following System Partners as well as wider stakeholders

NHS Shropshire Clinical Commissioning Group

NHS Telford and Wrekin Clinical Commissioning Group

NHS Shropshire Community Health NHS Trust

NHS Midlands Partnership NHS Foundation Trust
A Keele University Teaching Trust

healthwatch Telford and Wrekin

NHS Health Education England

Telford & Wrekin Council

healthwatch Shropshire

NHS The Shrewsbury and Telford Hospital NHS Trust

NHS The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

NHS West Midlands Ambulance Service University NHS Foundation Trust

Shropshire Council

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Foreword by: Sir Neil McKay, Shropshire, Telford & Wrekin STP Independent Chair

This 19/20 system operating Plan forms the first year of our refreshed STP LTP due in the autumn 2019.

The Shropshire, Telford & Wrekin STP have worked collaboratively to bring single organisational operating plans from all system partners, including **Local Authority** plans in to an aligned narrative description that captures the following:

- System Priorities& Deliverables
- System understanding of activity assumptions
- System understanding of capacity planning
- System understanding of strategic workforce planning
- System Financial understanding and agreed approach to risk management
- Understanding of efficiencies and our collective responsibility to deliver those.

In order to develop from an STP to an **Integrated Care System**, we are required to structure and manage ourselves differently going forward.

Our system will make better use of our collective data to inform the initial **Bronze Data Packs** and later in the year the **Population Health & Prevention Dashboard**, both designed to improve our system business intelligence, understanding and planning for improved outcomes.

As part of our LTP refresh, our system will be revisiting our ambitions and the expected outcomes for our population served. In conjunction with our local authority colleagues, we will focus on developing **Place Based Integrated Care**, ensuring quality services are supporting health and wellbeing, whilst improving health inequalities.

Details of these will be available in our LTP later this year.

- **System leadership capacity & capability** across all organisations is fundamental to our success and we will be completing two key programmes to support our strategic development in this area:
  - **System Commissioning Capability Programme**
  - **System ICS Development Programme**
- Transformation across all that we do to achieve ICS status by 2021/2022 is our goal. Our focus will be on system delivery and enablement to achieve high quality outcomes for our population whilst making best use of our collective system resources in order to get best value for every £ spent.
- System financial recovery is inherent in all our ambitions and plans and we are implementing a structure to support delivery of efficiencies.
- The Long Term Plan refresh is our opportunity to work as a system, to meet our challenges of a growing elderly population with increasingly complex needs. Our system expertise (health, social care & wider stakeholders) will come together via our system **Clinical Strategy Group** that will in turn inform our **System Programme Delivery Group,** this will be the engine room of our system transformation.
- This plan has the support and sign-off through all our system partners via **System Leadership Group** and corresponding individual organisational governance processes.
- Finally, this plan demonstrates how we will improve performance, quality, integrated place based working and financial recovery through 19/20.

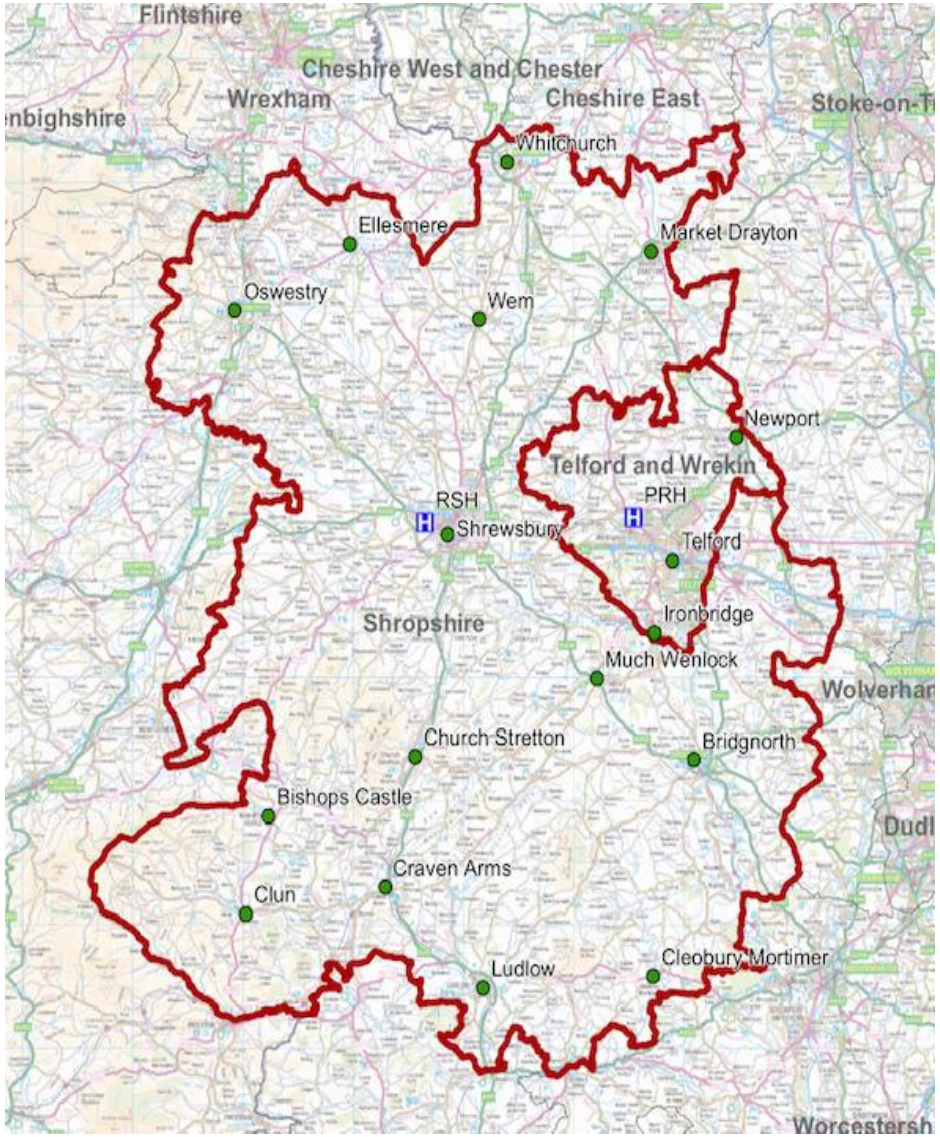
Sir Neil McKay, Independent Chair

Shropshire, Telford & Wrekin STP

2.
Context, Challenges, & ICS Development

Shropshire, Telford & Wrekin STP local context

- Shropshire, Telford & Wrekin STP can be characterised as a good place to live and work, with a good sense of community and volunteering, and the population we serve recognised as diverse, with challenges set by our geography and demography.
- Shropshire is a mostly rural county with 35% of the population living in villages, hamlets and dispersed dwellings; a relatively affluent county masks pockets of deprivation, growing food poverty, and rural isolation. Telford & Wrekin is predominantly urban with more than a quarter living in the 20% most deprived nationally and some living in the most deprived areas.
- The STP sits between some of the largest conurbations in the country (Birmingham to the South, Manchester and Merseyside to the North), as well as sharing its western border with Wales.
- The STP footprint is served by one acute provider (Shrewsbury & Telford Hospital NHST), one specialist provider (The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS FT) , one community health provider (Shropshire Community Health NHST) and one mental health provider (Midlands Partnership FT) The ambulance provider is West Midlands Ambulance Service FT.
- There are two CCGs across the footprint; Telford & Wrekin CCG has a large, younger urban population (173k) with some rural areas and is ranked amongst the 30% most deprived populations in England. Shropshire CCG (308k) covers a large rural population with problems of physical isolation and low population density and has a mix of rural and urban ageing populations.
- There are two corresponding local authorities in the footprint; Telford & Wrekin Council, and Shropshire Council
- There are two A&E sites within 28 minutes drive time of each other (Royal Shrewsbury Hospital and Princess Royal Hospital), both with growing volumes of attendances, regularly seeing 400-430 attendances across both sites each day.
- Residents of parts of the footprint will have reasonably long drive times to access acute services.
- The nearest major trauma centre is at Stoke on Trent (UHNM), in the neighbouring Staffordshire footprint.
- There are some high prevalence rates of mental health conditions identified in Shropshire, T&W; there is one mental health provider with a full coverage of services available within the footprint. In addition to minimum Tier 3 and 4 inpatient wards, specialist beds and Tier 4 secure/forensic services are provided.
- Shropshire/T&W has a good relationship with care providers facilitated by Shropshire Partners in Care (SPIC)



System Challenges

One of the significant challenges facing our system is the cultural shift required to move from overly medical care models to ones that align with the principles of prevention, self-help and early intervention. This applies equally to mental and physical health care, as does ensuring parity between physical and mental health care. Another challenge we face is that the system has struggled to make the cultural adjustment needed toward integrated working; this has been exacerbated by insufficient access to a substantive workforce which has impacted on quality, performance and finances. There are also reducing budgets in the care sector and complex political relationships across the system.

Demographics & geography:

- Ageing population: in the Shropshire Council area, 23% of the population is 65 years and over compared to the England average of 17.6% . T&W Council area has a greater number than average of young people but a rapidly growing older population.
- A largely rural Shropshire in contrast with a relatively urban T&W provides challenges to developing consistent, sustainable services with equity of access.
- Shropshire, T&W STP area can be described as a low wage economy; consequently the wider determinants of health including education, access to employment and housing are significant issues to consider when developing services that support good physical and mental health.

Operational performance

- A&E: workforce constraints with consultant and middle tier medical and nursing staff vacancies at SaTH have affected performance, with year to date 4-hour performance at 75.87%
- Cancer: the system is failing to deliver consistently against key cancer standards in all specialties due to challenges with staffing combined with high numbers of referrals

Financial position – the system is facing in year financial pressures:

- At the time of writing this plan, there remains a material gap from the collective Control Total of £21m deficit , driven largely by financial challenges within Shropshire CCG and Shrewsbury and Telford Hospitals Trust. This represents a deficit across the system of £48.6m, with a risk to delivery of £23.2m.
- The two local authorities have been required to make significant savings over recent years, compounded by significant rising costs in delivering social care for both children and adults.

Workforce

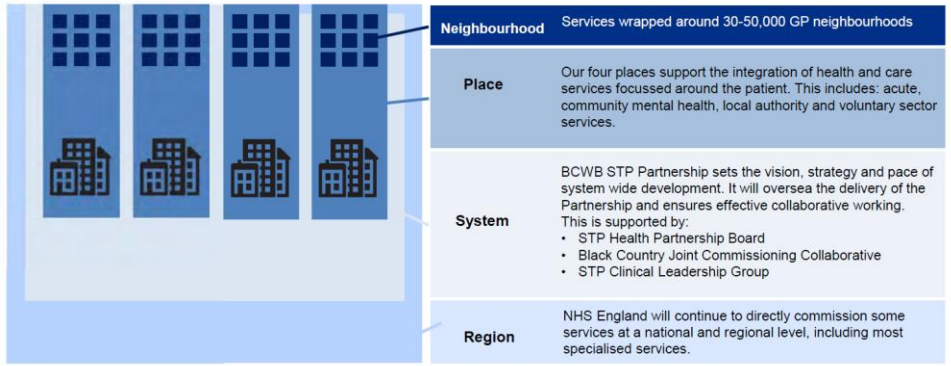
- All providers (including the social care and domiciliary sector) report issues recruiting qualified staff due in large part to the geography and demography of the area.

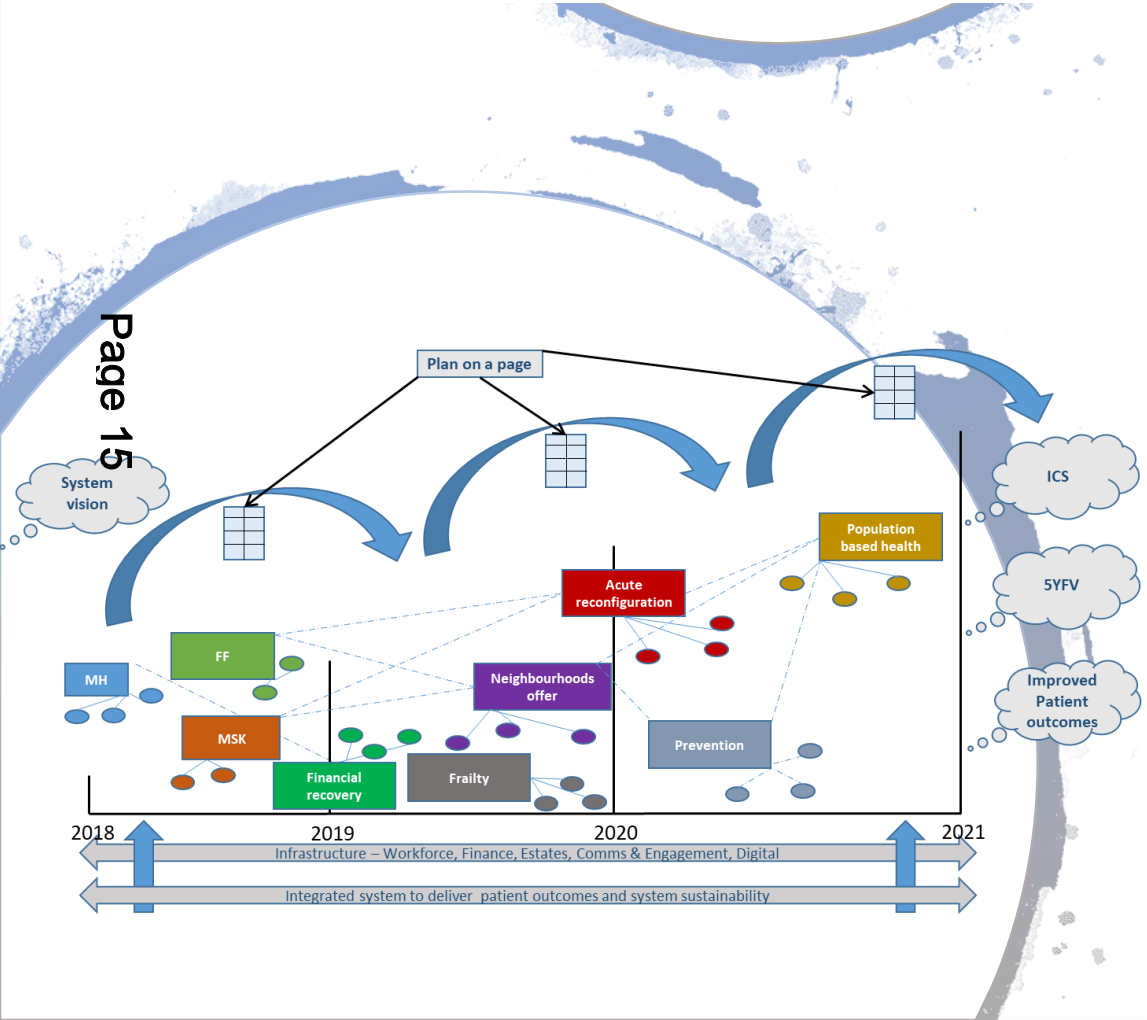
Quality

- Shrewsbury and Telford Hospital NHS Trust has recently been rated ‘inadequate’ by CQC and is in ‘special measures’, due to quality and leadership. The Trust is involved in an ongoing independent review into neonatal and maternal deaths.
- Shropshire Community Health NHS Trust is rated as ‘requires improvement’. The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is rated as good.
- 88% of care homes in Shropshire are rated good by CQC, as is the mental health care provided by MPFT (Midland Partnership NHS Foundation Trust)
- Healthwatch Shropshire and T&W both work to support and identify areas for quality improvement in our STP Footprint

Reconfiguration

- Public consultation on acute services reconfiguration (‘Future Fit’) completed; Final Decision Making Business Case approved by Joint Programme Board January 2019. Implementation over the next 5 years, subject to NHSI approval.
- Closer joint working between the two CCGs, exploring the options to move to a Single Strategic Commissioner. Interim Accountable Officer appointment for Shropshire County CCG commenced April 2019, following retirement of the incumbent.
- Midwifery-Led Units case for change just completed NHS England strategic sense check ahead of proposed reconfiguration consultation





Development towards an Integrated Care System

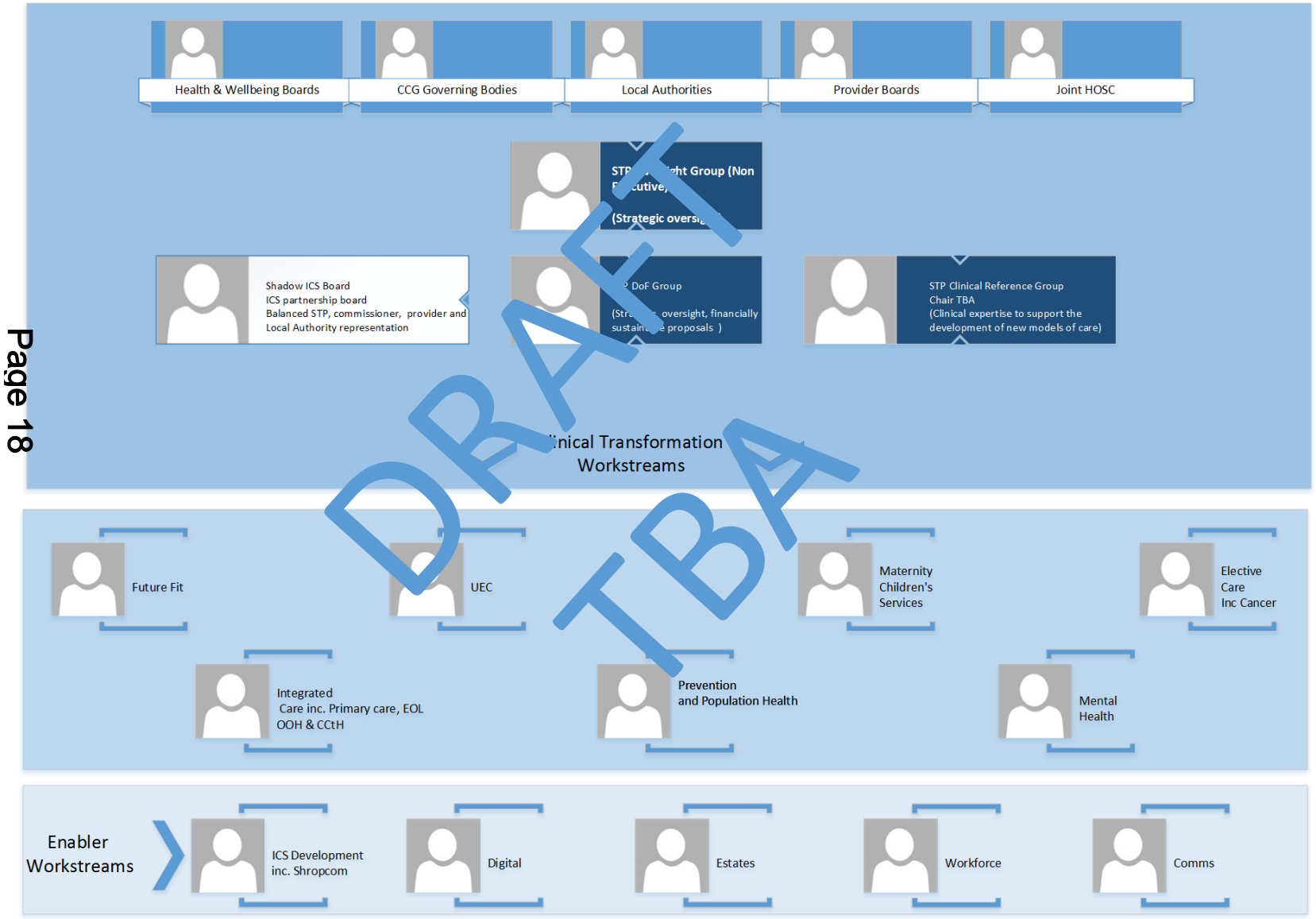
- **STP System Leadership** are progressing towards an Integrated Care System with aligned strategic thinking and delivery.
  - Shadow ICS board currently being developed
- **Renewed Governance and leadership**
  - STP governance refresh (in progress)
- **Commissioning Capability Programme**
  - Development of strategic commissioning and wider partner engagement to shape together
  - Strengthening the profile of mental health across the system
- **Integrated Care Development Programme**
  - Integrated Care System Development (ICSD) - A programme to develop long term behaviors and capabilities to progress the development of local ICS architecture.
  - Commissioning in our 'ICS System' commissioning arrangements to support our wider objectives in order to transform the quality of care delivery and improve health and wellbeing for our population.
    - Functions of the CCGs
    - Services the CCG provide
    - Teams are in the CCG and what are their areas of expertise
    - Merging STP/CCG resources where possible
- Understanding the optimal level/scale at which to commission and where greater efficiencies can be sought.
- **National Delivery Unit Data pack (Bronze Packs)** - a standard data analytical pack produced from national data sources provided to system to identify system opportunities that will contribute towards financial sustainability and improved health and wellbeing outcomes.

3.
System Structure, Governance & Performance

Future governance

- The current STP governance is a partnership between all current organisations in the system. Partners are prioritising the 2 key work programmes:-
    1. System Commissioning Capability Programme
    2. System ICS Development Programme
- We are also committed to working across the system on our **Integrated Place Based Care Programme**
- During 2019/20 we will design new system structures, including a ICS Strategic Commissioner and Place Based Alliances and the governance will evolve.
- The benefits will be:-
    - System efficiencies
    - System focus on Health AND Social Care
    - One strategic commissioner organisation able to drive improvements in performance and quality of care consistently to meet NHS constitutional and key Local Authority targets
    - Stronger local (place) arrangements to deliver care closer to home, as per Future Fit and individuals aspirations/wishes
    - Local synergy with other initiatives including development of Primary Care Networks, Population Health Management and wider prevention.

Refreshed System Governance (to be agreed)



The refreshed governance structure is currently being developed at the System Leadership Group (SLG) this will ensure a streamlined approach to our system transformation programmes this includes -

- Agreed standardised principles for each transformation workstream
    - Strategic oversight for all programmes
    - Specific Terms of Reference and membership for each workstream
    - CEO/AO lead for each programme
    - Dedicated Programme Management
    - Contributes to the LTP
    - Contributes to the implementation of the delivery plans
    - Each programme will have a clinical presence
- Quarterly Transformation checkpoint sessions
- Monthly Operational plan delivery meetings
- Quarterly Chair oversight meetings
- Monthly ICS Shadow board meetings to review and support each programme

Operational Plan Delivery Group

Governance

Delivery of the agreed Operational Plan will require robust integrated working across the whole system. To facilitate this the SLG have agreed an **Operational Plan Delivery Group**, which will be chaired by the STP Sustainability & Transformation Director and include senior Operational, Finance and Clinical representatives from each partner organisation.

This Group will:

- Monitor delivery against key milestones and performance targets
- Provide system support to collectively identify and implement mitigations required to ensure delivery of agreed plans
- Ensure balance of operational, financial and quality performance is maintained across the whole system

Implementation of this Group has been agreed in principle by SLG. We are progressing development with the support of nationally available programmes and resources.

Commissioning Capability

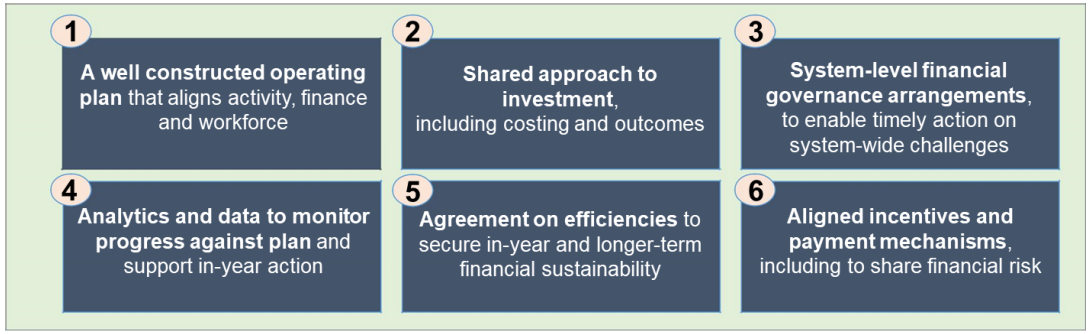
The system is currently considering the WSOA data pack (Bronze Pack) through the **System Commissioning Capability Programme** that includes health and local authority colleagues. Through this programme we are developing the skills and competencies that underpin the implementation of the **MCFR Framework.** This should position commissioners to fully support transition to the ICS.

Expected outcomes:

- All system efficiencies to be considered and actioned as agreed with system partners
- All efficiencies to be included in system financial position
- All risks to delivery to be identified and mitigated with system partners
- Population Health & Prevention Dashboard to be delivered later this year (expected Autumn 2019)

Managing Collective Financial Resources

- The Managing Collective Financial Resources (MCFR) framework has been developed to support systems to effectively manage their collective resources.
- The MCFR framework identifies six key activities that are critical to managing financial resources collectively. The framework is supported by a resource library of tools and case studies which will be updated regularly.



In addition to the six areas of system activity two additional factors have been identified as particularly important to whole system financial management.

These **factors** are:

- Implementation capacity and capability
- System leadership and culture

Shropshire and Telford & Wrekin STP Diagnostic: System Opportunity Overview – Bronze Pack

Key System Drivers / Summary Hypotheses

1 *Out of Hospital Care*

Lower social care and CHC spend, higher avoidable admissions and delayed discharged, with longer LoS for the elderly

The percentage of the **STP's population aged 60-79 (22%) is higher than the England average** (18%) and the growth rate for this segment is 6%, also higher than average (2%). **The percentage of population aged 80+ (6.2%), is higher than the average** (5%) and sees a growth rate of 2.4% against an average of 2.4% 2016.

The STP **spend on social care needs is c.£6m lower** than the national average (spend per head rate). **CHC spend is c.£0.2m higher** than the national average per 50,000 population at a STP level, **however c.£1.2m lower per 50,000 for Telford and Wrekin** CCG (2017/18).

Potentially **avoidable attendances at A&E referred from elsewhere in the system are c.45% higher compared to peers**, corresponding to a potential opportunity of 5,038 attendances compared to the best 5 peers (2016/17 Q4 - 2017/18 Q3).

Non-elective admissions per 1,000 are c.7-14% higher compared to the 5 best peers, a potential opportunity of 5,360 admissions. **Non-elective bed days are c.12% higher** for Shropshire CCG compared to peers, a potential opportunity of 19,043 bed days (17/18).

The **proportion of patients discharged to their usual place of residence is c.7% lower** compared to peers for Shropshire CCG, a potential opportunity of 758 discharges (2016/17 Q4 - 2017/18 Q3).

The **proportion of continuing healthcare eligibility decisions made within 28 days of the initial referral is below the England average** for both CCGs and lower compared to peers - a potential opportunity of 216 decisions compared to the 5 best peers (2017/18).

There has been a **decrease in the percentage of people in Telford & Wrekin (over 65) still at home 91 days after discharge** from hospital between 16/17 (71%) and 17/18 (62%).

2 *MSK*

Higher spend on MSK, widespread risk factors, higher prevalence and number of bed days/LoS

MSK is the second highest area of spend for the STP, c.£50m. Spend is c.£10m higher than the national average rate (2017/18).

Elective spend for MSK is higher compared to peers, a difference of £8.5m. c.87% of this spend (c.£7.4m) relates to Shropshire CCG (2017/18).

The STP **prevalence of obesity (18+), 10.8% is higher than the England average** (9.8%) (2017/18). The **percentage of physically inactive adults in Telford (30.3%) is higher than the England average** 22.2% (16/17).

21.5% of the STP population reports a long term MSK problem, higher than the England average of 18.5% (2018).

Shropshire CCG has a **higher number of bed days for MSK compared to peers**, a difference of 3,517 bed days (2017/18).

Shropshire CCG has a **higher number of MSK long stay patients (21+ days) compared to peers**, a difference of 17 patients (17/18).

For Robert Jones and Agnes Hunt Hospital elderly medicine the **% of day cases to all elective activity in elderly medicine is 31%**, below peer median (56%); **median LoS for elective admissions is 2 days**, below peer median (3) (Aug 18).

The **median length of stay for emergency admissions (elderly medicine) was higher than the peer median** (6 days) for Robert Jones and Agnus Hunt NHS Trust (9 days) (Aug 2018).

The **percentage of total STP elective MSK services sent to the independent sector, 9.6% is below the national average** (21.7%). There is geographical variation with **Telford & Wrekin sending a higher percentage than the average (25.7%) and Shropshire a lower percentage than the average (2.3%)** (17/18).

3 *Prevention and Detection*

Lower rates of detection, higher non-elective spend on circulation and respiratory services

Circulation and respiratory are the third and fourth highest expenditure areas in the STP (c.£84m in total). c.£3.5m more is spent on circulation and c£3m more on respiratory compared to national average rate (2017/18).

Non-elective spend on circulation and respiratory is higher compared to peers, c.£2.5m and c.£3.4m respectively (17/18).

Compared to peers, there is a potential opportunity to detect more patients with hypertension (5,640), coronary heart disease (3,128) and chronic obstructive pulmonary disease (2,279) (2016/17).

There are **opportunities compared to peers to improve circulation quality and outcome indicators** including the % of hypertension patients with BP >150/90 (2,686) (2016/17).

There are **opportunities compared to peers to improve across respiratory quality and outcome indicators including the uptake of over 65s receiving the PPV vaccine** (2,605 patients) (2016/17).

Compared to all local authorities, **Telford (123/149) is in the bottom quartile for tobacco control** (smoking prevalence and smoking status at time of delivery) and **Shropshire (103/149) is ranked "worse than average"** (2016/17).
Shropshire Council is 145th and Telford & Wrekin Council 96th out of 149 LAs for drug treatment summary (2016/17).

The number of **bed days is higher compared to peers for respiratory (6,170 days) and circulation (1,900)**. The number of **long stay patients (21 day +) for Telford CCG is higher compared to peers for respiratory** (27) (17/18).

Respiratory mortality is higher for Shropshire CCG compared to peers, with a potential opportunity of 43 patients (2012-14).

Using system data to drive system change - Bronze Pack

- **Mental health** c.£59m, c.£15m less than the 17/18 national average (spend per head rate).
  - The dementia prevalence (Shropshire CCG) 1.09% is in the highest quartile (16/17).
  - The dementia diagnosis rate for Telford CCG, 65.9% is lower than the national average (67.8%) (Aug 2018)
- **MSK** c.£50m, c.£10m more than the national average.
  - Fracture, hip and thigh, 3rd highest admission from care home
  - The percentage of STP population reporting a long term MSK problem, 21.5% is higher than the England average (18.5%) (2018).
  - The STP prevalence of obesity (18+), 10.8% is higher than the England average (9.8%) (2017/18).
- **Circulation** c.£42m, c.£3.5m more than the national average.
  - £0.73m opportunity for respiratory primary care prescribing (2017/18).
  - Non-elective spend on circulation and respiratory is higher compared to peers, a difference of c.£2.5m and c.£3.4m respectively (17/18).
  - The number of bed days is higher compared to peers for respiratory (6,170 days) and circulation (1,900) (17/18).
- **Respiratory** c.£40m, c.£3m more than the national average.
- **Gastrointestinal** c.£35m, c.£1m less than the national average.

There is lower spend for social care needs (c.£6m) and maternity and reproductive health (c.£3m) compared to the national average rate.

Public health indicators key highlights:

- **Healthy Life Expectancy in T&W significantly lower than Shropshire and lower than the national average**
- **Smoking at tine of delivery higher than national average Shropshire and T&W**
- **Obesity – adults higher than national average for both Shropshire and T&W, Children – higher than national average at reception (Shropshire), yr 6 T&W**
- **Prevalence of diagnosed hypertension all ages Shropshire higher than national average, T&W similar**
- **Alcohol harm T&W higher than national average**

CCG/Area	No. of GPs (WTE)		GPs per 10,000 Pop (HC)		% GPs over 55		% GPs over 65	
	Sept 15	Sept 18	Sept 15	Sept 18	Sept 15	Sept 18	Sept 15	Sept 18
Shropshire	194	202	8.0	8.5	21%	20%	0.5%	1.5%
Telford & Wrekin	103	101	5.9	6.4	17%	18%	0.5%	2%
North Midlands DCO	2,583	2,372	7.0	7.5	17%	18%	3%	3%

Area	Indicator	England	Shrop CCG	T&W CCG
Elderly pop %	% aged 60-79	18%	24%	19%
	% aged 80+	4.9%	6%	4%
Growth rate of Elderly pop	Annual growth pop 60-79	1%	2%	2%
	Annual growth 80+	2%	3%	3%

Using system data to drive system change - Performance

	Shropshire CCG					T&W CCG				
	Sep-18	Oct-18	Nov-18	Dec-18	Jan-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-18
RTT 18 Weks	91.46%	92.20%	92.17%	91.4%		91.10%	92.30%	91.97%	91.96%	
Number of 52 Week Waits	2	0	2	4		1	0	1	2	
Diagnostic Test Waiting Times	99.3%	99.0%	99.4%	99.1%		99.7%	99.3%	99.4%	99.5%	
A&E 4Hr -LHE all types	75.47%	75.71%	72.99%	70.61%	72.85%	75.47%	75.71%	72.99%	70.61%	72.85%
Cancer 2 Week Waits	86.7%	82.15%	84.5%	88.7%		89.17%	81.55%	85.40%	91.05%	
Cancer 2 Week Waits Breast	79.8%	35.6%	55.6%	87.7%		86.36%	36.67%	59.60%	91.11%	
Cancer 31 Day Waits All Cancers	99.4%	99.5%	98.4%	96.5%		97.8%	100.0%	97.5%	98.5%	
Cancer 62 Day Waits Urgent GP Ref	81.1%	73.0%	82.7%	84.7%		86.7%	75.0%	80.0%	90.9%	
MRSA	0	1	0	0	0	0	1	1	0	0
CDIF	4	4	4	2	2	3	1	0	4	1
E coli bacteraemia	21	36	25	19	15	9	13	7	14	9
Dementia Diagnosis Rate	70.5%	70.2%	70.2%	69.5%	69.8%	65.7%	66.3%	66.6%	66.3%	65.6%
DToC - SaTH	1.32%	1.78%	1.37%	1.52%		1.32%	1.78%	1.37%	1.52%	
EIP	66.7%	50.0%	100%	100%		100%	66.6%	100%	n/a	
IAPT Access	1.1%	1.5%	1.4%	1.2%	1.4%	1.8%	2.0%	1.7%	1.4%	2.0%
IAPT Recovery	57.6%	52.6%	50.2%	59.6%	53.7%	59.8%	57.9%	59.7%	60.6%	61.0%

4.
System Ambition & Priorities

System Leadership statement – agreed April 2019
(to be further refined and built upon as part of LTP refresh)

"The ambition of Shropshire, Telford & Wrekin STP is to deliver joined-up, transformed health and care services for local people.
Our focus for the next 5 years will be to work with primary and community care, hospital services, social care, independent providers and the voluntary and community sector to deliver services at a place level; ensuring that local needs are understood and addressed with people being cared for and able to access services and support as close to where they live as possible"

To achieve this :
We will deliver our transformation in partnership across our organisations, working with our staff, engaging our population, and by setting good policy and outcomes frameworks.
Do all we can to listen to and understand the needs of our communities and staff.
Work together, utilising all our collective resources, to provide quality services and support.
Use data, evidence and insight to underpin decision making at every level

Shropshire, Telford & Wrekin, Priorities, Linked to the Long Term Plan

Programmes and Priorities:

Population health and wellbeing

- Working across health, care and the VCSE, to proactively support people to improve and maintain their health & wellbeing

Integrated Community Services

- Boosting 'out-of-hospital' care and dissolving the divide between commissioning and providing as well as primary and community health services
- Integrated working (physical, mental health and social care) working and primary care models; implementing multi-disciplinary neighbourhood care teams
- Ensuring all community services are safe, accessible and provide the most appropriate care.

Acute & Specialist Hospital Services

Redesigning and delivering urgent and emergency care, creating two vibrant 'centres of excellence'

- Delivering high quality, safe services
- Transforming and digitizing

Cancer	Outpatient care
Maternity and Paediatrics	MSK
Stroke/ Cardiology	ENT
Ophthalmology	Respiratory
Mental Health	Elective Care

Enabled by:

Strong **partnership working** across health, care, public, private and voluntary and community sector

Making the best use of **technology** to avoid people having to travel large distances where possible

Communicating with and involving local people in shaping their health and care services for the future

Supporting the **workforce** to be a highly responsive, happy, confident and capable workforce that provides excellent quality services, in the right place with the right skills, ensuring the workforce engages with local opportunities for the future

Improving and making more efficient our **back office** functions

Making better use of our **public estate**

Outcomes:

- Improved healthy life expectancy
- Improved system efficiencies
- Increased partnership working across all delivery & enablement programmes
- Living independently at home for longer

Measured by:

Quarterly Checkpoint review meetings

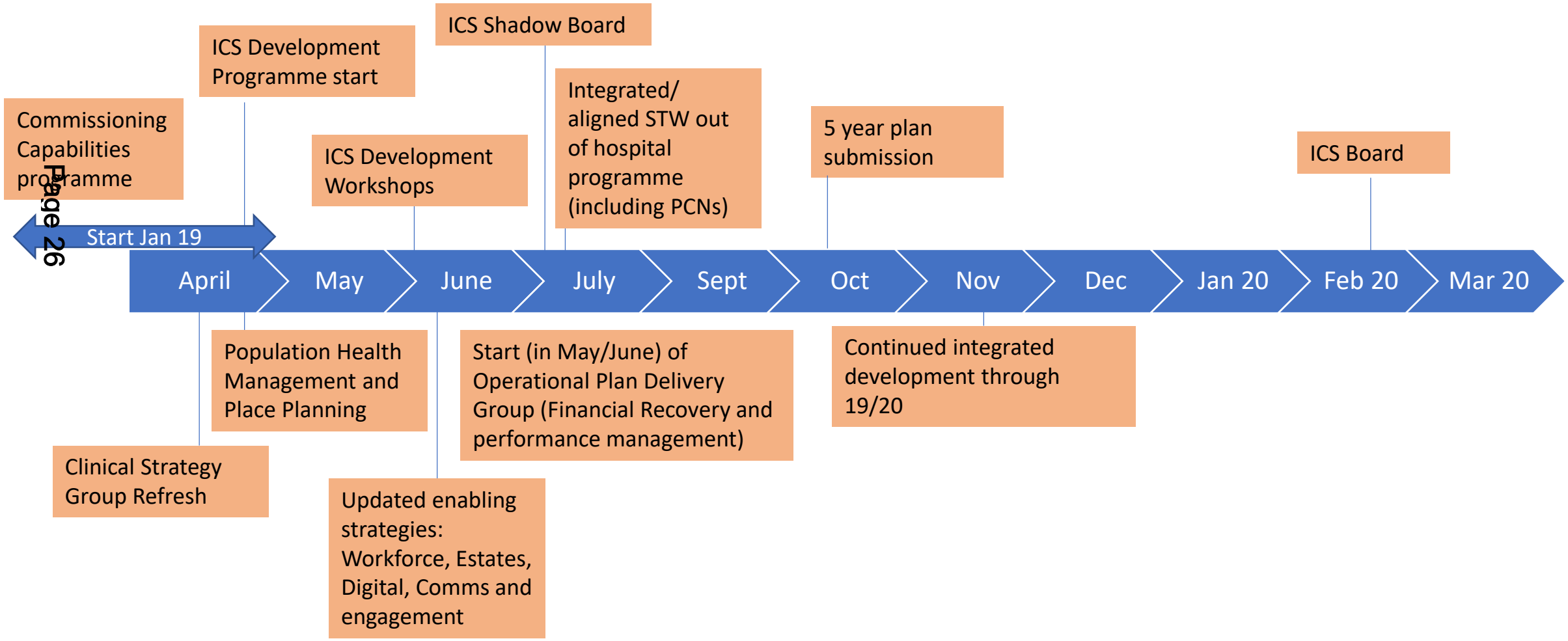
- Bronze pack/ right care
- Public Health Outcomes Framework
- Delivery Programmes
- Enablement Programmes

Governed by : *(proposed)*

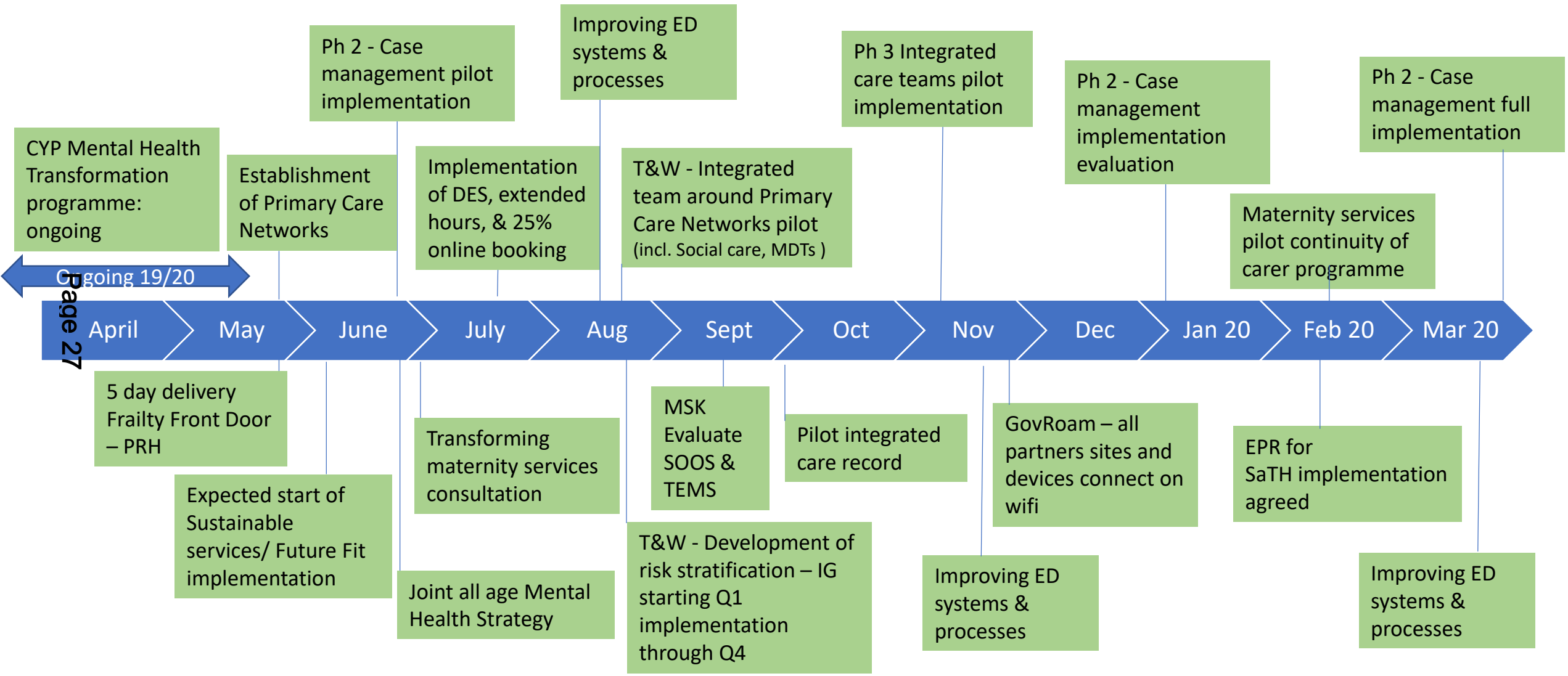
System ICS Shadow Partnership Board

- Shropshire CCG
- T&W CCG
- Shrewsbury & Telford Hospital
- Shropshire Community Health Trust
- Robert Jones and Agnes Hunt
- Midlands Partnership Foundation Trust
- Shropshire Council
- Telford and Wrekin Council

System development and governance 19/20; key highlights



System implementation timeline; key highlights



System approach to Quality

The system has a shared approach including:

- Individual Safety
- Individual & Patient Experience
- Effectiveness
- Well- Led
- Sustainability
- Equitable for all

Our Drivers for Quality include:

- Francis Report
- Berwick Report
- National Quality Board
- NHS Outcomes Framework
- Care Quality Commission Essential Standards
- NHS Assurance Framework
- CCG's Improvement & Assessment Framework
- NHS 10 Year Plan
- ASC outcomes framework
- Public Health Outcomes Framework

How we are working together as a system

Shropshire LA and T&W LA address quality across commissioned services through contract monitoring in conjunction with CQC and Healthwatch

- Shropshire CCG and T&W CCG quality teams working together to address quality across commissioned services to further increase effectiveness, integration and alignment is being planned
- Quality leads are aligned to each provider contract linked with performance, contracting and finance leads with 'buddying' arrangements in place across the two CCG quality teams
- The quality and safety of provided services is assured through quality schedules, commissioning for quality and innovation indicators (CQUIN), monitoring of the quality impact of cost improvement schemes and site visits of major providers.
- Quality exception reports are received and discussed monthly at Board.
- Quality dashboards are monitored with named quality leads aligned
- Quality leads are aligned to each QIPP and finance leads.
- Service development programme linked with performance, contracting and a programme of site visits is in place

As a system we are committed to working together to:

- Improve the issues facing quality, safety and patient experience management
- Operationalise the local quality and assurance framework across all providers
- Drive actions required to address concerns on the quality risk register
- Drive the Enhanced health in Care Homes framework
- Complete Equality, Quality Impact Assessments at the start of commissioning and decommissioning processes.
- Review Root Cause Analysis of Serious Incidents and Never Events to ensure learning is shared across all agencies to drive forward service improvements and patient safety
- Escalate quality concerns and reports to Board, QSG, NHSE and NHSI as required
- Develop a robust Quality Strategy with clearly identified priorities and that takes into account the full system, health and care
- Use all available resources including Right Care Opportunities to deliver improved quality by removing unwarranted variation and improving outcomes at a population health level

Aspiration - Creating outstanding quality by:

- Culture change within our organisations to work in an integrated way, reducing medical models of care when appropriate, and supporting people in their community, delivering the best possible care and support for our population (inclusive of Social Care, Dom Care and Private Providers)
- New dynamic that strengthens communities and individuals ability to self-care
- Patients are at the centre – to sustain and improve primary care, including strengthening integrated multi-disciplinary working ensuring people stay at home
- Streamlined care, robust pathways – to ensure we commission sufficient capacity for planned care and improve patient experience of appointments
- Support people in crisis with the right care at the right place – to make sure people can navigate a simplified urgent care system to meet both physical and mental health needs
- Aspiration that all providers to reach outstanding levels of care for our communities

System Quality Focus

Approach to improving quality at SaTH

Delivering against our Must Do actions from the CQC inspection – specific focus on ITU, ED, Maternity
Improving ambulance handover time in ED
Reducing Corridor Care in ED
Improving Ambulatory care to reduce unnecessary admissions
Improving frailty pathways
Improving discharge to reduce unnecessary Length of stay and reduce further patients that stay in hospital over 7 and 21 days
Maintaining Day Surgery capacity throughout the year in order to reduce waits for surgery
Improving workforce numbers through international recruitment for nursing and medical staff
Improving staff experience and well being through delivery of the OD plan

Seven steps to improve quality

These seven steps set out what all of us need to do together to maintain and improve the quality of care that people experience. We have strong foundations to build on – not least, the impressive improvements in care quality we have seen in many areas in recent years – but there is also much more for all of us to do if we are to close the care and quality gap.

1. **Setting clear direction and priorities** based on evidence.
2. **Bringing clarity to quality,** setting standards for what high-quality care looks like across all health and care settings.
3. **Measuring and publishing quality,** harnessing information to improve care quality through performance and quality reporting systems.
4. **Recognising and rewarding quality.**
5. **Maintaining and safeguarding quality.**
6. **Building capability,** by improving leadership, management, professional and institutional culture, skills and behaviours to assure quality and sustain improvement.
7. **Staying ahead,** by developing research, innovation and planning to provide progressive, high-quality care.

Note: Health Foundation A Clear Road Ahead (2016) developed this modified version of the NHS Quality Framework.

Workforce

- Key challenges:
  - Staff retention and recruitment
  - **Cultural challenges within existing organisations and staff groups resistant to change; preparing a workforce with no boundaries across organisations**
  - **Cultural change to support out of hospital working**
  - **Cultural change to embed prevention, self-care utilisation and health coaching**
  - Reducing dependency of bank and temporary staffing
- Key priority areas-
  - Recruitment and retention, education, training and staff development
  - Leadership, culture and organisational development
  - Workforce information, planning and intelligence

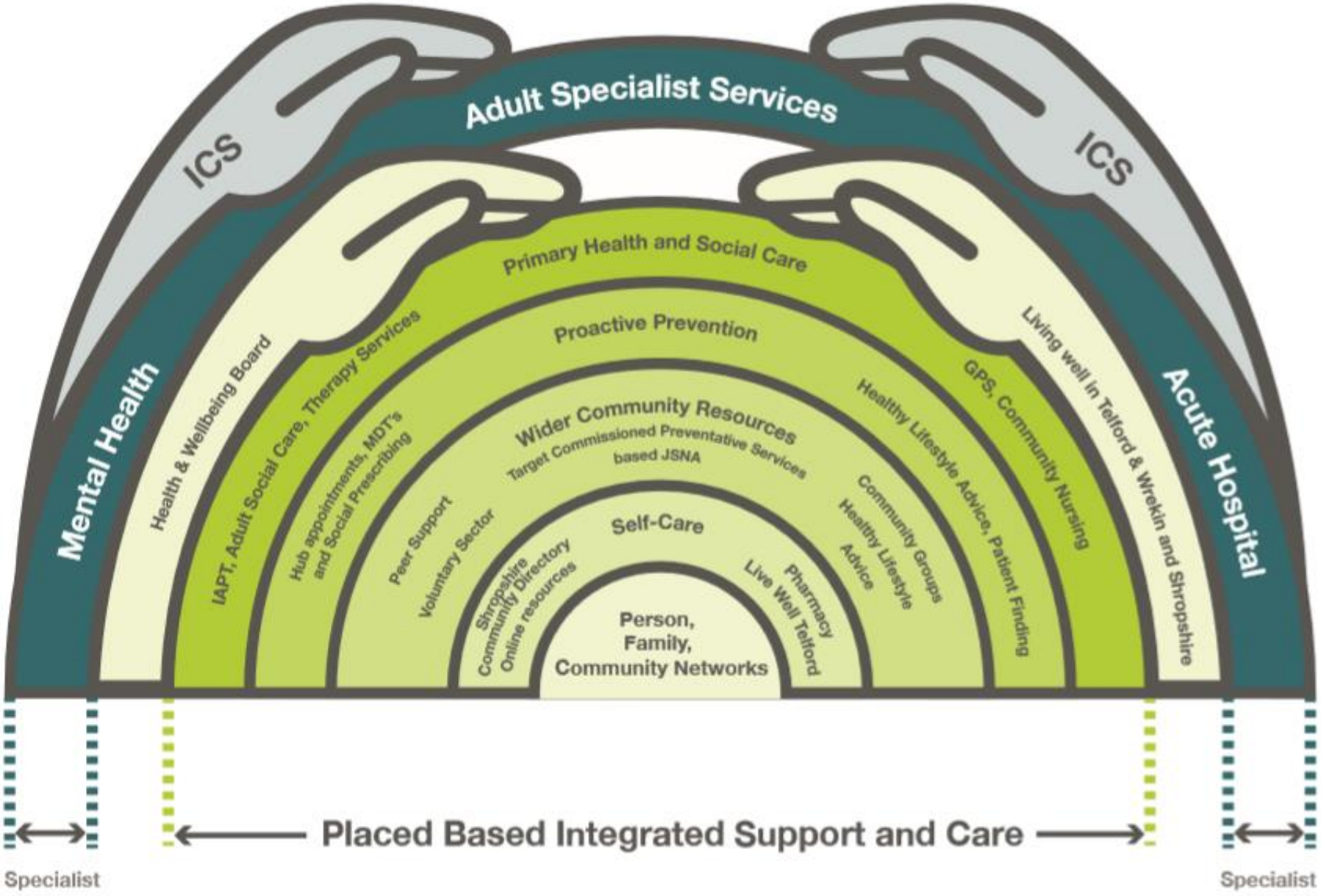
STW Process to improve quality

5.
Delivery Programmes

DRAFT - Vision of STW Integrated Support and Care Approach

As a STP we are developing a visual representation of how we are working in an place based integrated way; working in collaboration across organisations and with our communities.

This diagram is a draft of our joint vision that will be further developed for the 5 year plan.



Population health and prevention

Priorities:

1. Develop system architecture for population health, including a robust understanding of need through business intelligence and the JSNA
2. Working with the regional support offer to develop capacity and capability across Shropshire
3. Support improved working for prevention across all organisations; in particular
    - Embedding prevention through transformational work programmes, in particular Primary care and Community services
    - Develop our wider workforce in behaviour change and motivational interviewing
    - Proactively identify people at risk of ill health and behaviour change conversations, brief interventions
    - Prevent harm due to alcohol, obesity, CVD and poor mental health
    - Support culture change and new working practices that help people at the earliest opportunity
    - Support active signposting and develop a good understanding of how communities support people – linking to Social Prescribing
    - 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

Deliverables:

- Working with the regional support offer, deliver a prototype using the population health management approach to improving care
- Deliver system data repository, JSNA development and reporting processes
- Support for place based working with the local authorities (connected to primary care and community transformation);
- Deliver Stop smoking services for patients, expectant mothers, long term users of specialist mental health services and learning disabilities;
- Implement social prescribing, targeting CVD and weight loss services to people who need it most;
- Deliver greater uptake of the National Diabetes Prevention Programme;
- Ensuring children have the best start in life including access to mental health and early help support;
- Establish alcohol care teams in hospital and community

Primary care

Priorities:

1. Developing Primary Care Networks and New Models of Care (including the development of Care Closer to Home and Neighbourhood working)
2. Prevention and addressing Health Inequalities
3. Care Quality and Improvement
4. Improving Access to Primary Care – 7 days a week
5. Ensuring a workforce fit for the future
6. Improvements to technology and digital enablers
7. Ensuring high quality estate
8. Optimising workflow and addressing workload pressures in Primary Care
9. Ensuring quality and efficiency in prescribing

Deliverables:

- 100% coverage of Primary Care Networks by July 2019 including delivery of the extended hours Directed Enhanced Service
- Increase uptake of physical health checks and dementia diagnosis rates
- Meet the 7 core standard required in the extended access enhanced service including direct booking via 111
- Improvements to technology, digital enablers
- Deliver retention and recruitment programmes to secure a primary care workforce fit for the future including the enhancement of the primary care training hub
- Meet the required additional clinicians programme as outlined in the Long Term Plan .e.g social prescribing link workers and clinical pharmacists
- Deliver the requirements of use of technology e.g. 25% of appointments available online by July 2019, electronic repeat prescribing, implementation of the NHS App
- Completion of primary care estates review and full alignment with One Public Estate programme
- Delivery of the 10 high impact changes to support workflow optimisation
- Reduction in antimicrobial resistance and medication errors. Increase use of generic medicines and prescribe according to best practice

Out of hospital integrated care (including personalised health budgets and social prescribing)

Priorities:

- Developing a joint out of hospital integrated services that support the diverse population we serve; working collaboratively with Community Services, Acute Care, Primary Care, Social Care, Preventative services, and the VCS; this includes:
    - Integrated Place Programme (T&W)
    - Care Closer to Home (Shrops)
        - Phase 1 – Frailty at the Front Door (hospital service approach), Shropshire in progress, T&W in planning , delivery estimated June 2019
        - Phase 2 – Case management through demonstrator sites - Shropshire , June 2019
        - Phase 3 – Community services including admissions avoidance and delayed transfers, Autumn 2019
- Using data to drive the development of services (including case management and prevention services)
- Delivering admission avoidance , in reach and facilitated early discharge
- Developing joint personal health budgets governance and delivery with the Local Authorities
- Develop joint processes and commissioning for CHC (health and care)
- Connect social prescribing with out of hospital and primary care transformation programmes (Care Closer to Home and Neighbourhoods), and the Better Care Fund prevention strands and voluntary sector grants and contracts

Deliverables:

- Supporting the development of resilient communities, prevention and early help in conjunction with all partners
- Upscaling 'Frailty at the Front Door' to implement in PRH (already delivering in PRH)
- In collaboration with system partners, development and delivery integrated care models, including:
    1. Risk Stratification and case management
    2. Rapid Response
    3. Intermediate care/ hospital at home
    4. Care home support (including Care Home Advanced, Trusted Assessors, Care Home MDT)
    5. Social Prescribing and prevention services
- Implement an aligned programme across T&W and Shropshire
- Implement a robust system and governance for personal health budgets
- Implement new practices for jointly delivering CHC with local authority partners
- Progression of models of Social Prescribing by joining with out of hospital with additional funding, in connection with primary care and the local authorities
- Connect with data and infrastructure developments as part of Population Health Management programme

MSK Transformation Programme

Priorities:

- Ensure the model, priorities and resources relating to the vision and objectives for the MSK transformation programme
- Ensure there is strong patient and public engagement in the MSK Transformation programme
- Ensuring that an over-arching Communications and Engagement Strategy is in place and that key messages are circulated to partner organisations following each meeting.
- Ensure changes to the MSK services in Shropshire are based on clinical evidence and best practice (national and international)
- Monitor the impact of the transformation programme including unintended consequences/dis-benefits, and agree on an appropriate strategic response
- Ensure effective coordination of the planning and commissioning of services and operational delivery with a robust supporting infrastructure
- Engage with GP Clinical Directors, Academic Health Science Networks, inviting their representatives to attend Board meetings, as appropriate.
- Engage with clinical/operational teams to ensure all staff are aware of the strategy and their input required
- Review MSK services within community and secondary care;
- Transforming operational processes and developing a single service model for the whole MSK pathway, using the results of the review and the First Contact Practitioner pilot evaluation;
- Delivering referral targets;
- Delivering quality and financially sustainable services.

Deliverables:

- Establish STP MSK Programme Board
- Assess current delivery of services including TEMS (evaluation of SOOS completed with a provider review planned in the next 6 months)
- Assess resources for delivery – alignment of existing CCG and provider resource following the receipt of an agreed gap analysis
- Review current delivery board membership to ensure that the appropriate level of decision making can take place
- Scope of services to be determined within the agreed resource envelope
- Impact analysis throughout of implementation/changes
- Demand and capacity assessment of existing providers
- Development of a strategy to possibly consider the option to move to one integrated MSK provider
- Consider and support where necessary the reconfiguration and transformation programme to ensure the sustainability of services
- Review GIRFT outputs, Right Care and data sources to support changes/redesign
- Development of an agreed delivery outcome frameworks
- Completed MSK review;
- New single service model for MSK that integrates with community and secondary care;
- Continue to monitor progress and quality

Local Maternity System

Priorities:

- Improve Safety
  - Stillbirths and neonatal reduction
  - Reduction in brain injury
- Improve Choice and personalisation
  - enabling all women to have a personalised care plan and choice in the care they receive
- Increase midwife led births
  - increase the number of women giving births in a Midwife led unit
- Increasing investment in perinatal mental health
- Develop continuity of carer

Deliverables:

- Develop and progress the Midwife Led Unit Review
- Develop and implement pilot for continuity of carer programme
- Fully implement improvements in safety including Saving babies lives care bundle
- Deliver improvements in choice about maternity care, including by developing personalised care plans
- Implementing the neonatal quality improvement programme
- Develop workforce plan to improve core staffing with clear governance and reporting
- Developing a culture of learning and improvement

LMS Progress against KLOE 19 March 2019

Number of births				Key Lines of Enquiry																							
				Stillbirths and neonatal deaths					Intrapartum brain injuries					Key Lines of Enquiry								Key Lines of Enquiry							
														Number of personalised care plans				Number of women able to choose from three places of birth				Number of women receiving continuity of carer during pregnancy, birth and postnatally				Number of women giving birth in midwifery settings			
2015 baseline	2018/19	2019/20	2020/21	2015 baseline (and data source)	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021	Change in rate 2015 - 2020	Local baseline	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021	Change in rate 2015 - 2020	Local baseline	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021	Local baseline	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021	Local baseline	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021	Local baseline	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021
4887	4851	4827	4824	30	23	22	20		11	9	8	7		0	0	4827	4824	4887	4851	4827	4824	0	970	1,496	2,460	708	825	965	1,206
				6.15/1000	4.8/1000	4.5/1000 (	4.2/1000		2.2/1000	1.8/1000	1.7/1000	1.5/1000		0%	0%	100%	100%	100%	100%	100%	100%	0%	20%	31%	51%	14%	17%	20%	25%

A&E performance and trajectory- 19/20 – Top Three Priorities:

1. Workforce

Options being enacted to mitigate the challenges

- Frailty at the front door at PRH
- Protect Streaming workforce
- Plans in notes and clinical criteria for discharge
- Achieve Pre-12 discharge potential on all wards
- Achieve further reductions in length of stay by:
  - Discharging patients requiring IV therapy to community slots
  - Achieving the potential in PRH stranded patient reduction
- CDU capacity created in Head and Neck theatres at RSH from the 8th of April to release bed capacity in acute medicine.
- Space Utilisation prioritisation
- Workforce models to support the current workforce challenges

2. Acute Care /Frailty Model

Options being enacted to mitigate the challenges-

- Achieve Acute Medicine and Ambulatory care potential (project group facilitated by ECIST commenced 14th March). This will require additional acute medical workforce.
- Recruitment of doctors from India and nurses from Southern Ireland
- Approval of workforce business cases for ED staffing and Acute Medicine staffing.
- Transfer of stroke neuro-rehabilitation to the community and further development of early supported discharge(Whole system approach)
- Development of cardiology SDEC /heart failure/respiratory acute (from 6 A's audit).
- Development of cardiology direct access service (from 6 A's audit).
- Development of ambulatory and 72 hour frailty service across both sites (requires workforce).
- Development of a 24 hour CDU model (requires workforce)

3. ED systems and processes

Urgent & Emergency Care

The ambition for Urgent & Emergency Care is to:
Provide enhanced system-wide urgent and emergency care that ensures our patients are cared for in the most appropriate setting by skilled workforce able to meet their needs, develop services that are based on best practice, demand and capacity analysis and the needs of our local population with an overarching ambition to support all patients Home First.

Prioritise:	Improve care:	Improve Experience:
1. ED Systems and Processes	We aim to implement standardised best practice, enhance our workforce and appropriate capacity to improve emergency care provision resulting in improved patient outcomes and satisfaction, appropriate staffing, capacity and improved recruitment and retention of skilled staff to meet the needs of our patients.	• Improved system working • Improved access to clinically appropriate services • Reduced ambulance handover time • Reduce ambulance conveyance • Reduced attendances and inappropriate admissions • Increased number of patients being treated in SDEC • Improved identification and management of frail older adults • Increased home first • Improved patient outcomes • Reduced mortality and morbidity • Improved patient and carer satisfaction • Improved team working and staff morale • Meet the A&E 4 hour quality standard to avoid waiting.
2. Frailty	We aim to have a fully functioning Frailty Front Door Service for 5 days a week at both sites by May 2019. We aim to extend this service to run 7 days a week by October 2019. We will work with the STP Out of Hospital Group to co-design a whole system frailty pathway and service model.	
3. Ambulance	We aim to ensure that we maximise the opportunity to avoid conveyance to ED so that patients arriving by ambulance to ED are appropriate, and enjoy a seamless handover to ED without delay.	
4. Acute Medical, Short-stay and Same Day Emergency Care (SDEC)	We aim to develop and implement an enhanced Acute Medical, Short-Stay and Same Day Emergency Care (SDEC) model based on national best practice and needs of the local population.	
5. Care closer to home	We aim to enhance and embed 'Home First' services to enable all our clinically appropriate patients to be offered a home first solution that meets their needs.	
6. Discharge management	We aim to ensure that patients stay in hospital for the minimum time required to manage their presenting problem while avoiding the secondary harms arising from hospitalisation and ensuring as soon as they are safe to transfer they have the opportunity to be discharged to their usual place of residence and / or access to step-down services for re-ablement which maximises independence is required.	

Urgent & Emergency Care

Priorities: *continued from last year's high impact changes

- ED Systems and processes *
- Frailty at the front door *
- Ambulance Demand *
- Same Day Emergency Care/Acute Assessment/Short Stay
- Home First (Care closer to Home)
- Discharge Management

Enabling programmes:

- Demand and Capacity
- Improvement in Informatics

Deliverables:

- Successful recruitment to the workforce
- Improved patient outcomes
- Reduced mortality
- Reduced attendances and inappropriate admissions
- Improved staff morale
- Improved patient / carer satisfaction
- Improving access to Same Day Emergency Care (SDEC)
- Improvement and development of frailty at the front door programme
- Sustained improvement in the reduction in long stays
- Improving the data available and use effectively to inform clinical decision making and future priority planning
- Improve discharge planning from moment of admission to prevent deconditioning and ensure a timely, **home first** approach for as many patients as possible
- Improve ED systems and processes to ensure efficient and effective care for patients
- Identify and manage constraints identified throughout the patient journey to ensure timely and effective care
- Effectively match capacity and demand through the use of data and intelligence
- Better use data to avoid conveyance and ensure patients are treated in the right place in the first instance.
- Decreased deconditioning . Complications of hospitalisation will reduce
- Meet the 4 hour A&E Quality standard.

Cancer & Referral to Treatment

Cancer Priorities:

Ambition – fewer people to be diagnosed with preventable cancers; improve mortality rates and improve patient experience

Priorities:

- Deliver the Living with and Beyond Cancer;
- Deliver cancer services that are accessible, timely and sustainable;
- Workforce and capacity – testing new ways of system working that will deliver more timely care;
- Improve against performance targets;
- Explore opportunities for improving urological cancer through joint working across the system
- In conjunction with the Cancer Alliance implement best practice pathways in priority areas

Deliverables:

- Implement a holistic needs assessment and care plan
- Develop treatment summaries to guide patients and GPs post treatment
- Develop and deliver the living well offer – providing advice, support and signposting
- Deliver the cancer care review – between the GP (or nurse) and patient
- Deliver person centred follow – up tailored to the patients
- Develop joint working processes for urological cancer
- Develop a system wide cancer strategy
- Implement best practice pathways for Lung, Prostate, Colorectal and Upper GI

RTT Priorities:

- Streamlined care;
  - Outpatient activity
  - Cancer treatment
  - Musculoskeletal (MSK) services
  - Neurology
  - Local Maternity Services
- Robust pathways;
  - Achieving targets
    - 18 week referral targets – consultant lead treatment
    - 6 week diagnostic test target
    - 52 week treatment target
- Commission sufficient capacity;
- Improve patient experience of appointments and treatments;
  - Outpatient redesign

Deliverables:

- Monitor the acute trusts waiting list to ensure at the end of March 2020 does not exceed the waiting list at the end of March 2018
- Work with providers to develop a process for identifying patients exceeding 6 months on the waiting list and offering them an opportunity to move to an alternative provider
- Develop a process for identifying patients approaching 40 weeks on the waiting list to ensure no patient exceeds 52 weeks

Outpatient Redesign

- The CCGs plan to undertake a programme of work in relation to outpatients redesign. A task and finish group has been established with SaTH & RJAH to look at what changes can be made. The CCGs intend to use this task and finish group to undertake the following actions:
- Identify area where non face to face appointments can be implemented
- Explore areas where patient led follow ups can be implemented
- Develop process for identifying unnecessary frequent attenders (such as mental health) and implement mitigating actions for these patients
- Align diagnostics with appointments
- Use national outpatient improvement dashboard to improve clinic utilisation
- Use the learning from the IBD app project to roll out to other areas
- Identify technology opportunities in relation to outpatient appointments

Mental Health (Children and Adults) and Learning Disabilities & Autism

Priorities:
One of the key cultural challenges for mental health services is determining what mental health conditions should be treated in secondary services and what are treated within the community and primary care. Mental health services have been successful in moving from hospital/campus models of care to helping people recover in their own homes. We want to continue this through a choice of least restrictive environments and safe environments for short term interventions which the majority of people require. Equally, for those people who experience learning disabilities or autism, these long term conditions require access to both specialist and mainstream services where reasonable adjustments have been made to enable equality of access.
Our priorities are:

1. Ensuring a great start for children and young people and appropriate services for children and young people (CYP) when needed
2. Delivering person centred care, that takes into account mental and physical health
3. Creating open door access; understanding where people can get help, support, services they need (including prevention, primary care, community, online, vcs)
4. Ensuring Mental Health is integrated into neighbourhood models of care
5. Ensuring that carers are supported as an integral part of system planning, delivery and support
6. Ensuring a joined up, confident and appropriate workforce for the STP patch including prevention, support and evidence based care for people in the communities where they live.
7. Ensuring that people with learning disabilities and autism have access to the support and services they need
8. Creating time for front line practitioners to care

Deliverables:

- Improved mental health of children and young people through the delivery of the CYP transformation plan including:
  - Delivery of the CYP Transformation Plan
  - Improved Development of local SEND partnership arrangements
  - Review and joint work on complex care needs for children and adults
- Improved access to services and community support for people with emotional and mental health issues by:
  - Developing and implementing a system all age Mental Health Strategy and embedding mental health pathways into neighbourhood models of care
  - Strengthening out of hours crisis response and reduce admission where possible
  - Increasing investment and developing an integrated model of delivery to support STP priorities (e.g. physical health, IAPT), in communities
  - Realigning the existing workforce to support the development of preventative models, and transformed secondary care (including social care)
  - Strengthening relationships and integration with community services including primary care, local authority, charities, the third and voluntary sectors
  - Expansion of IAPT services in partnership with primary care and physical health services
  - Increased access rates to IPS, IAP, EIP
  - Trauma informed pathways for adults and CYP
- Reduced number of suicides and attempted suicides by implementing the suicide prevention strategy and action plan
- Improved outcomes for people with dementia by developing and implementing a Dementia Strategy including the delivery of newly developed dementia services.

End of Life

Priorities:

- Reducing the number of people dying in acute hospital
- Supporting Care Homes (competencies, skills, confidence)
- Supporting out of hospital programmes to include end of life pathways, training and support

Partnership working with all partners including hospices and the wider the voluntary and community sector

Deliverables:

Recommended Summary Plan for Emergency Care and Treatment (Respect)

- Implementation of the national ReSPECT model of care led by the STP End of Life Programme through partnership working
- Workforce support through the development and implementation of an education programme to deliver ReSPECT training and resources for the system utilising a train the trainer model including all system partners
- This will ensure a standardised and consistent process of transition and adoption of ReSPECT
- EOLC and Swan Scheme education programmes developed and delivered across system partners supported by the End of Life Care Handbook
- EOLC Volunteers trained at SaTH and Shropshire Community Health NHS Trust (looking to scale across the social care workforce)
- System-wide access to Sage and Thyme training including communication tools and techniques for all partners acute, community, hospices, council and domiciliary care.

Contribution of carers

The contribution 'carers' of all ages make to society cannot be underestimated. Locally, we acknowledge and value what carers provide day to day and the impact this has on their own lives. We believe that supporting carers is everyone's responsibility and important in the considerations of all our strategic planning and service delivery.

We must ensure:

- Carers are recognised through all of services
- Supported to maintain their caring role and to maintain their wellbeing
- Are able to contribute to service planning and individual care as appropriate

Voluntary and Community Sector

Working with the voluntary and community sector

In Shropshire and T&W voluntary, community and enterprise sector (VCSE) exists in abundance. The people of Shropshire recognise the role, importance and power of communities and the organisations that support our local areas to thrive. The role of services is to ensure that the VCSE is supported so that it can continue to thrive. When we work together, we can achieve great things. As a partnership we will continue to work with the VCSE, communities and people to support:

- **The development and delivery of services**
- **Commissioning**
- **Delivery of services in communities**
- **Understanding of population need**
- **Wider determinants of health**

6.
System Enablement

System strategic approach to Workforce

The system workforce objectives are:

- To ensure the planning, recruitment and development of an engaged, talented and compassionate workforce for the future system

- To develop a sustainable future workforce who are equipped to meet the needs of our communities

Our **STP People Strategy** sets out how local organisations delivering health and social care services plan to work better together to ensure the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place to deliver quality and sustainable services to members of the public.

- The Strategy identifies four key areas for collective working; 1) Attract, Recruit and Retain; Agile Workforce, 2) Workforce Planning and Modelling, 3) Learning through Education, Development and Training Opportunities and 4) Organisational Development and Leadership including Equality and Diversity. The Strategy is underpinned by principles of system-wide, cooperation and collaboration, improvement and innovation, integration and redesign.

- As a result of achieving the ambition outlined in our People Strategy, we hope to succeed in:
    - Realising the vision of the People Strategy and new models of care
    - Improving outcomes for service users, families and staff
    - Building a better understanding of system workforce
    - Optimising our system workforce
    - Supporting and enabling service improvement and redesign, especially across boundaries

- Since the publication of the NHS Long Term Plan work continues to ensure the People Strategy reflects the ambitions and intentions outlined in the plan e.g. digital workforce and the volunteer workforce are new areas of focus that will be included within the next iteration of the People Strategy which remains a live document.

Primary Care

- Significant improvement in the quality of workforce data and ability to set targets and trajectories, & appointment of Primary Care workforce leads
- Success in funding proposals for running retention programmes for GPs
- Success in attracting funding for new Clinical Pharmacists
- Introduction of the Physician Associate internship with four PAs to be placed in local practices
- Significant increase in engagement with GP trainees with plans for fellowships and post-qualification support
- Improved engagement with GP Nurses via established GP Nurse Educators/Facilitators and delivery of GP Nurse 10-point action plan
- Upskilling of primary care workforce in independent prescribing, spirometry, management of long-term conditions, physical assessment and mentorship

- **Mental Health**
- Realignment of the mental health workforce to support person-centred approach to neighbourhood working
- Training delivered across services around effective care planning/ care co-ordination
- Development of system-wide mental health workforce plan which led to the establishment of an STP Mental Health Delivery Group
- HEE investment to support delivery of the mental health workforce development plan by upskilling the workforce to achieve Five Year Forward View for mental health
- Health awareness and first aid training made available across the system including health, social care, domiciliary care, fire service, police, ambulance
- Targeted recruitment for Shropshire area, focussing on selling Shropshire as a lifestyle and good place to work
- Focus on developing a new pathway for 0-25 (CYP) mental health including a workforce model

Our Local Workforce Challenges:

Fragility of workforce for acute provider across medical, nursing and therapies
Recruitment challenges and high vacancy rates, related to factors such as national workforce shortages, varying terms and conditions, geographical rurality, levels of morale
Cultural challenges within organisations, with some staff groups or individuals resistant to change
Morale and retention of staff as a result of major change or retendering within the system
An ageing workforce and a reduced community of suitable people to seek to attract
An uncertain future supply of staff, with difficulty attracting students to some courses, placements and recruitment to jobs upon qualifying
Different expectations of the younger workforce, e.g. increased part-time and flexible working
The image of health and social care in the general population

System People Strategy

Shropshire, Telford & Wrekin LWAB People Strategy

STP Workforce Leaders and Groups

Attract, recruit, retain

Retention Strategy
Collaborative **Recruitment**
'Team STW'; Employment Offer and Branding
Health and Wellbeing of our people
Agile Workforce; integrated, rotational and new roles
Collaborative Bank
System-wide **People Development Plan**
Widening Participation

Planning & Modelling

System-wide **workforce profile** (baseline)
Service/pathway specific **workforce plans**
Longer term collective planning and **forecasting**
Supply improvement
Workforce **modelling** tools
Benchmarking

Education

Redesign roles and skills
EDT needs for system
Current **EDT offer**; gaps & duplication
Develop **'core' system EDT offer**
System-wide approach to **induction**
Standardise statutory and mandatory training (**skills passport**)
System-wide approach to **Preceptorship**

OD & Leadership

Leadership; shared leadership development approach
STW STP **leadership offer**
Managing **talented people**
Service / Quality **Improvement Methodology**
Culture and values
Equality and diversity

Our Values

system-wide engagement, involvement and leadership; working in co-operation with all our stakeholders; stimulating continuous improvement and innovation for high quality person-centred delivery; driving forwards prevention and the integration of health and social care to create a more holistic approach for our people and communities; and supporting the redesign of roles and skills

OUTCOMES

- Realise the vision
- Improved outcomes for service users, families and staff
- Better understanding of system workforce
- Ability to optimise system workforce
- Support and enable service improvement and redesign, especially across boundaries

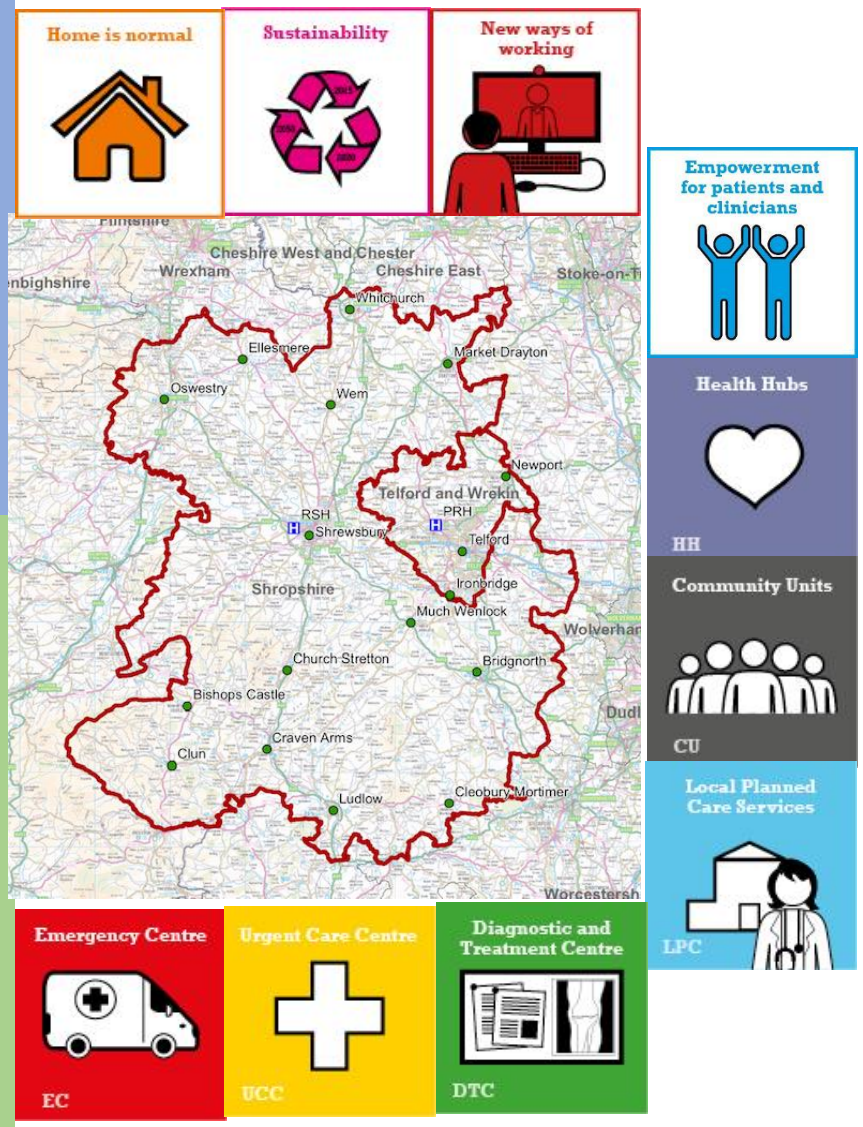
System Strategic Estates

Priorities:

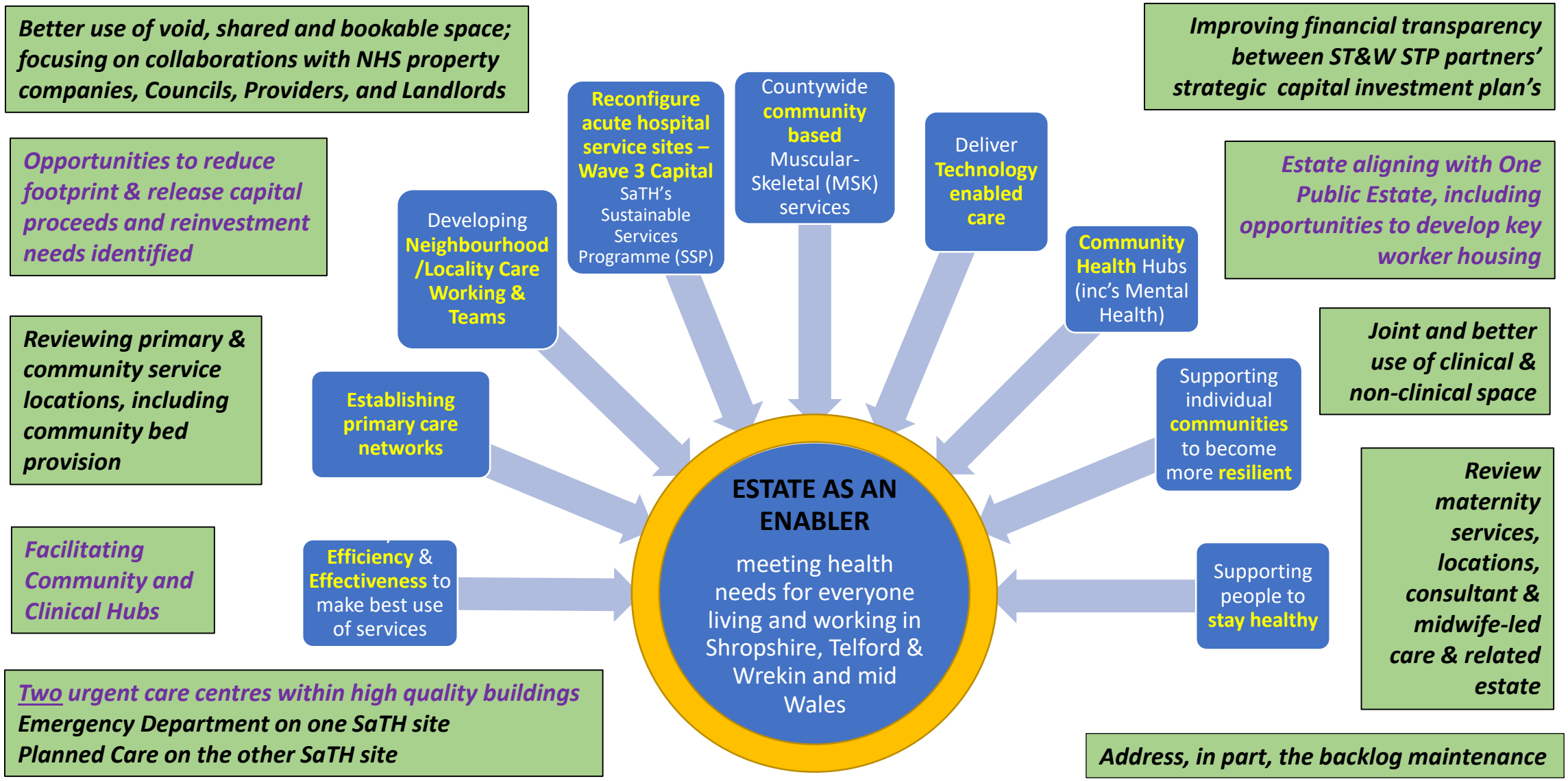
- Put people rather than buildings first, with population need at the heart of our estate focus
- Develop **'Place'** based integrated & co-ordinated healthcare estate, relevant to redesigned person, patient, service user and staff delivery pathways, embedded with decisions based on a wider system view; supported by hub solutions, backed up with One Public Estate philosophy, rather than organisational self-interest
- Ensure best system use of estate assets which are relevant, accessible, efficient, safe, fit for use & purpose
- Collaborate with system partners; examine & challenge organisational estate strategies and plans to identify all of the potential opportunities for improvement and rationalisation
- Support system delivery programmes leads in articulating & translating their system need into estate requirements
- Ensure capital plans & asset management align with clinical strategies
- Future proofing of GP services through closer working with Council planning teams to negate future planning problems down the line
- Establish a virtual STP estates team, based on supporting STP, rather than individual organisations

Deliverables:

- Submit Estates Strategy Checkpoint template by June 2019
- Resubmit the STP Estate Strategy Autumn 2019 for further assessment – must be rated as 'Good' in order to receive future STP estate capital
- Progress project pipelines with 'Place' health and social care hub concept as the driver, including the acute reconfiguration aspects associated with 'Future Fit' Wave 3 capital funding, co-ordinated by Sustainable Services Programme, Paul's Moss Whitchurch health and social care hub development, and primary care at scale projects
- Produce the refresh of the Estates Chapter for the STP Long Term Plan
- Improve system-wide potential disposal information, through creation of a system-wide occupancy planner, sharing of disposals, with a disposal plan and timetable to include an understanding of associated capital investment to release assets and lead to efficiency savings
- Support efficiency programmes, estate rationalisation strategies and utilisation plans to maximise the opportunity to create a system-wide capital plan
- Support the drive to make more efficient use of space and deliver the Carter metrics, with better use of void, shared and bookable space
- Create a matrix of existing leases, marking the break clause etc. to enable system planning to take place and better manage occupancy



STW STP Estates Implications



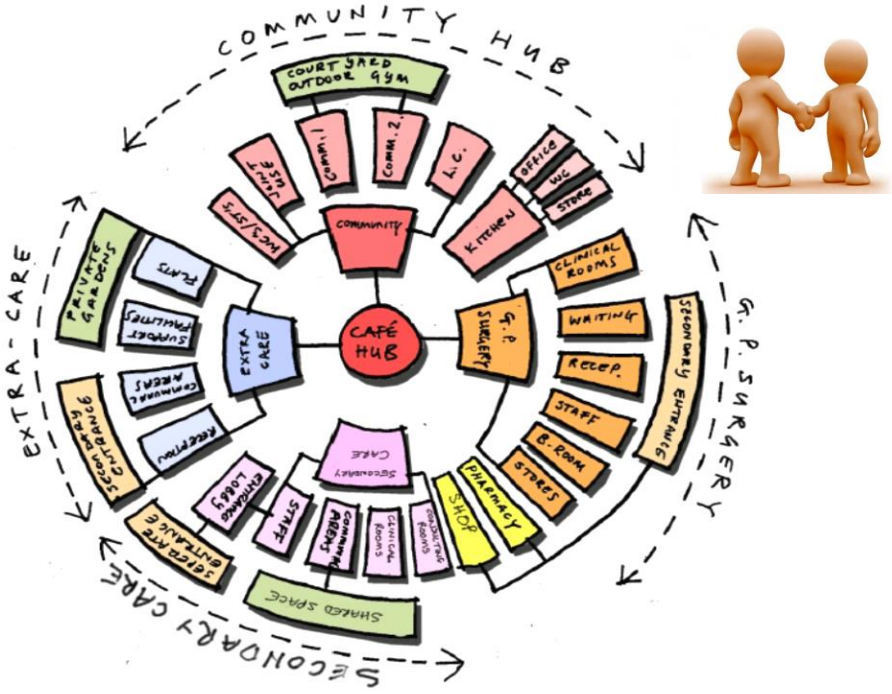
'People' and 'Place' not 'Building' focused

Estates focusing on long-term service transformation and efficiencies

- Fit for purpose, community hubs, based on community need
- Programme of opportunities, across patch, which will transform service delivery, deliver efficiencies and enable inward investment
- The proposed approach is one of prevention and wellness, building up communities, developing resilience and reducing the future cost of care with a clear focus on housing. Reduction in packages of care costs, less stress on future finances
- Increased self sufficiency through community support and independent living – housing type is hugely important
- Long term, generational change will reduce reliance on public services

How this can be delivered

- Through creating independent living opportunities and appropriate housing to give people the lives they want
- Enabling people and organisations to integrate, work together, share problems and solutions, all in one place – collaborative working across estates function, look at shared procurement
- Allowing generational change to occur whereby people look to their own community for support, not to the public services
- Bespoke financial model for each opportunity
- Funding opportunities through grants
- Recycle any capital receipts through identified surplus buildings



Principles of our community centric approach

- To put people at the heart of decisions
- Understand the needs of the people in each area
- Empowering the community to support its self
- Enabling a change in community culture
- Supporting people through social action
- Building capacity within the voluntary sector offer space to deliver
- Targeting the specific needs of individual communities
- Providing new models of ‘wrap around care’
- Developing the ‘Community Hub’
- Up-scaling and enhancing the primary care offer
- Providing joined-up public services delivered at a local level
- Incorporating specialist housing
- Developing housing models for step down care

System Digital Enablement

Priorities:

1. Developing and delivering an Integrated care record (MCR)

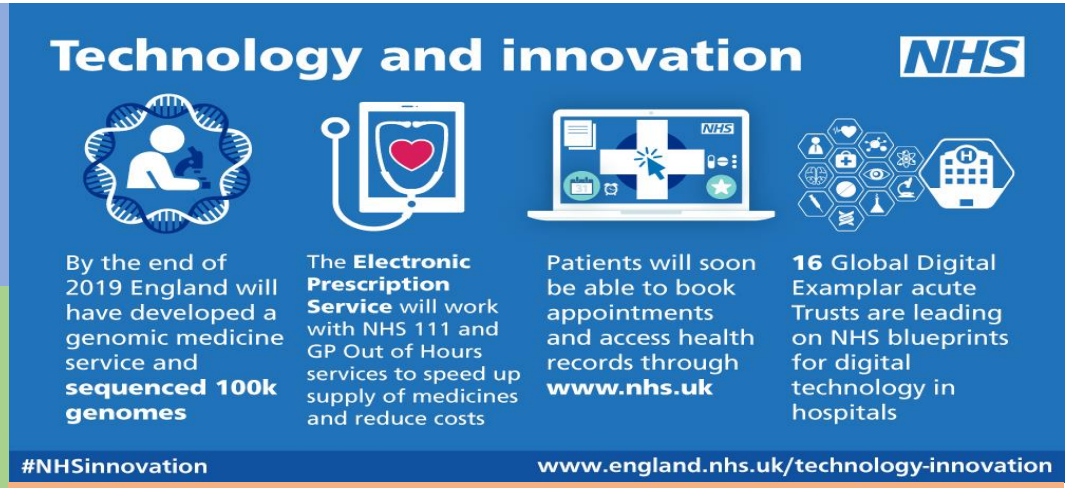
2. One approach to Information Governance and data sharing for our system

3.Business Intelligence and data sharing with a focus on one system-wide view and support for population health management and prevention

4. System wide approach to infrastructure & security.

Deliverables:

- Digital sufficiently embedded as enabler in all transformation programmes
- System data is available from all partners and informs integrated working and population health management
- Improved IG and data sharing
- Local Digital Roadmap for 2019; focussing on:
- People empowerment ("All people")
- Processes – workflow and efficiency
- Pace
- Digital shared care record available for appropriate use.
- Initial plan to include organisations already having Electronic Patient systems, to obtain early benefits. Other orgs to phase in later.
- A standard of infrastructure across all partner sites and devices to enable digital transformation.
- Early stages focussing in improving system access for mobile staff.
- Mobile enabled workforce.
- Progression towards Electronic Patient Record in Acute.
- Electronic patient management system in UEC to replace use of paper.
- Remove use of faxes across the STP area.



Next Steps:

- Deliver refreshed Local Digital Roadmap for 2019.
- Engage with out of hospital programmes to support and enable transformation.
- Continue to engage with Maternity Services to support and enable transformation.
- Create local digital infrastructure.
- Define plan to deliver shared care record.
- Investigate options for shared care records, including discussions with STP neighbours
- Communicate and disseminate information about system digital capabilities.
- Liaise with Academic Health Science Network (AHSN) to connect with proven digital transformation.

First GovRoam sites and devices go live (April) → LDR agreed (May 2019) → Pilot Integrated care record specified and out for funding (Sept 2019) → GovRoam – all partners sites and devices connect on wifi (Nov 2019) → EPR for SaTH implementation agreed (Feb 2020)

System Communication & Engagement

Priorities:

- Establish an initial infrastructure and operating arrangements to ensure that opportunity to build confidence and engagement are not missed
  - A refreshed visual identity, new website, twitter account and a regular Stakeholder Bulletin
  - Further developing our single, shared narrative and clear briefing to help inform stakeholders' understanding of the work underway
  - The new appointment of a C&E SRO for the C&E Workstream to represent the health and care system, allowing co-ordination and dissemination of communications messages and joint working on issues and challenges
  - Ensure continuous stakeholder engagement including seldom heard groups
  - Presence at events, speaking opportunities and networking events where appropriate
- To further develop the communications and engagement approach using the C&E Workstream
  - Manage communication and engagement capacity and support for STP programmes
  - Facilitate discussion between communication and engagement colleagues and effectively manage change
  - Ensure key messages are focused at a public and staff level and answer the question that audiences are asking
  - Produce communication materials to allow managers/stakeholders to communicate the key STP priorities and themes to include toolkits, website copy, social media tools, leaflets, videos and other specific materials as required for internal and external communications
  - Ensure a consistent approach, understanding and messaging across the system internally and externally
  - Share resources, best practice and share thinking to deliver effective campaigns for change
  - Cascade clear decisions and leadership messages to staff and partners
- Engage in the development and delivery of our refreshed system wide plan following the publication of the Long Term Plan
  - Utilising existing engagement channels/relationships such as Healthwatch, to continue to engage and use insights to inform decision making – undertake the work, share the findings, and act on it
  - Ensure wider stakeholder engagement and involvement in every delivery and enablement programme
  - Build awareness of the partnership working amongst the local voluntary and community sector organisation so that they can be closely involved in shaping strategy
  - Inform and involve all stakeholders in the development of the ICS and our emerging vision for health and care partnership in Shropshire, Telford & Wrekin so that the plan is best for our patients

Deliverables:

- Delivery of STP communications & engagement strategy
- Establish communications & engagement network
- Evidenced engagement within every programme of work
- Every organisation has increased awareness of system understanding of the transformation programme
- Increased understanding amongst Shropshire, Telford & Wrekin residents, staff and stakeholders of the challenge we face, our health and care partnership and our vision for future health and care services
- Increased understanding that we all have a role to play in developing how services may change and the importance of engaging in the debate about the future of health and care services in Shropshire, Telford & Wrekin
- Support consultations on service change

NHS
Long Term Plan
#NHSLongTermPlan

7.
Activity & Capacity Planning

System Approach to Capacity Planning

- The system is working together to understand shared capacity across collective resources
- Significant amount of work was undertaken across the system to model the capacity requirements for winter 2018/19 and this learning is being used to plan for 19/20
- Real time activity data has been used to develop this model given the significant, unpredicted growth in demand
- Further work is being undertaken to determine capacity requirements in acute and community settings
- Significant work is being done by the system to improve models of admissions avoidance, such as the ambulance conveyance reduction work. Improvement in ambulatory care models also being undertaken to minimise bed utilisation.
- The system are reviewing their assumptions and then reviewing for impact on workforce and finance to then create the plans for 2019/20
- Significant changes predicted and improvement in patient management by direction to out of hospital services will need to be profiled, in order to accurately forecast demand, e.g. 111, urgent treatment centres and Future Fit
- Use **valued care in mental health**; and **improving for excellence** to improve the emergency care of people with mental health

System Winter Planning Approach

- The Plan has been developed through robust engagement of all key system partners overseen by the A&E Delivery Group.
- In parallel, system demand and capacity modelling has been undertaken to determine predicted winter demand and required acute bed capacity to inform the bed bridge calculations.
- All Providers are asked to share their understanding of their demand and capacity over the winter months and provide an organisational winter plan which includes:
    - Additionally, and phasing of escalation
    - A workforce model to support 7-day working, senior decision making and escalation capacity
    - 7-day working
    - Christmas, New Year and Easter period
    - Options for further surge capacity if required

System Capacity Planning Modelling - Based on 92% occupancy

	April	May	June	July	August	Sep	Oct	Nov	Dec	Jan	Feb	Mar
beds available (core)	642	642	642	642	642	642	642	642	642	642	642	642
Total beds available for +1 day	589	589	589	589	589	589	589	589	589	589	589	589
BEDS REQUIRED with LOS 6 days	633	625	664	645	624	637	628	688	654	654	634	676
8% to reduce occupancy to 92%	683	675	717	697	674	688	678	743	707	706	685	730
BED GAP	-94	-86	-128	-108	-85	-99	-89	-154	-118	-117	-96	-141
Improvement schemes to bridge bed gap												
This Varies by month and includes schemes such as Acute medicin (Front door), frailty, Stranded Patients/Los Improvements												
Total Improvements	10	15	24	38	37	36	37	38	38	38	38	38
RESULTING BED GAP	-84	-71	-104	-70	-48	-63	-52	-116	-80	-79	-58	-103
Capacity schemes to bridge bed gap												
winter beds open all year	30	30	30	30	30	30	30	30	30	30	30	30
RSH ward 35				28	28	28	28	28	28	28	28	28
RESULTING BED GAP	-54	-41	-74	-12	10	-5	6	-58	-22	-21	0	-45
Additional solutions that can be in place as currently utilised as additional winter capacity												
care home beds	11	11	11	11	11	11	11	11	11	11	11	11
Hospital full protocol (without day surgery or AEC)	8	8	8					8	0	0	0	8
RESULTING GAP	-35	-22	-55	-1	21	6	17	-39	-11	-10	11	-26
Potential solutions that currently don't exist e.g. PRH additional capacity (from November), additional care home beds												
?additional community capacity	20	20	20									
PRH additonal capacity								28	28	28	28	28
rehab out of hospital				10	10	10	10	10	10	10	10	10
Potential GAP if these are accepted	-15	-2	-25	9	31	16	27	-1	27	28	49	12

System Capacity Planning Modelling - Based on 95% occupancy

	April	May	June	July	August	Sep	Oct	Nov	Dec	Jan	Feb	Mar
beds available (core)	642	642	642	642	642	642	642	642	642	642	642	642
Total beds available for +1 day	589	589	589	589	589	589	589	589	589	589	589	589
BEDS REQUIRED with LOS 6 days	633	625	664	645	624	637	628	688	654	654	634	676
5% to reduce occupancy to 95%	664	656	697	677	655	669	659	723	687	686	666	710
RESULTING BED GAP	-75	-67	-108	-88	-66	-80	-70	-134	-98	-97	-77	-121
Improvement schemes to bridge bed gap												
This Varies by month and includes schemes such as Acute medicin (Front door), frailty, Stranded Patients/Los Improvements												
Total Improvements	10	15	24	38	37	36	37	38	38	38	38	38
RESULTING BED GAP	-65	-52	-84	-50	-29	-44	-33	-96	-60	-59	-39	-83
Capacity schemes to bridge bed gap												
winter beds open all year	30	30	30	30	30	30	30	30	30	30	30	30
RSH ward 35				28	28	28	28	28	28	28	28	28
RESULTING BED GAP	-35	-22	-54	8	29	14	25	-38	-2	-1	19	-25
Additional solutions that can be in place as currently utilised as additional winter capacity												
care home beds	11	11	11	11	11	11	11	11	11	11	11	11
Hospital full protocol (without day surgery or AEC)	8	8	8					8	0	0	0	8
RESULTING BED GAP	-16	-3	-35	19	40	25	36	-19	9	10	30	-6
Potential solutions that currently don't exist e.g. PRH additional capacity (from November), additional care home beds												
?additional community capacity	20	20	20									
PRH additonal capacity								28	28	28	28	28
rehab out of hospital				10	10	10	10	10	10	10	10	10
POTENTIAL POSITION if these are accepted	4	7	-5	29	50	35	46	19	47	48	68	32

8.
System Finances

System Financial Position

£m	SCCG	TWCCG	SaTH	RJAH	SCHT	TOTAL
2019/20 Control Total	(12.3)	0.0	(17.4)	2.0	0.0	(27.7)
2019/20 Plan Surplus / (Deficit)	(23.8)	0.0	(24.3)	(0.5)	0.0	(48.6)
Variance to Control Total	**(11.5)**	**0.0**	**(6.9)**	**(2.5)**	**0.0**	**(20.9)**
Risk to Delivery:						
Unidentified CIP/QIPP	0.0	(4.9)	(7.8)	0.0	(2.0)	(14.7)
High/Medium Risk Schemes	(7.0)	(2.0)	(4.8)	(3.3)	(1.5)	(18.6)
Transformational Change Programmes	1.1	0.9	2.5	1.3	0.2	6.0
Contingencies/Reserves/Other	1.3	2.5	0.0	0.8	(0.5)	4.1
Total Risks to Delivery	**(4.6)**	**(3.5)**	**(10.1)**	**(1.2)**	**(3.8)**	**(23.2)**

Note:

- *All figures exclude PSF, FRF and MRET*
- *Issues referred for national resolution to NHSI/E have been included in the plans:*
  - *Resolution of national tariff (RJAH) - £2.5m*
  - *GP indemnity delegated budget adjustment (SCCG) - £1.5m*

  Favourable resolution of these issues would reduce the variance to Control Total
- *Confirmation of national solution required from NHSI/E regarding pay award funding for LA services (SCHT) - £0.5m*

- Delivery of current plans require total cost-out savings of £51.6m across the system. All organisations in the system continue to review QIPP/CIP plans to maximise deliverable savings in 2019/20 and to manage internal organisational cost pressures.
- Our transformational change programme identifies a pipeline of opportunities that can deliver up to £53m over the next four years. We are committed to accelerating the work on these programmes but this is unlikely to address in full the gap identified in 2019/20
- In recognition of the financial situation we continue to review a number of additional potential cost savings. However a number of these areas would impact on organisational performance and the delivery of constitutional targets and would therefore require full commitment from commissioners, providers and regulators.

Health and Wellbeing Board
23rd May, 2018

HWBB Joint Commissioning Report - Better Care Fund 19/20

Responsible Officers
Email: Tanya.miles@shropshire.gov.uk; gail.fortes-mayer@nhs.net Tel: Fax:

1. Summary

1.1 This report provides an update on the progress on the Better Care Fund (BCF), and development of the Better Care Fund for 19/20; it includes:

- 1.1.1 Non-elective admissions analysis paper (Appendix A) – for information
- 1.1.2 Summary national Policy Framework for the BCF 19/20 (full policy framework attached as Appendix B) – for information
- 1.1.3 Statement of intent to strengthen the integrated approach across Shropshire Council and Shropshire CCG (Appendix C) – for endorsement
- 1.1.4 Proposed key areas of development for 19/20, section 1.5 below – for endorsement
- 1.1.5 Quarter 4 18/19 Return (Appendix D) – for information

1.2 At the January HWBB the Board requested an analysis of Shropshire's non-elective admissions target, as we had not met the quarter 2 target. Appendix A attached, assesses a number of reasons that could account for this including demographics, care home admissions, adverse weather, and working practices. It highlights further work to be done to reduce admissions through improved working with care homes, care closer to home, and the Integrated Community Services team and helps inform planning for 19/20 BCF development.

1.3 The 19/20 National Policy Framework is summarised in the report below and emphasises that the BCF will retain the same National Conditions as in 2017-19. Areas will be required to set out how the National Conditions will be met through jointly agreed BCF Plans signed off by the Health and Wellbeing Board. The national guidance has yet to be published, but it is anticipated that the plan development will be streamlined, with a reduced narrative, and a focus on scheme highlights and delivery. In light of this, our local planning is focussing on demonstrating improvement through measurable outcomes aligned with the strategic direction of the STP/ ICS.

1.4 To build on local planning for integrated services, attached in Appendix C is a Statement of Intent that has been jointly developed by Shropshire CCG and Shropshire Council. Its purpose is to strengthen integrated working across health and care, to add context to our Partnership Agreement (section 75), and to guide and support our decision making for the BCF 19/20.

1.5 Based on the Statement of Intent the key areas that we will focus on for the coming year pooled arrangements include:

- 1.5.1 Prevention – community referral including Social Prescribing, Dementia Companions, sustainable support for the voluntary and community sector, population health management
- 1.5.2 Admissions Avoidance/ developing services in place – out of hospital focus (Care Closer to Home, Integrated Community Service (ICS), Continuing Healthcare (CHC), Children's Centre hubs, Children's complex cases
- 1.5.3 Delayed Transfers – Development of a joint equipment contract, estate planning, ICT infrastructure, Integrated Community Service, Red Bag scheme

2. Recommendations

2.1 The HWBB endorse the Statement of Intent (Appendix C);
2.2 The HWBB endorse the key areas of development for the 19/20 (outlined in section 1.5 above) with the caveat that the guidance has yet to be published.

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.

4. Background

4.1 The BCF Policy Guidance summarised:

1. The BCF in 2019-20 will retain the same National Conditions as in 2017-19, areas will be required to set out how the National Conditions will be met in jointly agreed BCF Plans signed off by Health and Wellbeing Boards.

National Conditions & Metrics for 2019-20 2.15

- For 2019-20, there continue to be four National Conditions, in line with the vision for integrated care:
  (i) Plans to be jointly agreed
  (ii) NHS contribution to adult social care to be maintained in line with the uplift to CCG Minimum Contribution
  (iii) Agreement to invest in NHS commissioned out-of-hospital services, which may include 7-day services and adult social care
  (iv) Managing Transfers of Care: A clear plan for improved integrated services at the interface between health and social care that reduces

- Delayed Transfers of Care (DToC), encompassing the High Impact Change Model for Managing Transfers of Care – adopt the centrally-set expectations for reducing or maintaining rates of DToC in the BCF plans.
- Beyond this, areas have flexibility how the BCF is spent over health, care and housing schemes or services, but need to agree how the spend will improve in:
  - Delayed Transfers of Care;
  - Non-elective admissions (General and Acute);
  - Admissions to residential and care homes; and
  - Effectiveness of reablement.

2. NHS England to put in place arrangements for CCGs to pool a mandated minimum amount of funding. CCGs were advised that the uplift would be c. 1.79%, but I asked the regional lead yesterday who said the minimum contribution will be made on a HWBB basis, not a flat rate nationally, and that the range sit somewhere between 1.7%-5.2%.
3. The Government will require local authorities to continue to pool grant funding from the improved Better Care Fund, Winter Pressures funding and the Disabled Facilities Grant.

4. 2019-20 is to be a year of **minimal change** for the Better Care Fund. Any major changes from the BCF Review will be from 2020 onwards.
5. The only notable changes for 2019-20 are that requirements for narrative plans have been simplified, with more meaningful information on the impact of the BCF to be collected through the planning process. This will be determined through the template submissions. Further information on how this will work in practice will be set out in the Planning Requirements.

Funding and conditions of access for 2019-20 – (covers 2019-20 only).

6. The mandate to NHS England and the annual remit for NHS Improvement for 2019-20 will include an expectation of a minimum CCG contribution, to establish the BCF in 2019-20 (the amended NHS Act 2006 gives NHS England the powers to attach conditions to the amount that is part of Clinical Commissioning Group allocations).
7. NHS England is to look to include conditions that allows for the recovery of funding where the National Conditions are not met. (this does not apply to the amounts paid directly from Government to local authorities).
8. Allocations of improved Better Care Fund, Winter Pressures funding and Disabled Facilities Grant will be paid directly from Government to local authorities. Any future year's allocations will be decided through the 2019 Spending Review.
9. As in previous years, the NHS contribution to the BCF includes funding to support the implementation of the Care Act 2014. Funding previously earmarked for reablement and for the provision of carers' breaks also remains in the NHS contribution.
10. The local flexibility to pool more than the mandatory amount will remain.

The assurance and approval of local Better Care Fund plans for 2019-20

11. Plans should align with (not duplicate) other strategic documents such as plans set out for local Strategic Transformation Partnerships/Integrated Care Systems.
12. Final decisions on plan approval and permission to spend from the CCG ringfenced contribution will be made by NHS England (as the Accountable Body for the BCF) having consulted the respective Secretaries of State for Health and Social Care, and Housing, Communities and Local Government.

5. **Financial Implications**

5.1 The minimum required budget for the BCF has yet to be published (it will be published with the guidance expected in June), however it will likely be similar to previous years with some uplift. The final plan, including all financial requirements, will be brought the HWBB for approval as soon as possible.

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**
Cabinet Member (Portfolio Holder) **Cllr Lee Chapman**
Local Member n/a
Appendices Appendix A: Non-elective admissions analysis paper Appendix B: BCF 19/20 Policy Framework Appendix C: Statement of Intent Appendix D: BCF Quarter 4 18/19 Return

Appendix A -
BCF Target - Non- elective Admissions Activity Trend Analysis.

Background

1 A number of nationally described metrics are used to determine the performance of the Better Care Fund (BCF), one such metric is the number of Non-Elective Admissions (NEAs) that take place.

2 This metric can be considered on a number of different levels; for the purpose of the BCF the NEA activity target is considered at CCG level. The metrics description is for Shropshire patients aged 65+ years, that:

> ***it is believed that through effective delivery of those services commissioned within the BCF, a number of NEAs are avoided; this is known as Admission Avoidance (AA).***

3 At the outset of each financial year the AA target is set centrally relative to expected growth in demand. All BCF these targets are quarterly and are shared with NHS England (NHSE).

4 Shropshire CCG has been able to meet its AA target, however in Q2 of 18/19 the NEA target was missed, the system however rebounded in Q3 to meet the target, however, it is estimated that there will be a further shortfall for Q4. There are a number of potential causes for the NEA target being missed, these are:

- Widespread cause of increased ill-health across the Shropshire population (increased need demand)
- Reduction in effectiveness of community-based services including the Integrated Community Service and Care Home admissions, due to demand and increasing complexity
- Flawed target-setting methodology, increasing age profile, with static service provision

5 The purpose of this paper is to present the reasons for why this activity shift may have occurred and whether it is likely to continue.

Scope of Data / Modes of Analysis

6 The analysis triangulates a number of data sources, some at the national level and local level data. NEA activity has been derived via NHS digital, whereas population data has been drawn from the Office for National Statistics (ONS).

7 Local-level NEA target data has been derived through interrogation of local NHSE BCF return data sources.

8 Provider activity data is taken from CCG held data-sources

9 The data from the report takes into account quality assured data to end Q2 18/19 and makes estimates for final end of year calculations.

Shropshire CCG Population

10 The volume of 65+ people living in the Shropshire contributes considerably to the number of NEAs observed. Table 1 provides an overview of population growth (2013-2019) coupled with the percentile weighting of the 65+ population.

Table 1 - Percentage of Shropshire Population Aged 65+ 2013-2019

Year	Total Population	Total on-year Population Growth (%)	Cumulative Population Growth %	% 65+	65+ Population	65+ Population Growth (%)	65+ Cumulative Population Growth %
2013	308,567			22.25%	68,668		
2014	310,121	0.50%	0.50%	22.86%	70,883	3.23%	3.23%
2015	311,380	0.41%	0.91%	23.34%	72,685	2.54%	5.77%
2016	313,373	0.64%	1.55%	23.70%	74,277	2.19%	7.96%
2017	315,400	0.32%	2.20%	24%	75,696	1.91%	9.87%
2018	316,700	0.41%	2.61%	24.5%	77,592	2.50%	12.37%

(Source: the Office for National Statistics online resources, years 2017-2019 are ONS projections based upon 2016 data).

11 Table 1 demonstrates how the population of Shropshire has seen a cumulative rate of growth of 2.61% over the last 5 years; whilst the 65+ population has seen a rate of growth nearly 10% above this figure. This could be a contributory factor to increase in the NEA activity shift observed this 2018-19 financial year.

Working with partial 2018/19 data.

12 At the time of writing for 2018-19 only Apr-Nov qualified data was available for NEA activity. Table 2 takes this period of activity and considers it over the period 2013 to 2018. Extrapolating forward suggests the outturn position for Shropshire, based on Apr –Nov (M8). Table 2 suggests that the end of year activity for NEA will be 33,739

Table 2 - Whole-year/Nov-Apr comparison 2013/14 – 2017/18

Year	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
NEA Actual	27,788	28,642	30,194	31,448	31,917	**33,739**
NEA Actual Apr-Nov	18,093	18,843	19,898	20,746	21,135	22,442
Apr-Nov (% of whole year)	65.11%	65.79%	65.90%	65.97%	66.22%	**66.51%**

NEA vs BCF NEA Target

13 Based upon the information in Table 2, Table 3 displays NEA target figures against NEA actual activity (including the 18/19 extrapolated figure). N.B. winter period for 2018-19 has been extremely busy for emergency admissions.

Table 3 - NEA activity vs NEA target – count

Year	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
NEA Target/ Plan		27,631	30,449	32,262	33,611	34,349
NEA Actual	27,788	28,642	30,194	31,448	31,917	**33,739**
Variance		-1,011	255	814	1,694	**610**

Possible Target Development methodology

14 Table 3 demonstrates the relationship between the NEA BCF target and NEA activity. What is unclear is how the 2014-15 NEA target was set. Shropshire over performed against NEA target 2014-15 by 1,011.

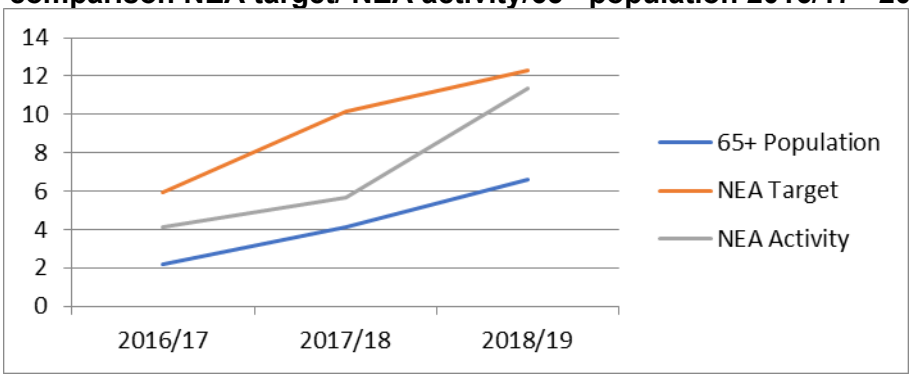
15 Table 4 demonstrates 10.2% uplift on the targeted activity to the previous year, following which point a relationship between targets set and the previous year's NEA activity emerges.

Table 4 - NEA activity vs NEA target – growth 2014/15

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
NEA Target growth (on-year)		10.20%	5.95%	4.18%	2.20%	**6.3%**
NEA Actual growth (on-year)	3.07%	5.42%	4.15%	1.49%	5.71%	
Variance (target/previous year actual)			0.54%	0.03%	0.70%	**0.59%**

16 Methodology for target development appears broadly based upon previous year's activity with some form of uplift applied (variance figure outlined in the bottom row). Extrapolating this variance enables a projected target growth figure to emerge for 2019/20.

Figure 1 - Growth comparison NEA target/ NEA activity/65+ population 2016/17 - 2018/19



17 Figure 1 demonstrates a progressive rise in the 65+ age group over a three year period along with a progressive rise in NEA activity, noticeably a significant rise is seen in 18/19 (green line).

18 Conversely, whilst also increasing, the NEA target begins to level-out in 2018/19. Table 3 demonstrates a marked reduction in terms of variance between the NEA target and NEA activity seen in between 2017/18 and 2018/19.

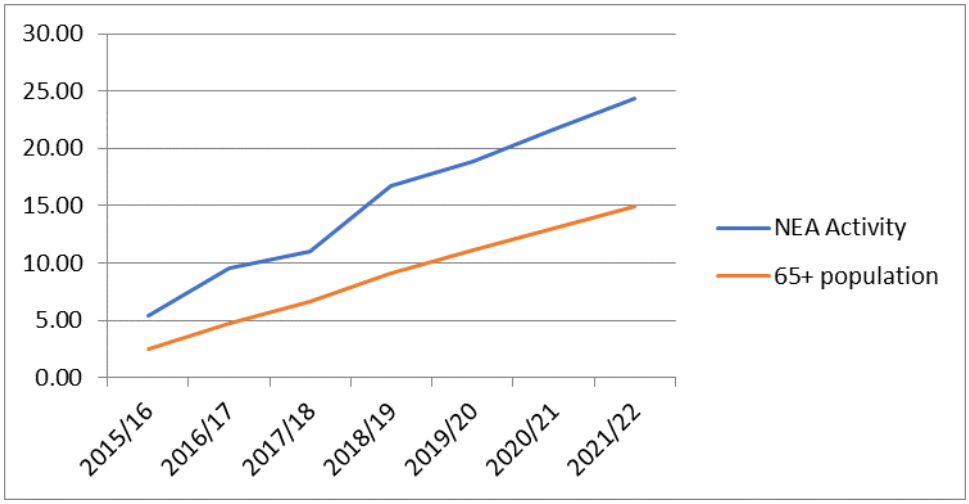
19 However, Table 4 identifies a trend/methodology for target setting, which if broadly applicable, should result in a 2019/20 NEA target of around 36,500. Considering this against other statistical information presented within this document, it becomes increasingly likely that positive performance against the 19/20 NEA target will resume.

Future projections

20 It appears that there is some correlation between the rise in the 65+ population and NEA activity. Using the population information in Table 1 and the NEA activity information in Table 3; a variance can be estimated, which can be used to create a trend line.

21 Using Office for National Statistics population projections, it is possible to use the extrapolated trend line to project NEA activity. Figure 2 illustrates the respective correlation between projected rates of growth.

Figure 2 - Projected correlations between 65+ Population growth and NEA activity based upon 2013 - /18 Table 2 activity data and ONS 2016 projections.



22 Based upon 2013/18 activity data and the it relationship with 65+ population statistics, Figure 2 illustrates how an increased volume of 65+ population is likely to translate into NEA-type demand, following present model remaining unchanged over the next 3 years. This trajectory is concerning given that the projection indicates the rise in NEA activity is forecasting acceleration compared to projected growth of the population over in Shropshire.

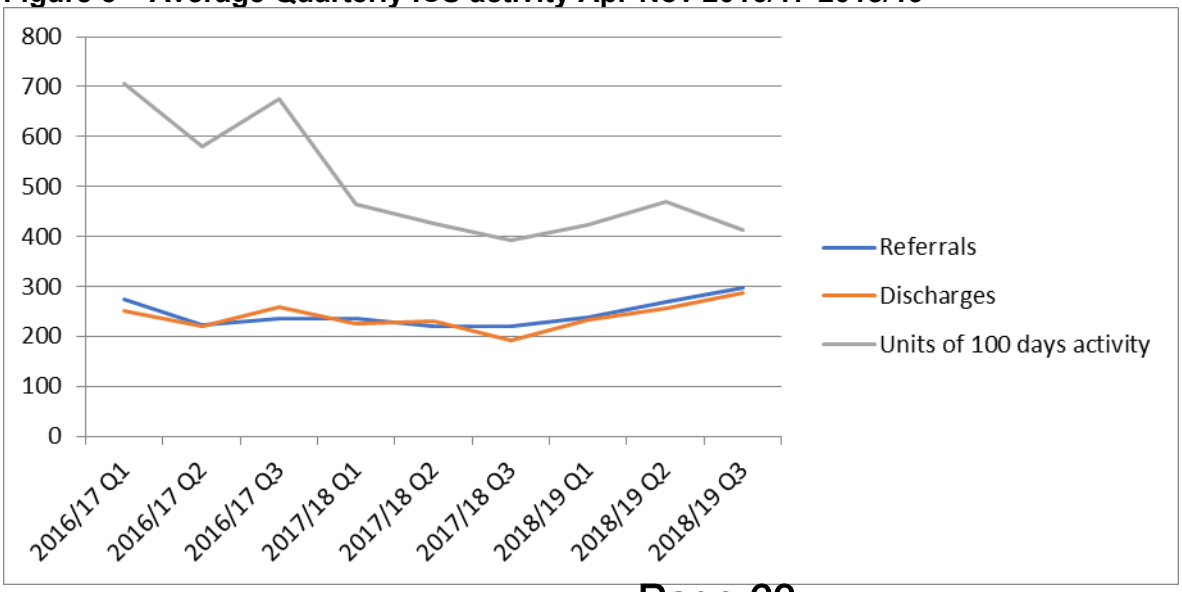
Intermediate Care Service (ICS) Performance

23 The admission avoidance specification for Integrated Care Services (ICS) is currently being redeveloped.

24 Shropshire Community Health Trust (SCHT- the provider) has shared an activity report with the CCG; data available to 16/17. (Note for a year-on-year comparison to extend into 18/19, only the months Apr-Nov are included within the analysis presented here).

25 Comparing the numbers of people referred into service each month, with the numbers who have been closed, it becomes apparent that the numbers of referral do not include those who have been refused service (inappropriate referrals). Based upon this information, the average monthly length of stay has enabled an overview of activity to emerge.

Figure 3 – Average Quarterly ICS activity Apr-Nov 2016/17-2018/19



26 Figure 3 demonstrates an increase in referral activity having taken place, 2018 – 19 year to date, compared to the previous year, suggesting that referrals have increased since Q2 17/18.

Wide spread cause of ill health across Shropshire

28 A widespread cause of ill health may have contributed to a large increase in NEAs, such as significant meteorological factors (e.g. an exceptionally hot summer). High temperatures and pollen-counts are known antagonists for UTIs and respiratory complaints. Previous cohort analysis of NEA activity identifies these condition cohorts among the most common. Further work is required to understand if this might have affected admission avoidance, as corresponding data of reablement targets, have demonstrated that Shropshire has routinely achieved its target of 82% of people being home 91 days after they have been discharged.

Additional Information

29 The **Frailty Board** monitors +65 admissions to hospital, length of stay and a number of other indicators through the Frailty Dashboard. This dashboard demonstrates that there is a 7.9% rise year to date (Figure 4 below), on NEAs from 17/18. Telford and Wrekin show a 27.08% rise for the same period(Figure 5 below) . One notable difference between the two hospitals is that the Royal Shrewsbury Hospital (RSH) has implemented Phase one of Care Closer to Home; Frailty at the Front Door. This service works to keep those frail and vulnerable out of hospital, if possible and appropriate. Additional data from the Frailty Dashboard demonstrates that the readmissions rate is similar to previous years, this together with the reablement data discussed in 28 above, provides further information as we work to understand the volume of NEAs in the system.

Figure 4 – Shropshire CCG trend analysis NEA admissions +65

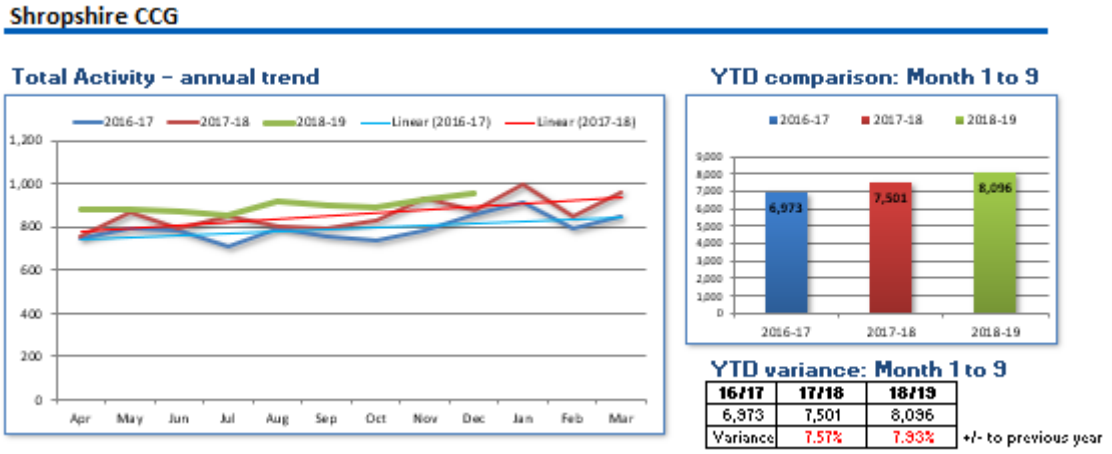
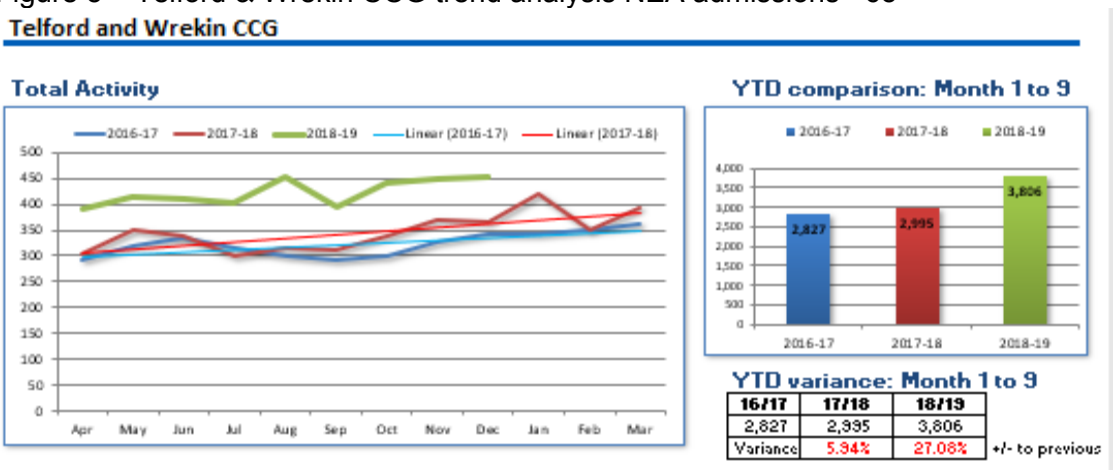
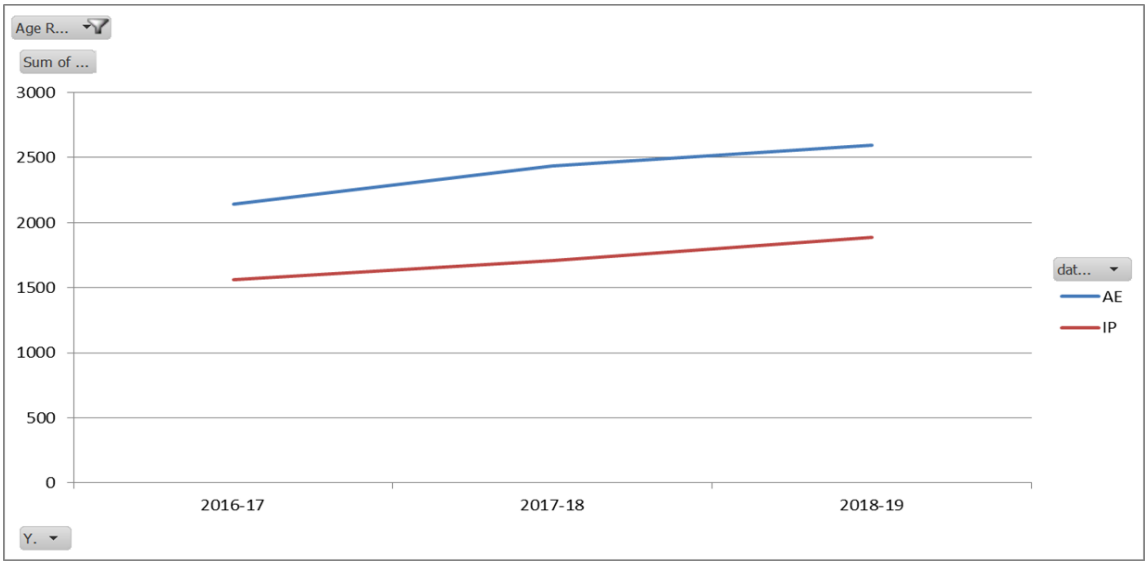


Figure 5 – Telford & Wrekin CCG trend analysis NEA admissions +65



Admissions from Care Homes

29 There has been a year on year increase in A&E attendance and Non Elective Admissions from Care Homes.
There are a number of schemes in place to support the care of residents and the Care Closer to Home transformation programme will enhance this support.
For 2019/20 it is planned to consolidate the work to date, ensure there is alignment to Care Closer to Home and the NHSE Enhanced Health in Care Homes Framework, this will also give the opportunity of identifying if there is additional improvements that can be made to reduce the number of NEL from Care Homes.



Year	A&E attendance	NEL	Total
2016/17	2145	1565	3710
2017/18	2435	1709	4144
2018/19	2598	1889	4487
Totals	7178	5163	12341

Conclusion

30 In terms of understanding why Shropshire BCF NEA target was not achieved in Q2, and why it is not likely to be achieved again in Q4, the causality is likely to be multi-faceted. Whilst the methodology for target setting has been shown to exhibit flaws, the average NEA activity growth has been identified as above that of the previous year.

31 This means a widespread cause may have contributed such as an exceptionally hot summer. High temperatures and pollen-counts are known antagonists for UTIs and respiratory complaints. Previous cohort analysis of NEA activity identifies these condition cohorts among the most common.

32 Additionally it has been identified that there has been a year on year increase of NEAs from care homes.

33 Additional work needs to be carried out to support the development of the model of delivery for Admission Avoidance; this work must connect with the out of hospital work developing as Care Closer to Home. As well continual improvement and support for care homes is required to ensure that we can reduce the number of admissions and support care homes as the preferred place to keep people well and comfortable when needed.

34 Based upon this analysis, it is recommended that the focus of BCF commissioning intentions should be around promoting Admission Avoidance.

Appendix B – 2019/20 BCF Policy Framework

1. Introduction

Person-centred Integrated Care

1.1 The Government is committed to the aim of person-centred integrated care, with health, social care, housing and other public services working seamlessly together to provide better care. This type of integrated care is the key to strong, sustainable local health and care systems which prevent ill-health (where possible) and the need for care, and avoid unnecessary hospital admissions. It also ensures that people receive high-quality care and support in the community. For people who need both health and social care services, this means only having to tell their story once and getting a clear and comprehensive assessment of all their needs with plans put in place to support them. This means they get the right care, in the right place, at the right time.

Progress on the Better Care Fund and Integration

1.2 Since 2015, the Government's aims around integrating health, social care and housing, through the Better Care Fund (BCF), have played a key role in the journey towards person-centred integrated care. This is because these aims have provided a context in which the NHS and local authorities work together, as equal partners, with shared objectives. The plans produced are owned by Health and Wellbeing Boards, representing a single, local plan for the integration of health and social care in all parts of the country.

1.3 In every year of its operation, most local areas have agreed that the BCF has improved joint working and had a positive impact on integration. In 2017-18, for example, 93% of local areas agreed that delivery of the BCF had improved joint working between health and social care in their locality, whilst 91% agreed that delivery of BCF plans had a positive impact on the integration of health and social care. Additionally, since its inception, local areas have voluntarily pooled at least £1.5 billion above the minimum required, in each year, with approximately £2.1 billion planned in voluntary pooled funding in 2018-19.

1.4 There are signs of real progress in joining up care and wider integration:

(a) The **New Care Model Vanguards** have provided valuable lessons for Sustainability and Transformation Partnerships, which are now being taken to the next stage by the emerging Integrated Care Systems. The Vanguards have seen a positive impact on emergency admissions, with community

models demonstrating the benefits of a more proactive approach that helps keep people independent for longer. Vanguards made progress in reducing the pressure on A&E. Emergency admissions in Vanguards on average grew by 0.9% in Multispecialty Community Providers and 2.6% in Primary and
Acute Care Systems compared with 6.9% in the rest of the NHS. For Enhanced Health in Care Home Vanguards, emergency admissions from care residents flatlined compared with an increase of 9% for care homes that were not part of a Vanguard.

(b) The **Integration Accelerator Sites**, building on the work previously conducted through the Integrated Personalised Commissioning programme, continue to make encouraging progress in empowering people to manage their healthcare, and the better integration of services across health, social care and the voluntary and community sector. Integrated personal budgets are one way of delivering more integrated and personalised care. Covering both health and social care, they have been developed based on the lessons learned through personal budgets, personal health budgets, and direct payments. NHS England has now published Universal Personalised Care: Implementing the Comprehensive Model - co-produced with partners in social care - which sets out the road map to deliver the Long Term Plan's objective to deliver the Comprehensive Model for Personalised Care to 2.5 million people by 2023-24.

(c) We are committed to creating a technology infrastructure that allows systems to communicate securely, using open standards for data and interoperability. This will enable health and care professionals to have access to the information they need to provide care. We are encouraging local areas to ensure data is collected consistently and made available to support joined-up and safer patient care by investing in the development of Local Health and Care Record Exemplars. This will enable data to be accessed as patients move between different parts of the NHS and social care. The first five Exemplars cover 23.5 million people and will each receive up to a total of £7.5 million over two years.

(d) Both the NHS and social care have been working hard to **reduce delays and free up beds**. Since February 2017, more than 2,280 beds per day have been freed up nationally by reducing NHS and social care delays. This has been supported by the Better Care Fund and targeted funding from Government through the improved Better Care Fund (iBCF).

1.5 The Shifting the Centre of Gravity report on making person-centred, place-based integrated care a reality was published in October 2018, and produced by the Association of Directors of Adult Social Services, Association of Directors of Public Health NHS Confederation, NHS Clinical Commissioners, NHS Providers and the Local Government Association. The report noted that there are now many more examples of joined-up working across the country than there were at the time of the previous report, Stepping up to the Place, in June 2016.

1.6 The NHS Long Term Plan outlines objectives for joined-up care across the system with commitments to increased investment in primary medical and community health services to support new service models including an urgent response standard for urgent community support; integrated multi-disciplinary teams; NHS support to people living in care homes; the NHS Personalised Care model; an integration index; reducing Delayed Transfers of Care; and supporting local approaches to blend health and social care budgets, amongst other initiatives.

1.7 The forthcoming Adult Social Care Green Paper will also build on the approach to joined-up, person-centred integrated care.

2. The Better Care Fund in 2019-20

What the BCF will look like in 2019-20

2.1 The BCF in 2019-20 will retain the same National Conditions as in 2017-19. Areas will be required to set out how the National Conditions will be met in jointly agreed BCF Plans signed off by Health and Wellbeing Boards. The Government will continue to require NHS England to put in place arrangements for CCGs to pool a mandated minimum amount of funding. The Government will also require local authorities to continue to pool grant funding from the improved Better Care Fund, Winter Pressures funding and the Disabled Facilities Grant.

2.2 2019-20 is to be a year of minimal change for the Better Care Fund. Any major changes from the BCF Review will be from 2020 onwards. The only notable changes for 2019-20 are that requirements for narrative plans have been simplified with areas not required to repeat information they previously provided in their 2017-19 plans, and for more meaningful information on the impact of the BCF to be collected through the planning process.

2.3 Further information on how this will work in practice will be set out in the Planning Requirements.

Funding and conditions of access for 2019-20

2.4 This Policy Framework covers 2019-20.

2.5 The mandate to NHS England and the annual remit for NHS Improvement for 2019-20 will include an expectation of a minimum CCG contribution of £3.84 billion to establish the BCF in 2019-20. The amended NHS Act 2006 gives NHS England the powers to attach conditions to the amount that is part of Clinical Commissioning Group allocations. NHS England will look to include conditions that allow the recovery of funding, in consultation with the Department of Health and Social Care and the Ministry of Housing, Communities and Local Government, where the National Conditions are not met. These powers do not apply to the amounts paid directly from Government to local authorities. The expectation remains that in any decisions around BCF Plans and funding, Ministers from both aforementioned departments will be consulted.

2.6 Allocations of improved Better Care Fund, Winter Pressures funding and Disabled Facilities Grant will be paid directly from Government to local authorities. Any future year's allocations will be decided through the 2019 Spending Review.

2.7 As in previous years, the NHS contribution to the BCF includes funding to support the implementation of the Care Act 2014. Funding previously earmarked for reablement (£300 million) and for the provision of carers' breaks (£130 million) also remains in the NHS contribution.

2.8 The local flexibility to pool more than the mandatory amount will remain.

2.9 Further details of the financial breakdown are set out in Table 1.

Table 1 – BCF funding contributions in 2019-20

BCF funding contribution	2019-20
Minimum NHS (Clinical Commissioning Groups) contribution	£3.840bn
Disabled Facilities Grant (capital funding for adaptations to houses)	£0.505bn
Grant allocation for adult social care (improved Better Care Fund). Combined amounts were announced at Spending Review 2015 and Spring Budget 2017.	£1.837bn
Winter Pressures grant funding	£0.240bn
Total	£6.422bn

Disabled Facilities Grant (DFG)

2.10 Funding for the DFG in 2019-20 will be £505 million. This will be paid to local government via a section 31 grant. The DFG capital grant must be spent in accordance with an approved joint BCF plan, developed in keeping with this Policy Framework and Planning Requirements that will follow.

2.11 In two-tier areas, decisions around the use of the DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. Full details will be set out in the DFG Grant Determination Letter.

Winter Pressures funding

2.12 This money will be paid to local government, via a Local Government Act 2003 section 31 grant. Government will attach a set of conditions, requiring the funding to be used to alleviate pressures on the NHS over winter, and to ensure it is pooled into the BCF. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care. The Grant Determination will be issued in April 2019. Reporting in relation to this funding will be managed through wider BCF reporting. Health and Wellbeing Boards will be required to confirm plans for the use of this funding in their BCF plans.

Improved Better Care Fund (iBCF) Funding

2.13 The iBCF grant will again be paid to local government, via a section 31 grant. The total allocation of the iBCF in 2019-20 will be £1.837 billion. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care.

2.14 The Government will attach a set of conditions to the section 31 grant to ensure it is pooled in the BCF at local level and spent on adult social care. The final conditions will be issued in April 2019. As part of our ambition to maintain continuity in 2019-20, the iBCF will not have any additional conditions of usage above what has previously been set out. The grant is to be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.

2.15 For 2019-20, there continue to be four National Conditions, in line with our vision for integrated care:

(i) Plans to be jointly agreed

(ii) NHS contribution to adult social care to be maintained in line with the uplift to CCG Minimum Contribution

(iii) Agreement to invest in NHS commissioned out-of-hospital services, which may include 7-day services and adult social care

(iv) Managing Transfers of Care: A clear plan for improved integrated services at the interface between health and social care that reduces Delayed Transfers of Care (DToC), encompassing the High Impact Change Model for Managing Transfers of Care. As part of this all Health and Wellbeing Boards adopt the centrally-set expectations for reducing or maintaining rates of DToC during 2019-20 into their BCF plans.

2.16 Beyond this, areas have flexibility in how the Fund is spent over health, care and housing schemes or services, but need to agree how this spending will improve performance (for example by agreeing ambitious expectations across the metrics with plans setting out how the ambitions will be met) in the following four BCF 2019-20 metrics: **Delayed Transfers of Care; Non-elective admissions (General and Acute); Admissions to residential and care homes; and Effectiveness of reablement.**

2.17 Since June 2018, local health systems have been tasked with reducing the number of extended stays in hospital. This has required changes to the way that hospitals work but is also affected by what happens outside of acute hospital when patients are fit to go home. The BCF should continue to support the aim to reduce the number of patients who remain in acute hospitals for an extended period (21 days or more) by continuing ongoing work to implement and embed the High Impact Change Model for Managing Transfers of Care that support this ambition.

2.18 Across the country, areas have made strong progress in reducing Delayed Transfers of Care. From February 2017 to January 2019, there have been more than 2,280 fewer people delayed in an NHS bed per day. We believe that no-one should stay in a hospital bed longer than necessary as it removes people's dignity and can lead to poorer health and care outcomes. We want to continue to drive down Delayed Transfers of Care and for 2019-20 the national ambition will remain for no more than 4,000 delayed days per day (reported as 'DTOC beds').

The assurance and approval of local Better Care Fund plans for 2019-20

2.19 Plans will be developed locally in each Health and Wellbeing Board area by the relevant local authority and CCG(s). In order to reduce planning burdens we will collect narrative elements and confirmation of agreements through a set template, rather than freeform narrative. Areas should look to align with, and not duplicate, other strategic documents such as plans set out for local Strategic Transformation

Partnerships/Integrated Care Systems. BCF plans will need to set out priorities for embedding implementation of the High Impact Change Model (National Condition four), and update their local visions and approaches to integration - see paragraph 3.1. Areas will need to submit full planning templates, confirming that the HWB has signed them off, in order for the National Conditions to be assured. Plans will be assured and moderated regionally in line with the operational planning assurance process set out in the Better Care Fund Planning Requirements. As in 2017-19, there will be one round of assurance, after which plans deemed compliant by assurers at regional level will be put forward for approval.

2.20 Final decisions on plan approval and permission to spend from the CCG ringfenced contribution will be made by NHS England (as the Accountable Body for the BCF) having consulted the respective Secretaries of State for Health and Social Care, and Housing, Communities and Local Government.

2.21 The NHS Act 2006 allows NHS England to direct the use of the CCG elements of the fund where an area fails to meet one (or more) of the BCF conditions. This includes the requirement to develop an approved plan. If a local plan cannot be agreed or other National Conditions are not met, any proposal to direct use of the CCG elements of the Fund will be discussed and agreed with Ministers.

2.22 Local authorities are legally obliged to comply with section 31 grant conditions.

3. The Better Care Fund, Housing and Wider Integration Initiatives

3.1 The BCF offers a good opportunity to support the delivery of wider objectives and strategies around health and social care. In particular, every health and care system in England has agreed a Sustainability and Transformation Plan (STP) and formed a delivery partnership, providing the system-level framework within which organisations in local health and care economies can plan effectively and deliver a sustainable, transformed and integrated health and care service. Local areas should ensure the financial planning and overall approach to integrated care within BCF plans and local STP plans are fully aligned.

3.2 The Department of Health and Social Care and the Ministry of Housing, Communities and Local Government, along with NHS England, the Local Government Association, and the Association of Directors of Adult Social Services are currently reviewing the BCF beyond 2020. We intend to provide an update on the future of the BCF shortly.

3.3 STPs and Integrated Care Systems (ICSs) will be required to agree new plans during the first half of 2019-20. We expect every STP and ICS plan to cover their work on Integrated Care; and for Health & Wellbeing Boards, and STP/ICS colleagues to engage proactively in producing this. Where these collaborative strategies exist, we will allow them to form the basis of integration narratives in planning for the BCF (or alternative programme, depending on the review of the BCF) for the following years. Graduation as previously set out has not been possible to date. As part of our review, Government will consider the use of graduation.

3.4 The Long Term Plan also sets out proposals on integration including investing in models of care that strengthen links between primary care networks and local care homes, such as the roll-out of Enhanced Health in Care Homes. The Government will encourage and support the NHS to use this as an opportunity to involve local government in the implementation of the Long Term Plan.

3.5 Building on previous work, a refreshed memorandum of understanding (MoU) 'Improving health and care through the home' was published by Public Health England in March 2018. This MoU, signed by over 25 stakeholders, emphasises the importance of housing in supporting people's health and sets out a shared commitment to joint action across Government and health, social care, and housing sectors in England.

3.6 There is an increasing range of material available to support local systems with the practical development of joint integration strategies and integrated services. The NHS England Integrating Better project recently produced a practical guide based on learning from 16 areas, which is available to health and care practitioners as part of the STP/ICS library of good practice (access requires a login). The Local Government Association also provide a range of support, tools and case studies, such as through a recently published evidence review and case studies of integrated care or the support provided through its Care and Health Improvement Programme.

3.7 Although the Disabled Facilities Grant (DFG) has been part of the BCF since 2015, it was last reviewed in 2008. Following calls from the sector and local authorities to ensure that it continues to provide help and meet users' needs as effectively as possible, the Government commissioned an independent review in February 2018. This was conducted by the University of the West of England in conjunction with several other partners, and both the main report and executive summary were published in December 2018. There are 45 recommendations and Government is carefully considering the detailed findings and will issue a response in due course.

Appendix C:

Statement of Intent
Shropshire CCG and Shropshire Local Authority 2019/20

1. Background

Nationally as well as locally there is a move for greater partnership working across health and care and community support. The move towards integrated care has been in place for some time across Shropshire, and there is a renewed vigour to develop this further. Transformation work streams to deliver an integrated approach to out of hospital care are in place where health and care are co-operating to develop intermediate care services.

The implementation of the Better Care Fund (BCF) provided a platform to enable and facilitate joint working and joint decision making; the success of this has ranged from a successful accounting exercise to improved joint working, communication and improved delivery. More recently Sustainability and Transformation Partnerships have brought about a whole system focus on integrated care, and further developments are on the horizon as STPs morph into Integrated Care Partnerships.

In Shropshire the approach to the delivery of the initiatives as set out in the Better Care Fund has also demonstrably improved our delayed transfer of care. However, we recognise that more work could be done to develop this partnership over the coming year.

Strong place-based working and asset-based approaches exist in abundance in Shropshire, as well as good infrastructure and working relationships with the voluntary and community sector. Further collaborative development of these relationships and ways of working can be a real strength for transforming service going forward.

Benefits to closer working, joint delivery and decision making, can be considered in a number of ways, most notably improved outcomes for people and improved efficiency for the system. Across the health and social care system, we have taken some steps to improve how we design, develop and deliver care, however more can be done.

As well as the Section 75 Partnership agreement, we have entered into an Alliance Agreement on 24 January 2019, bringing together commissioners and providers. To further this stepped approach, this statement of intention reflects the principles as set out in our previous agreements and works to embed better ways of working across health and care.

2. Potential areas for co-operation 2019/20

Building on the good work of the BCF, Shropshire Care Closer to Home, and Integrated Community Services, there is more that can be done to join up planning and delivery of our out of hospital services.

Potential areas to connect and reframe as the health and care transformation to improve outcomes, efficiency and effectiveness:

1. Reframe out of hospital focus to an all age programme focussing on vulnerability
    - Community referral/signposting - All out of hospital developments have a degree of utilisation of community referral. This is done routinely through Shropshire Council's First Point of Contact (FPOC), through Let's Talk Local, through GPs, nurses and the Primary Care Community Care Coordinators. Additionally, the CCG working with SATH is looking at how community hubs for midwifery services can be developed effectively as well as referral for living well and beyond cancer. A well evaluated model of Social Prescribing has been developed and the out of hospital programme has self-care as a focus. If we consider these developments along with the development of primary care networks and a joint approach with the voluntary community sector; there are plenty of opportunities to join up this work.
    - Primary Care - We will also work with the developing primary care networks and individual GPs specifically on admission avoidance linking to the work of the

development of an integrated care system, e.g. develop routine risk stratification and prevention interventions for all ages
    - Development of multi-disciplinary teams to focus on admission avoidance (case management, rapid response, crisis, hospital at home) (care closer to home)
    - Embedding Social Prescribing across the county
    - Development of a joint equipment contract
2. Admission avoidance and transfers
    - Developing the ICS model as a whole system opportunity to smooth transfer out of hospital, drawing in specialities as needed (such as stroke rehab); in addition developing the ICS model in tune with the Care Closer to Home work to ensure that people are supported to remain in their own homes as much as possible.
    - Developing a whole system falls prevention model, linking with community referral, delivering early prevention through Elevate, and secondary prevention through fracture liaison and a dedicated falls service.
3. Development of closer working and sustainable support for the voluntary and community sector
    - Developing a better understanding of how the VCS can support people in place and sufficiently resourcing the sector to provide this support
4. Development of service in place; joining up the out of hospital offer in places where people and services coalesce. This will require working with:
    - estate planning,
    - children's service transformation,
    - adult social care and
    - ICT requirements
    - Voluntary and Community Sector
5. Continuing Healthcare and complex care
    - Continuing Healthcare (adults, children and young people) – specifically the development of a joint approach to the assessment and procurement of packages of care. The nursing team within CHC are working closely with social workers to ensure that there is the most effective care package delivered and reviewed. Our approach is one of joint co-operation and setting strategic direction rather than shifting costs. We also will review current and legacy issues between the CCG and the Council.
    - Following the initial assessment of an audit of 30+ CHC cases the CCG and Council, that should hopefully prove the delivery of more effective care; an agreed joint framework would be developed and then implemented during 2019/20. This framework would also include a risk and gain share agreement and address how both parties would address the funding increases of packages of care. It would be our aim during 2019/20 to move to joint commissioning of services.
    - Integrating a children's social worker within complex care team – developing joint packages of care

3. Enabling programmes

The need to work together to support significant transformation across the system is recognised. The demands upon finance, estates, business intelligence and workforce planning require that we will need to work jointly on solutions. Key areas being:

1. Use Business Intelligence/ Population health management approach to drive decision making

- The CCG has a small team of analysts supporting the broad responsibilities of the CCG. The Council similarly has a relatively small team supporting change initiatives and public health. The intent would be to work together to explore how we can work more closely to support the development of predictive analytics, scenario planning and modelling. This would include remodelling and co-design of the analysis and use of relevant public health data.
- Connect with the NHS population health programme to pick an area in Shropshire that we really want to take an intelligence and evidence-based approach to transforming and, together with a multi-disciplinary team, develop through the population health academy offer.

2. Estates
    - Social care services are delivered in sites across Shropshire including schools, community centres, children's centres with the opportunity of possible other sites currently owned by Shropshire Council. Advice is also provided in libraries and other council-owned buildings. Health also is provided in community hospitals and health centres, clinics and hospitals.
    - We intend to work together to realise how we can effectively utilise our estate to deliver a broad spectrum of health, social care and community referral services. This will require joint work on a feasibility study on a joint programme of estate development and utilisation that supports our joint strategic aims
    - Areas for possible joint work include accommodation support to health and social care staff and patient hotels. We recognise the need to build broader links with housing services to create innovative solutions that focusses on early intervention and prevention.
3. Workforce
    - Ensure the joining up of workforce planning across health and care to include the independent and voluntary and community sectors. E.g. we could work with the VCS to implement a VCS managed agency scheme for health and care to match skills to the new ways of working in communities

4. Better care fund

The BCF can be seen as an enabler in delivering integrated care. Its focus should remain prevention, admission avoidance and delayed transfers, in line with national developments. Both Shropshire Council and Shropshire CCG are committed to working together to implement the findings of the review and reflect how we can work more effectively via the BCF and its successor to support out of hospital care.

We have worked closely on the development of a section 75 agreement in 2018/19. It was recognised however that further work on the development of the BCF and specifically the review initiatives to support our joint strategic goals. A review of the BCF was completed in 2018/19 which identified areas for joint review and development during 2019/20.

5. Our approach to joint working

Although the various programme boards will be considering the approach, coordinated strategic solutions will need to be aligned between the local NHS and local government. The opportunities for joint development of community referral initiatives are significant, and both the Shropshire Council and the Shropshire CCG intend to work cooperatively and align initiatives where possible

This document reflects the need to maintain the impetus on building on the good work to date between the CCG and the Council. There is a recognised risk that the internal issues on structures and potential change of personnel will result in a loss of traction. The six-month priorities detailed below aims to ensure that all focus on these priorities during a period of change.

We will ensure that both health and social care jointly engages locally with elected members to greater effect; using the H&WBB and Scrutiny effectively, taking full advantage of communication opportunities and taking as many opportunities as possible to speak publicly with one voice. We will also prove the efficacy of partnership working by 'doing' and demonstrating results.

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Better Care Fund Template Q4 2018/19

Guidance

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 (funding announced in the 2017 Spring Budget) is included with 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. Though not required for Q3 2018/19, quarterly reporting for the iBCF is required for Q4 2018/19.

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, as below:

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 contain the word “Yes”
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 england.bettercaresupport@nhs.net

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 completion.
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 needs.

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 geography
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 improvement

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

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 ADASS representatives.

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 respective changes.

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. Income and Expenditure

The Better Care Fund 2017-19 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and CCGs. The mandatory funding sources are the DFG (Disabled Facilities Grant), the improved Better Care Fund (iBCF) grant and the minimum CCG contribution. A large proportion of areas also planned to pool additional contributions from LA and CCGs. Instead of collecting Income/Expenditure on a quarterly basis as was the case in previous years 2015/16 & 2016/17, 2018/19 requires annual reporting of Income and Expenditure at a HWB total level.

Income section:

- Please confirm the total HWB level actual BCF pooled income for 2018/19 by reporting any changes to the planned additional contributions by LAs and CCGs as was reported on the BCF planning template. Please enter the actual income from additional CCG and LA contributions in 2018/19 in the yellow boxes provided.
- Please provide any comments that may be useful for local context for the reported actual income in 2018/19.

Expenditure section:

- Please enter the total HWB level actual BCF expenditure for 2018/19 in the yellow box provided.
- Please provide any comments that may be useful for local context for the reported actual expenditure in 2018/19.

6. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2018/19 through a set of survey questions which are overall consistent with those from previous years.

The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 9 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund

There are a total of 10 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:

- Strongly Agree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:

1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2018/19

3. The delivery of our BCF plan in 2018/19 had a positive impact on the integration of health and social care in our locality
4. The delivery of our BCF plan in 2018/19 has contributed positively to managing the levels of Non-Elective Admissions
5. The delivery of our BCF plan in 2018/19 has contributed positively to managing the levels of Delayed Transfers of Care
6. The delivery of our BCF plan in 2018/19 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
7. The delivery of our BCF plan in 2018/19 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)

Part 2 - Successes and Challenges

This part of the survey utilises the SCIE (Social Care Institue for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

Please highlight:

8. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2018/19.
9. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2018/19?

As noted above, these are free text responses to be assigned to one of the following categories from the SCIE Integration Logic Model - Enablers summarised below. Please see link below for fuller details:

SCIE - Integrated care Logic Model

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rurual factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

7. 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 related impact.
8. Additional improved Better Care Fund: Part 1
For 2018/19 the additional iBCF monitoring has been incorporated into the BCF template. The additional iBCF sections of this template are on tabs '8. iBCF Part 1' and '9. iBCF Part 2'. Please fill these sections out if you are responsible for the additional iBCF quarterly monitoring for your organisation, or local area. To reflect this change, and to align with the BCF, data must now be entered on a Health and Wellbeing Board level. The iBCF section of the monitoring template covers reporting in relation to the additional iBCF funding announced at Spring Budget 2017 only. Specific guidance on individual questions is present on the relevant tab.
9. Additional improved Better Care Fund: Part 2
Specific guidance is present on the sheet.

Better Care Fund Template Q4 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, Val Banks
E-mail:	penny.bason@nhs.net
Contact number:	01743 252767
Who signed off the report on behalf of the Health and Wellbeing Board:	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. Income and Expenditure	0
6. Year End Feedback	0
7. Narrative	0
8. improved Better Care Fund: Part 1	0
9. improved Better Care Fund: Part 2	0

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

Local Government Association

NHS England

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<< Link to Guidance tab

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

2. National Conditions & s75 Pooled Budget

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	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

3. Metrics

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	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

4. High Impact Change Model

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	Cell Reference	Checker
Chg 1 - Early discharge planning Q4 18/19	G12	Yes
Chg 2 - Systems to monitor patient flow Q4 18/19	G13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q4 18/19	G14	Yes
Chg 4 - Home first/discharge to assess Q4 18/19	G15	Yes
Chg 5 - Seven-day service Q4 18/19	G16	Yes
Chg 6 - Trusted assessors Q4 18/19	G17	Yes
Chg 7 - Focus on choice Q4 18/19	G18	Yes
Chg 8 - Enhancing health in care homes Q4 18/19	G19	Yes
UEC - Red Bag scheme Q4 18/19	G23	Yes
Chg 1 - Early discharge planning, if Mature or Exemplary please explain	H12	Yes
Chg 2 - Systems to monitor patient flow, if Mature or Exemplary please explain	H13	Yes
Chg 3 - Multi-disciplinary/agency discharge teams, if Mature or Exemplary please explain	H14	Yes
Chg 4 - Home first/discharge to assess, if Mature or Exemplary please explain	H15	Yes
Chg 5 - Seven-day service, if Mature or Exemplary please explain	H16	Yes
Chg 6 - Trusted assessors, if Mature or Exemplary please explain	H16	Yes
Chg 7 - Focus on choice, if Mature or Exemplary please explain	H17	Yes
Chg 8 - Enhancing health in care homes, if Mature or Exemplary please explain	H18	Yes
UEC - Red Bag scheme, if Mature or Exemplary please explain	H23	Yes
Chg 1 - Early discharge planning Challenges	I12	Yes
Chg 2 - Systems to monitor patient flow Challenges	I13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Challenges	I14	Yes
Chg 4 - Home first/discharge to assess Challenges	I15	Yes
Chg 5 - Seven-day service Challenges	I16	Yes
Chg 6 - Trusted assessors Challenges	I17	Yes
Chg 7 - Focus on choice Challenges	I18	Yes
Chg 8 - Enhancing health in care homes Challenges	I19	Yes
UEC - Red Bag Scheme Challenges	I23	Yes
Chg 1 - Early discharge planning Additional achievements	J12	Yes
Chg 2 - Systems to monitor patient flow Additional achievements	J13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Additional achievements	J14	Yes
Chg 4 - Home first/discharge to assess Additional achievements	J15	Yes

Chg 5 - Seven-day service Additional achievements	J16	Yes
Chg 6 - Trusted assessors Additional achievements	J17	Yes
Chg 7 - Focus on choice Additional achievements	J18	Yes
Chg 8 - Enhancing health in care homes Additional achievements	J19	Yes
UEC - Red Bag Scheme Additional achievements	J23	Yes
Chg 1 - Early discharge planning Support needs	K12	Yes
Chg 2 - Systems to monitor patient flow Support needs	K13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Support needs	K14	Yes
Chg 4 - Home first/discharge to assess Support needs	K15	Yes
Chg 5 - Seven-day service Support needs	K16	Yes
Chg 6 - Trusted assessors Support needs	K17	Yes
Chg 7 - Focus on choice Support needs	K18	Yes
Chg 8 - Enhancing health in care homes Support needs	K19	Yes
UEC - Red Bag Scheme Support needs	K23	Yes

Sheet Complete:	Yes

5. Income and Expenditure

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	Cell Reference	Checker
Do you wish to change your additional actual CCG funding?	G14	Yes
Do you wish to change your additional actual LA funding?	G15	Yes
Actual CCG Add	H14	Yes
Actual LA Add	H15	Yes
Income commentary	D21	Yes
Do you wish to change your BCF actual expenditure?	E28	Yes
Actual Expenditure	C30	Yes
Expenditure commentary	D32	Yes

Sheet Complete:	Yes

6. Year End Feedback

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	Cell Reference	Checker
Statement 1: Delivery of the BCF has improved joint working between health and social care	C10	Yes

Statement 2: Our BCF schemes were implemented as planned in 2018/19	C11	Yes
Statement 3: Delivery of BCF plan had a positive impact on the integration of health and social care	C12	Yes
Statement 4: Delivery of our BCF plan has contributed positively to managing the levels of NEAs	C13	Yes
Statement 5: Delivery of our BCF plan has contributed positively to managing the levels of DToC	C14	Yes
Statement 6: Delivery of our BCF plan ihas contributed positively to managing reablement	C15	Yes
Statement 7: Delivery of our BCF plan has contributed positively to managing residential admissions	C16	Yes
Statement 1 commentary	D10	Yes
Statement 2 commentary	D11	Yes
Statement 3 commentary	D12	Yes
Statement 4 commentary	D13	Yes
Statement 5 commentary	D14	Yes
Statement 6 commentary	D15	Yes
Statement 7 commentary	D16	Yes
Success 1	C22	Yes
Success 2	C23	Yes
Success 1 commentary	D22	Yes
Success 2 commentary	D23	Yes
Challenge 1	C26	Yes
Challenge 2	C27	Yes
Challenge 1 commentary	D26	Yes
Challenge 2 commentary	D27	Yes

Sheet Complete:	Yes

7. Narrative

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	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

8. Additional improved Better Care Fund: Part 1

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	Cell Reference	Checker

A1) Do you wish to revise the percentages provided at Q1 18/19?	C14	Yes
A2) a) Revised meeting adult social care needs	D17	Yes
A2) b) Revised reducing pressures on the NHS	E17	Yes
A2) c) Revised ensuring that the local social care provider market is supported	F17	Yes
A3) Success 1	C23	Yes
A3) Success 2	D23	Yes
A3) Success 3	E23	Yes
A4) Other commentary 1	C24	Yes
A4) Other commentary 2	D24	Yes
A4) Other commentary 3	E24	Yes
A5) Commentary 1	C25	Yes
A5) Commentary 2	D25	Yes
A5) Commentary 3	E25	Yes
A6) Challenge 1	C28	Yes
A6) Challenge 2	D28	Yes
A6) Challenge 3	E28	Yes
A7) Other commentary 1	C29	Yes
A7) Other commentary 2	D29	Yes
A7) Other commentary 3	E29	Yes
A8) Commentary 1	C30	Yes
A8) Commentary 2	D30	Yes
A8) Commentary 3	E30	Yes
B1) Initative 1: Progress	C37	Yes
B1) Initative 2: Progress	D37	Yes
B1) Initative 3: Progress	E37	Yes
B1) Initative 4: Progress	F37	Yes
B1) Initative 5: Progress	G37	Yes
B1) Initative 6: Progress	H37	Yes
B1) Initative 7: Progress	I37	Yes
B1) Initative 8: Progress	J37	Yes
B1) Initative 9: Progress	K37	Yes
B1) Initative 10: Progress	L37	Yes
B2) Initative 1: Commentary	C38	Yes

B2) Initative 2: Commentary	D38	Yes
B2) Initative 3: Commentary	E38	Yes
B2) Initative 4: Commentary	F38	Yes
B2) Initative 5: Commentary	G38	Yes
B2) Initative 6: Commentary	H38	Yes
B2) Initative 7: Commentary	I38	Yes
B2) Initative 8: Commentary	J38	Yes
B2) Initative 9: Commentary	K38	Yes
B2) Initative 10: Commentary	L38	Yes

Sheet Complete:	Yes

9. Additional improved Better Care Fund: Part 2

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	Cell Reference	Checker
C1) a) Actual number of home care packages	C11	Yes
C1) b) Actual number of hours of home care	D11	Yes
C1) c) Actual number of care home placements	E11	Yes
C2) Main area spent on the addition iBCF funding allocation for 2018/19	C12	Yes
C3) Main area spent on the addition iBCF funding allocation for 2018/19 - Commentary	C13	Yes
Metric 1: D1) Additional Metric Name	C20	Yes
Metric 2: D1) Additional Metric Name	D20	Yes
Metric 3: D1) Additional Metric Name	E20	Yes
Metric 4: D1) Additional Metric Name	F20	Yes
Metric 5: D1) Additional Metric Name	G20	Yes
Metric 1: D2) Metric category	C21	Yes
Metric 2: D2) Metric category	D21	Yes
Metric 3: D2) Metric category	E21	Yes
Metric 4: D2) Metric category	F21	Yes
Metric 5: D2) Metric category	G21	Yes
Metric 1: D3) If other category, then detail	C22	Yes
Metric 2: D3) If other category, then detail	D22	Yes
Metric 3: D3) If other category, then detail	E22	Yes
Metric 4: D3) If other category, then detail	F22	Yes

Metric 5: D3) If other category, then detail	G22	Yes
Metric 1: D4) Metric performance	C23	Yes
Metric 2: D4) Metric performance	D23	Yes
Metric 3: D4) Metric performance	E23	Yes
Metric 4: D4) Metric performance	F23	Yes
Metric 5: D4) Metric performance	G23	Yes

Sheet Complete:	Yes

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Better Care Fund Template Q4 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 (DD/MM/YYYY)**
Have the funds been pooled via a s.75 pooled budget?	Yes		

Better Care Fund Template Q4 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 metrics
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	Not on track to meet target	we met the target in Q3 but it looks as though it won't be met in Q4 - January in particular being a difficult month for the system.	June - 2,684, July 2,804, August 2,766, Sept 2756, Oct 2,921, Nov 2933, Dec 2884, Jan 3189, Feb, 2950	n/a
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	Growth in older population numbers and life expectancy is likely to extend the length of dependent support and to present more complex cases. Enabling people to live at home independently for longer, thus	Continued long - term reduction in the rate of admissions continues.	n/a
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	Shropshire Council has migrated from Care First to Liquid Logic and there is a delay in reporting for December - March	expected to be well below target	n/a
Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	On track to meet target	n/a	Sustained improvement has been made across all service areas. There has been a marked improvement in the reduction of joint delays.	National co-operation of out of area trusts to ensure correct processes are followed to prevent mis-reporting and unnecessary delays

Better Care Fund Template Q4 2018/19

4. High Impact Change Model

Selected Health and Wellbeing Board: Shropshire

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

							Narr
		Q1 18/19	Q2 18/19	Q3 18/19 (Current)	Q4 18/19 (Current)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges
Chg 1	**Early discharge planning**	Established	Established	Established	Established		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.
Chg 2	**Systems to monitor patient flow**	Established	Established	Established	Established		Workforce challenges and heavy reliance on agency staff restricts provider ability to embed the required systems and processes to support early supported discharge sustainably.
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Mature	Mature	Mature	Mature	Multidiscipliary 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 mental health.	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
Chg 4	**Home first/discharge to assess**	Mature	Mature	Mature	Mature	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 care 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

Chg 5	**Seven-day service**	Not yet established	Not yet established	Plans in place	Established		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 to implementation will signficantly contribute to an improved workforce position.
Chg 6	**Trusted assessors**	Established	Mature	Mature	Mature	integrated assessment teams work together appropriately; resources are accessed by a singel assessment; confidence and trust increaseing across organisations	challenges are being over come by working collaboratively, governance through the discharge to assess working group
Chg 7	**Focus on choice**	Plans in place	Established	Established	Established		Challenges will be worked through the A&E delivery group
Chg 8	**Enhancing health in care homes**	Established	Established	Established	Established		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 targetted for maximum impact.

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 ca						
	Q1 18/19	**Q2 18/19**	**Q3 18/19**	**Q4 18/19 (Current)**	**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**

UEC	**Red Bag scheme**	Not yet established	Not yet established	Plans in place	Established		time contraints, engaging with whole system - work in progress. And very positive response

ative	
Milestones met during the quarter / Observed impact	**Support needs**
EDDs in place within 48 hours, Audit evidence on 75+ achievement of date set, embedded check chase challenge, safer bundle, red to green, criteria led discharge	n/a
sufficient capacity to meet demand	n/a
Accurate FFAs completed within 24 hours ; Embed Independent Assessor role for care homes; currently in place for RSH	n/a
Consistent desired ratio splits of 60% P1, 30% P2, 10%; Embed Independent Assessor role for care homes; currently in place for RSH	n/a

7 day availability of GP appointments has been established. Consistent DLNs on both sites at weekendsSystems and processes in place to ensure target discharge numbers over 7 days (Discharge Teams; clinical staff for reviewing; ensuring planned discharges take place)	n/a
Care Act – 'notice for assessment' and 'discharge notice' incorporated into pathways/revision of FFAs, DTOC definitions and processes.	n/a
Available Patient information explained consistently to patients and carers from admission	n/a
Out of Hospital care model (Shropshire) and Care Home MDT (T&W) in place. CHAS in place (Shropshire) Red Bag scheme rolled out	n/a

are settings and hospital.	
Achievements / Impact	**Support needs**

working through engagement across the system; care homes in place, bags purchased, documentation is ready, additional training and engagement needed with hospital staff at A&E and on wards	n/a

Better Care Fund Template Q4 2018/19

5. Income and Expenditure

Selected Health and Wellbeing Board: Shropshire

Income

	2018/19	
Disabled Facilities Grant	£ 2,974,155	
Improved Better Care Fund	£ 8,288,253	
CCG Minimum Fund	£ 20,021,004	
Minimum Sub Total		£ 31,283,412

	Planned	
CCG Additional Fund	£ -	
LA Additional Fund	£ 2,482,127	
Additional Sub Total		£ 2,482,127

Actual		
Do you wish to change your additional actual CCG funding?	No	
Do you wish to change your additional actual LA funding?	No	
		£ -

	Planned 18/19	Actual 18/19
Total BCF Pooled Fund	£ 33,765,539	£ 31,283,412

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2018/19	

Expenditure

	2018/19
Plan	£ 38,999,563

Do you wish to change your actual BCF expenditure?	No

Actual	

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2018/19	

Better Care Fund Template Q4 2018/19

6. Year End Feedback

Selected Health and Wellbeing Board: Shropshire

Part 1: Delivery of the Better Care Fund Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.		
Statement:	Response:	Comments: Please detail any further supporting information for each response
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	BCF drives regular, joint working
2. Our BCF schemes were implemented as planned in 2018/19	Agree	schemes implemented as planned
3. The delivery of our BCF plan in 2018/19 had a positive impact on the integration of health and social care in our locality	Agree	n/a
4. The delivery of our BCF plan in 2018/19 has contributed positively to managing the levels of Non-Elective Admissions	Neither agree nor disagree	demand continues to outstrip the supply based on our planning assumptions. For the next year we are enhancing our admissio
5. The delivery of our BCF plan in 2018/19 has contributed positively to managing the levels of Delayed Transfers of Care	Strongly Agree	DTOC best in West Midlands
6. The delivery of our BCF plan in 2018/19 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Agree	n/a
7. The delivery of our BCF plan in 2018/19 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)	Agree	n/a

Part 2: Successes and Challenges Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing. Please provide a brief description alongside.		
8. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2018/19.	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes

Success 1	5. Integrated workforce: joint approach to training and upskilling of workforce	Frailty at the front door
Success 2	8. Pooled or aligned resources	Individual

9. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2018/19.	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges
Challenge 1	5. Integrated workforce: joint approach to training and upskilling of workforce	more work to be done with community provision regarding admission avoidance
Challenge 2	1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rurual factors)	system funding deficit, challenge in delivering in a rural settings

Footnotes:

Question 8, 9 and 10 are should be assigned to one of the following categories:

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rurual factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Other

Better Care Fund Template Q4 2018/19

7. Narrative

Selected Health and Wellbeing Board: Shropshire

Remaining Characters:	16,657

Progress against local plan for integration of health and social care

The STP ensures that the BCF High Impact Changes across T&W and Shropshire are considered collectively through the Frailty Board.
We continue to utilize our updated Partnership Agreement (section 75) and to bolster this agreement we have developed a draft statement of intent which further strengthens our commitment to work together on a number of key schemes including:
- Continuing Healthcare
- Complex cases (including children and young people)
- Out of hospital programme
- Integrated Community Service (ICS)
- Estate planning
- Connection with Primary Care including Social prescribing and other community referral options

Prevention:
- Developing our STP Population Health Management approach (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. Working now to connect the model of Social Prescribing with the development of Primary Care Networks.

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.

Remaining Characters:	18,838

Integration success story highlight over the past quarter

scheme - 2 carers in a car operates throughout the night (10-7am) to quickly support people who need it during those hours. The intention is to reduce the number of peole who need to go into hospital through care support needs during the night.What are the benefits?
Support for people to stay at home,
Support people to have choices for night support
Less admissions into residential care
Improve hospital discharges
Improve admission avoidance
Support our Emergency duty team
Support the out of hours GP service
Reduce pressure on ambulance services
Value for money
56% referrals come from hospitals and GPS
32% of people have gone on to be self supporting
25% of people supported have been discharged from hospital or have avoided admission

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 Q4 2018/19

8. Additional improved Better Care Fund: Part 1

Selected Health and Wellbeing Board:	Shropshire
Additional improved Better Care Fund Allocation for 2018/19:	£ 3,959,448

Section A

Distribution of 2018/19 Additional iBCF funding by purpose

At Q1 18/19, it was reported that your additional 2018-19 iBCF funding would be allocated across the three purposes for which it was intended as follows:	a) Meeting adult social care needs	b) Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready	c) Ensuring that the local social care provider market is supported
(Percentages shown in these cells are automatically populated based on Q1 18/19 return):	38%	57%	5%

A1) Do you wish to revise the percentages provided at Q1 18/19 as shown above? Please select "Yes" or "No" using the drop-down options:	Yes

	a) Meeting adult social care needs	b) Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready	c) Ensuring that the local social care provider market is supported	If submitting revised figures, percentages must sum to 100% exactly
A2) If you have answered 'Yes' to Question A1, please enter the revised amount for each purpose as a percentage of the additional iBCF funding you have been allocated for the whole of 2018/19. If the expenditure covers more than one purpose, please categorise it according to the primary purpose. You should ensure that the sum of the percentage figures entered totals to 100% exactly. If you have not designated any funding for a particular purpose, please enter 0% and do not leave a blank cell. If you have answered "No" to Question A1, please leave these cells blank.	31%	62%	7%	100%

Successes and challenges associated with additional iBCF funding in 2018/19

Success 1	Success 2	Success 3

A3) Please use the options provided to identify your 3 key areas of success associated with the additional iBCF funding during 2018/19. Hover over this cell to view the comment box for the list of options if the drop-down menu is not visible. Aside from "Other", please do not select an option more than once.	Reducing DTOC	Reablement	Partnership working with the NHS
A4) If you have answered Question A3 with 'Other', please specify. Please do not use more than 50 characters.			
A5) You can add some brief commentary on your key successes if you wish. Please do not use more than 200 characters.			

	Challenge 1	Challenge 2	Challenge 3
A6) Please use the options provided to identify your 3 key areas of challenge associated with the additional iBCF funding during 2018/19. Hover over this cell to view the comment box for the list of options if the drop-down menu is not visible. Aside from 'Other', please do not select an option more than once.	Workforce – recruitment	Tackling capacity within the local care market	Stabilising the local care market
A7) If you have answered Question A6 with 'Other', please specify. Please do not use more than 50 characters.			
A8) You can add some brief commentary on your key successes if you wish. Please do not use more than 200 characters.			

Section B

At Q1 18/19 it was reported that your additional iBCF funding would be used to support the following initiatives/projects in 2018/19

Initiative / Project 1	Initiative / Project 2	Initiative / Project 3	Initiative / Project 4	Initiative / Project 5	Initiative / Project 6

Project title (automatically populated based on Q1 18/19 return):	Continuation	Continuation	Continuation	Maintain existing preventative services that would not otherwise be able to be supported due to budget pressures within the Council	Continuation	Continuation
Project category (automatically populated based on Q1 18/19 return)	3. DTOC: Reducing delayed transfers of care	3. DTOC: Reducing delayed transfers of care	2. Expenditure to improve efficiency in process or delivery	11. Prevention	3. DTOC: Reducing delayed transfers of care	3. DTOC: Reducing delayed transfers of care
B1) If a project title is shown in either of the two rows above, use the drop-down options provided or type in one of the following options to report on progress to date: Planning stage In progress: no results yet In progress: showing results Completed Project no longer being implemented	In progress: showing results	In progress: showing results	In progress: showing results	In progress: showing results	In progress: showing results	In progress: showing results
B2) You can add some brief commentary on your projects if you wish. Please do not use more than 200 characters.						

Initiative / Project 7	Initiative / Project 8	Initiative / Project 9	Initiative / Project 10

Continuation	Continuation	Continuation	Continuation
9. NHS: Reducing pressure on the NHS	1. Capacity: Increasing capacity	3. DTOC: Reducing delayed transfers of care	9. NHS: Reducing pressure on the NHS
In progress: showing results	In progress: showing results	In progress: showing results	In progress: showing results

Better Care Fund Template Q4 2018/19

9. Additional improved Better Care Fund: Part 2

Selected Health and Wellbeing Board:	Shropshire
Additional improved Better Care Fund Allocation for 2018/19:	£ 3,959,448

Section C

We want to understand how much additional capacity you have been able to purchase / provide in 2018-19 as a direct result of your additional iBCF funding allocation for 2018-19 and, where the iBCF has additionality, to understand why this is the case. Recognising that figures will vary across areas due to wider budget and service planning assumptions, please provide the following:

	a) The number of home care packages provided in 2018/19 as a result of your addition iBCF funding allocation	b) The number of hours of home care provided in 2018/19 as a result of your additional iBCF funding allocation	c) The number of care home placements for the whole of 2018/19 as a result of your additional iBCF funding allocation
C1) Provide figures on the actual number of home care packages, hours of home care and number of care home placements you purchased / provided as a direct result of your additional iBCF funding allocation for 2018-19. The figures you provide should cover the whole of 2018-19. Please use whole numbers with no text, if you have a nil entry please enter 0 in the appropriate box.	112	13176	234

C2) If you have not increased the number of packages or placements, please indicate **the main area** that you have spent the **addition iBCF funding allocation** for 2018/19. Hover over this cell to view the comment box for the list of options if the drop-down menu is not visible.	
C3) If you have answered C2 with 'Other', please specify. Please do not use more than 50 characters.	

Section D

Metrics used locally to assess impact of additional iBCF funding 2018/19

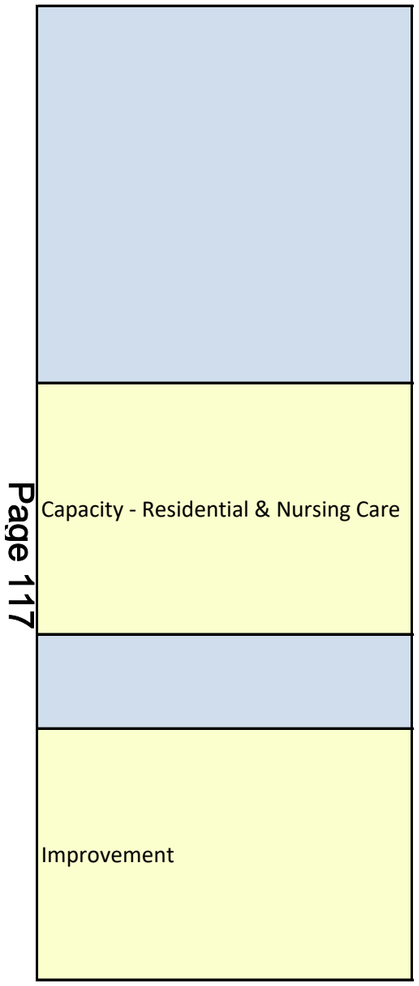
At Q1 18/19 it was reported that the following metrics would be used locally to assess the impact of the additional iBCF funding. (Metrics are automatically populated based on Q1 18/19 return)

	Metric 1	Metric 2	Metric 3	Metric 4
Metric (automatically populated based on Q1 18/19 return):	Reduction in Delayed Transfers of Care	Increase in number of people discharged from hospital within 48 hours	Reduction in hospital re-admission	Increase in Admission Avoidance

D1) Additional Metric Name **If the cell above is blank, you can provide details of an additional metric. If you did not submit any metrics at Q1 18/19, please ensure you have provided details of at least one metric. You can provide details of up to 5 metrics in total based on your combined Q1 18/19 and Q4 18/19 returns e.g. if you submitted 3 metrics at Q1 18/19, you can submit an additional 2 metrics.** Please do not use more than 100 characters to describe any additional metrics.				
D2) If a metric is shown in either of the two rows above, use the drop-down menu provided or type in one of the categories listed to indicate which of the following categories the metric primarily falls under. Hover over this cell to view the comment box for the list of categories if drop-down options are not visible.	DTOC/Discharge	DTOC/Discharge	Reducing NHS Pressures	Reducing NHS Pressures
D3) If you have answered D2 with 'Other', please specify. Please do not use more than 50 characters.				
D4) If a metric is shown above, use the drop-down options provided or type in one of the following options to report on the overall direction of travel during the reporting year: Improvement No change Deterioration Not yet able to report	Improvement	Improvement	Improvement	Improvement

s not provided any such

Metric 5
Reduction in Long Term Admissions to Residential Care


Capacity - Residential & Nursing Care
Improvement

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Health and Wellbeing Board
Meeting Date 23rd May 2019

Item Title: HWBB Joint Commissioning Report – Healthy Lives Update

Responsible Officer: Val Cross, Health and Wellbeing Officer/Healthy Lives Co-ordinator
Email: val.cross@shropshire.gov.uk

1.0 Summary

1.1This report provides updates for theHealthy Lives, Programme the Partnership Prevention Programme of the Health and Wellbeing Board.

1.2 It includes information about developments and partnership working for; Cardio-Vascular Disease (CVD) risk prevention, Physical Activity, Social Prescribing and the Shropshire Food Poverty Alliance. It also highlights specific identified risks from the Healthy Lives Risk Register, and describes the recent Patient Activation Measure (PAM) workshop.

2.0 Recommendations

That the Board notes the ongoing work and notes the risks to the Healthy Lives Programme as the prevention programme of the Health and Wellbeing Board.

REPORT

3.0 Background

3.1 Healthy Lives is the name of the prevention programme of the Health and Wellbeing Board. Partners across health, social care and the voluntary and community sector are working together proactivelyrather than in isolation, to reach Shropshire's residents before their health or condition develops or gets worse.

3.2 Healthy Lives is a proactive and reactive programme, where these partner organisations are combining to innovate, make the best use of their human and monetary resources, and individual knowledge and expertise to help make a difference to Shropshire people. Evidence base is used for in all Healthy Lives work. Figure 1 illustrates some of the main partners.

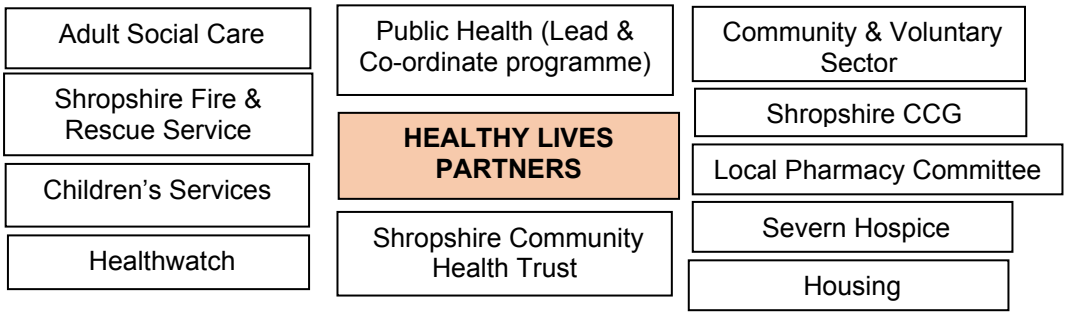

Fig. 1 Examples of Healthy Lives Partners for illustrative purposes

4.0 Programme updates

4.1 Physical activity

4.1.1 *Elevate*
The total number of referrals to these classes are 502. (449 reported at last meeting) 66% are self-referrals and 38% are partner referrals from sources such as; the Fall Team, Physiotherapy, GP practices, Social Prescribing, Community and Care Coordinators and Functional Fitness MOT events.
23 classes have started, and 12 classes (these are 20 week classes) have been completed.
70% of participants assessed at 20 weeks showed a reduction in falls risk through improved physical function, as measured by the 'Timed Up and Go' Score.

4.1.2 Functional Fitness (FF) MOT events
On behalf of Public Health, Shropshire RCC has held FF MOT events in Bishops Castle, Albrighton, Oswestry, Ludlow, Shrewsbury Town Centre and Harlescott. A total of 113 clients attended the six FF MOT events. Their ages ranged from 65 to 95.
30% of participants had below their age-average functional fitness test scores that indicate falls risk, such has 'Timed Up and Go' and 'Sit to Stand'. At a 3 month follow up, 25% of clients reported that they had joined an exercise class within six weeks of attending the FF MOT event and a further 23% said that they intended to start a new class. Further FF MT events are planned in Market Drayton and Craven Arms.

4.2 Cardio-Vascular Disease (CVD) risk prevention AliveCor Kardia Atrial Fibrillation (AF) testing

4.2.1 122 people have been screened to date in Shropshire Pharmacies. Further training is being planned and delivered, which will give greater opportunity for people to be screened countywide.
This has enabled people with abnormal readings to seek help earlier, rather than later, and is a good example of a public health 'upstream' approach.

4.2.2 The AF device is being used at some outlying Shropshire General Practices where there is an indication of a low observed prevalence of AF, compared with expected prevalence according to the National Cardiovascular Intelligence Network (***NCVIN***). Use of the device is supplementary to the NHS Health Check manual pulse check, and lets patients check their risk of AF. The onscreen visual heart rhythm display reinforces the value of cardiovascular health.

4.2.3 One AF device has been placed in a community setting in a small Shropshire rural town for people to use opportunistically in partnership with the NHS Health check lead from the local GP Practice. Staff training has been provided, including advice and guidance for those with an abnormal reading. Within a short period, abnormalities have already been detected.

4.3 Social Prescribing

4.3.1 There have been a total of 470 referrals to the service so far.

4.3.2 A Social Prescribing (SP) event with SP Advisors and the organisations providing SP interventions, was held on the 9th of April and attended by 19 people. This was a positive event which enabled networking, information sharing and building of working relationships.

4.3.3 Mental health referrals are currently the most common reason for opportunistic referral to Social Prescribing, with risk of loneliness and isolation the second highest. Advisors have reported that the mental health referrals they are receiving are becoming more complex and challenging. As the

criteria for Social Prescribing referral is low level mental health difficulty and anxiety, this is worth the Board noting in terms of availability of mental health support for people.

4.4 Shropshire Food Poverty Alliance

4.4.1 £10,000 of surplus grant funding was identified, and agreed to be transferred to the Shropshire Food Poverty Alliance through the Healthy Lives Steering Group. This will be used as a means for the Alliance to implement their Action Plan. A Memorandum of Understanding (MOU) has been agreed and signed, and reporting on progress will come back to the Steering Group.

5.0 Healthy Lives Risks

5.1 The Healthy Lives Programme Risk Register is regularly reviewed. At the last Healthy Lives Steering Group meeting, risks identified included:

5.1.1 Savings to the future Public Health budget and a proposed restructure are likely to result in changes to the design and delivery of the Healthy Lives programme. Discussions with partners are continuing to ensure the programme keeps moving forward.

5.1.2 Implementation of the Shropshire All-Age Carers Strategy needs to progress with a greater understanding of the support that will be of most value to carers. The council plans to undertake a deep dive review of the current support for carers with the involvement of partners and carers. The Implementation of the Dementia Strategy has been affected by a long term vacancy in the Dementia Lead officer role. This post has now been recruited to.

5.1.3 Shropshire's Social Prescribing (SP) programme is a priority for the system and is currently delivered through 11 GP practices, receiving referrals from a number of agencies. The local authority has committed to the long term support of the infrastructure of the programme including leadership, data gathering, directories, contracting with the voluntary and community sector and lead advisor. Discussions have begun with Shropshire CCG and GPs in the county regarding the potential for bringing together the current SP model with the opportunity the new Primary Care Networks will have to access funding for SP Link Workers to ensure that the model can grow and develop across the county. Integral to the model will be continued joint working across the system with primary care and the voluntary and community sector, amongst many other local partners –

5.1.4 Ensuring close links between Healthy Lives activity and links to Shropshire Care Closer to Home (SCCtH) is important, particularly in Phase 2 of the programme. The Phase 2 pilot implementation will start in June 2019 and the operational leads are including Healthy Lives leads in their discussions about each local pilot.

6.0 Patient Activation Measure (PAM) workshop held 28/03/19

6.1 NHS England is working with partners to understand how patient activation can lead to more personalised care. 'Patient activation' describes the knowledge, skills and confidence a person has in managing their own health and care. Evidence shows that when people are supported to become more activated, they benefit from better health outcomes, improved experiences of care and fewer unplanned care admissions[1].

6.2 The PAM tool is already being used with patients referred for Social Prescribing in Shropshire, who have long term conditions, i.e. CVD and pre-diabetes.

6.3 Shropshire has successfully obtained 3,500 licences, and a desire to use these collaboratively across the system, resulted in a multi-agency workshop in March 2019.

6.4 There was good representation across services including; Shropshire CCG, SaTH, GPs, the Voluntary and Community Sector, Adult Social Care and Public Health in Shropshire Council. The context of PAM was presented, and three discussion groups answered three questions; which patient groups would it be useful for**?** Where could this tool be used? and how will we implement it across the system?

6.5 Outcomes of the workshop were as follows:

- Agreed formation of a small project group to implement PAM into 8 x GP Practices as a pilot. The group will have representatives from; Shropshire CCG, Shropshire Community Health Trust, Shropshire Council Public Health and the Voluntary and Community Sector

[1] https://www.england.nhs.uk/ourwork/patient-participation/self-care/patient-activation/

- The Project Group updates will be provided by a representative/s at the Healthy Lives Steering Group meeting
- A PAM interest group for those who attended the workshop, and those who expressed interest but were unable to attend, has been created electronically, so everyone is kept in the loop with PAM developments.

7.0 Conclusions

7.1 Excellent work is continuing through the Healthy Lives Prevention Programme, but the HWBB are asked to note the risks identified in 5.0 and continue to support the Programme.

8.0 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.

9.0 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)
Cabinet Member (Portfolio Holder) Cllr. Dean Carroll Portfolio Holder for Adult Services, Health and Housing
Local Member
Appendices

Health and Wellbeing Board
Meeting Date

Responsible Officer:
Mr. David Stout, Accountable Officer, Shropshire Clinical Commissioning Group
Mr. David Evans, Accountable Officer, Telford & Wrekin Clinical Commissioning Group

Email: david.stout3@nhs.net **Telephone: 01743 277500**

1. Summary

The purpose of this report is to brief the Health and Wellbeing Board on the recent decision by Shropshire CCG and Telford and Wrekin CCG to dissolve the existing two organisations, with a view to creating one single strategic commissioner across the Shropshire and Telford and Wrekin footprint.

In November 2018 NHS England (NHSE) set a new running cost savings target of 20% for CCG's to attain by the end of the financial year 2019/20 Following this announcement in January 2019, the NHS Long Term Plan was published setting out key ambitions for the service over the next 10 years. The long term plan included the requirement to streamline commissioning organisations with typically one commissioner for each STP/Integrated Care System. In response to these announcements and with NHSE support, Shropshire CCG and Telford & Wrekin CCG carried out separate facilitated sessions and then a joint session early in 2019 to begin exploring the appetite for and mechanisms required to support closer working. These sessions were positively received and resulted in a firm commitment to explore the formation of a strategic commissioning organisation to cover the entire country.

This report sets out the proposal that both CCG Governing Bodies considered and agreed at their recent Board meetings regarding future working arrangements within the context of the likely changes to the NHS landscape in the next few years and NHSE's requirements regarding running cost savings.

2. Recommendations

The Health and Wellbeing Board is asked to note the content of the report.

3. Risk Assessment and Opportunities Appraisal

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

4. Financial Implications

- Future working arrangements are a key consideration in the financial and clinical sustainability of the CCG's going forward.
- Future working arrangements will impact on future resources required by the CCG's

5. Background

Set out in the report

6. Additional Information

- Clinical engagement will be key in moving forward with and shaping future working arrangements
- It is likely that a programme of engagement with the populations of both Shropshire and Telford and Wrekin CCGs will be required

7. Conclusions

Set out in the report

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder)
Local Member
Appendices "Procedures for Clinical Commissioning Groups to apply for Constitution change, merger or dissolution" (NHSE)

Shropshire Health and Wellbeing Board meeting 23rd May 2019

Single Strategic Commissioner for Shropshire, Telford and Wrekin

David Stout, Accountable Officer, Shropshire CCG

David Evans, Accountable Officer, Telford & Wrekin CCG

Introduction

1. The NHS is now in a period of transition with new emerging concepts of the role of commissioner and provider organisations. CCGs must respond flexibly to the new landscape and consider where best to focus clinical and managerial leadership and how they can adapt and interface with their local Sustainability and Transformation Partnership to transform into a commissioning organisations fit for this future. The recently published NHS Long Term Plan reinforces this direction of travel.

2. In addition CCGs have been tasked with making 20% reductions in their running costs by the end of the financial year, 2019/2020.

3. This report is to brief the Health and Wellbeing Board on the recent decision by Shropshire CCG and Telford and Wrekin CCG to dissolve the existing two organisations with a view to creating one single strategic commissioner across Shropshire and Telford and Wrekin footprint.

Report

4. With NHS England (NHSE) support, Shropshire and Telford & Wrekin CCGs carried out separate facilitated sessions and then a joint session early in 2019, to begin exploring the appetite for and mechanisms required for closer working. These sessions were positively received and resulted in a commitment to explore this further, including the formation of a new single strategic commissioning organisation.

5. In order to ensure it is fit for purpose, remains efficient and effective and can best serve its population, Shropshire CCG must consider the most appropriate organisational form for strategic commissioning going forward. Discussions have included both options of closer working; informal working using joint management and collaborative mechanisms whilst still retaining two statutory bodies and the alternative of dissolving the two CCGs and creating one new strategic commissioning organisation.

6. To meet the 20% reduction in running costs*, the total reduction in allocations between 2018/19 and 2019/20 is £1.218m across both CCG's (£0.775m Shropshire and £0.443 for T&W). Although the first option has some benefits, it was felt that the efficiencies both CCGs could achieve by stripping out all the duplication of effort, time and staff resource currently used to commission services and oversee contractual performance of the same providers would not be fully realised, as some duplication will still remain.

- The '20%' reduction quoted in the NHSE guidance is based on comparing 2019/20 allocations to 2017/18 outturns adjusting for pay awards , pension changes etc. and assumes that the CCGs are operating within their running cost allocations.

7. The conclusion of these discussions has been that the second option of dissolution of both CCGs and the creation of a new strategic commissioning organisation across the whole footprint of Shropshire, Telford and Wrekin will realise the following benefits:

    - It will immediately respond to the requirements set out in the NHS Long Term Plan for one strategic commissioner per STP area by allowing both CCGs to redesign a new organisation that will have the right capacity and capability to commission at a strategic level and also at a more local 'place' level.
    - It will allow duplication of staff time that is currently used to contract and oversee performance to be focused on other commissioning priorities, i.e. health inequalities/prevention.
    - By reducing duplication both CCGs will be well placed to reach the 20% running cost target set by NHS England.
    - Although creating uncertainty for staff in the short term, this option will provide a more sustainable future for our staff in the long term.

8. At recent CCG Board meetings, the Governing Bodies of both CCGs have given support to the creation of a single strategic commissioner for the Shropshire, Telford and Wrekin footprint.

9. Discussions have taken place with NHS England (NHSE) regarding the considerations for the CCG's in order to make this happen and NHSE have recently published new guidance entitled "Procedures for Clinical Commissioning Groups to apply for Constitution change, merger or dissolution" which are attached at Appendix 1.

10. In moving towards the creation of a single strategic commissioning organisation the following key elements must be considered:

    Timeline – NHS England's new guidelines have relaxed the timescales for applications to bring commissioning organisations together. Applications must now be made by 30 September preceding the April in which the change would take effect. It is proposed that the CCG support an application by 30 September 2019 with a view to a new strategic commissioning organisation taking effect on 1 April 2020.

    Whilst it is acknowledged that there is a significant amount of work involved in the planning, preparation and implementation of this, so far as it is possible, it is also considered that it would be most beneficial to all stakeholders, both internal and external, that this process is managed expeditiously, preferably to conclude for 1 April 2020.

    Recruitment of a single Accountable Officer – A key step in forming a single strategic commissioning organisation will be the recruitment of a single Accountable Officer early in the process to oversee its development. This should also include the early integration of the CCGs management teams.

    Resources – In line with NHSE guidance the CCGs will need to create a Programme Management Office (PMO) to oversee what will be a significant change programme.

    Updates – regular updates will be required by the Governing Body as the process is developed.

11. In order to meet the challenging timescales set out in NHS England guidance, both CCGs are now focusing on actioning the following:

    - Early recruitment of a single Accountable Officer and the early integration of management teams;

- Develop a timetable for the formation of the single strategic commissioning organization by April 2020; and
- Create a programme management office to oversee the programme.

As part of the development of a timetable for this work, we expect to schedule regular updates to the Health and Wellbeing Board on the design of a single strategic commissioning organisation and progress against the agreed timeline.

Recommendations

The Health and Wellbeing Board is asked to note the content of the report.

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Health and Wellbeing Board
Meeting Date

Item Title: Changes to Public Health within Shropshire Council

Responsible Officer: Andy Begley – Director of Adult Social Care, Housing and Health

Email: andy.begley@shropshire.gov.uk **Telephone:** 01743 258 911

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1. Summary

This paper provides an update on Public Health within Shropshire Council, following Council approval of the 2019/20 budget and Financial Strategy on 28th February 2019.

2. Recommendations

That the Health and Wellbeing Board notes the information provided in this report on changes to public health services and configuration of the team within Shropshire Council.
That the Health and Wellbeing Board endorse the ambition to redesign and co-produce a new model of public health delivery with Shropshire

REPORT

The gap in Government funding for social care, combined with reductions in the Public Health grant, is putting severe financial pressure on Shropshire Council and limiting its ability to fund non-mandatory services. The Revenue and Capital Budget 2019/20 approved by Council sets out the requirement to deliver savings of £2m through the recommissioning of services across Adults, Children's and Public Health Directorates. As a consequence, there is a need for the Council to achieve efficiency savings through improved integration of the Public Health function across the Council, decommission some non-mandated services and a see reduction in staffing.

Integration of the Public Health Function

The ambition is that there will be improved integration of public health across health and social care in Shropshire and that this model will be co-designed with partners.

In order to achieve the required savings, Public Health will no longer exist as a separate Directorate within Shropshire Council but will be integrated to form an Adults, Housing and Health Directorate. The Council's Public Health duties will be delivered through a Hub and Spoke model which will create greater connectivity and alignment with other Council services, support the delivery of a wide range of Health and Wellbeing priorities and demonstrate optimal return on Public Health investments.

Whilst there will be a reduction in core Public Health staff numbers in order to achieve financial efficiencies, the intention is that this new operating model will increase Public Health influence and achievement of outcomes, by building Public Health into every aspect of Council activity. A key objective of the changes will be to increase Public Health expertise across the Council.

There will be a particular focus on improving integration across health and social care and making better use of health and social care intelligence and evidence to drive prevention. This will include, the use of predictive analytics developed by Public Health will allow services to be targeted to need and help to reduce inequalities in Shropshire; a key requirement of the HWB Strategy.

Previous performance management metrics will be reviewed to produce a consolidated set of outcome measures that the Council can contribute to achieving as part of the wider system change across health and care in support of population health.

There will be a consistent approach to commissioning across the Council, taking account of Public Health outcomes, which will open up the opportunity to share functions with the health system and drive greater benefits from integration.

A staffing restructure is underway to achieve the integration of services and deliver efficiencies as outlined above.

There will be a series of changes to non-mandated services. These changes include:

- Help2Slim and Help2Quit to be decommissioned including public health financial contributions to prescription funding for tobacco dependency, opioid dependency and alcohol dependency.
- The Social Prescribing Programme and Smoking in Pregnancy services have been recognised as system priorities.
- Smoking in Pregnancy services will be funded for a fixed term period if a shared funding model can be agreed.
- A negotiated efficiency saving across contracts currently held in Public Health
- General working budget reductions across Public Health. It is anticipated that this will not have any direct impact on service delivery.
- End Public Health contributions to the CCTV service in Shrewsbury

3. Risk Assessment and Opportunities Appraisal

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

The requirement to achieve financial savings through the reconfiguration of Public Health forms part of the Council's financial strategy for 2019-20 to 2021-22, and has been approved by Cabinet on 28th February 2019. Recommendations from the Health and Adult Social Care Scrutiny Committee were considered by Cabinet before approving the changes.

The development and delivery of the Council's financial strategy is a key process in managing the Council's strategic risks. The opportunities and risks arising are assessed each time the document is refreshed for Cabinet consideration. The Council's strategic risks are reported separately, but the financial strategy makes specific reference to the Council's ability to set a sustainable budget (the highest of the Council's strategic risks).

The Revenue and Capital Budget 2019/20 approved by Council has taken into account the requirements of the Human Rights Act, any necessary environmental appraisals and the need

for Equality and Social Inclusion Impact Assessments (ESIIA) will form part of the consultation process.

Public Consultation on the 2018-19 Council savings proposals was launched on 25th October 2018 and the Budget Consultation relating to 2019-20 savings was launched on 8th January 2019. Detailed responses can be found in the listed background papers.

4. Financial Implications

Since April 2013, the Public Health services referred to in this report have been funded by the ring-fenced Public Health grant. The reconfiguration of Public Health, the integration of Public Health services within other Council Directorates and the resulting efficiency savings as detailed above, will allow for a substitution of the Public Health ring fenced grant to allow us to deliver on a wider range of public outcomes across a wider range of Council functions including; Emergency Planning, aspects of Environmental Health, Housing, Social Care prevention, Child Health Promotion and Leisure Services. Public Health outcomes against these areas will be formally agreed and monitored.

5. Conclusions

Further updates regarding the changes being implemented will be brought to the HWBB in due course and HWBB members are invited to work with Shropshire Council to co-design the model of public health moving forward. Shropshire Council are currently in conversation with colleagues within the CCG to ensure minimal disruption and maximise the impact of the changes.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) Public Health Grant 2018-2020 – Health & Adult Social Care Overview Scrutiny Committee 24th September 2018 Public Health Grant 2018-2020 Update report – Health & Adult Social Care Overview Scrutiny Committee 12th November 2018 Financial Strategy 2019-20 – 2021-22 – Cabinet 13th December 2018 Stop Smoking Services – Health & Adult Social Care Overview Scrutiny Committee 21st January 2019 Financial Strategy 2019-20 – 2023-24 – Council 28th February 2019
Cabinet Member (Portfolio Holder) Cllr Dean Carroll
Local Member n/a
Appendices n/a

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