Shropshire Community Health NHS
NHS Trust

SUMMARY REPORT	Meeting Date:	26 November 2015
	Agenda Item:	9.1
	Enclosure Number:	8

Meeting:	**Trust Board**		
Title:	**Transformation Report**		
Author:	**Vic Middlemiss, Deputy Director of Planning and Development**		
Accountable Director:	**Steve Gregory, Director of Nursing and Operations**		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/ Recommendation from that Committee**
	Resource and Performance Committee	23 November 2015	To be updated verbally, as relevant

Purpose of the report		
To update the Board on the current position with regard to key service transformation initiatives and developments which are being implemented or planned. This is a summarised version of the report to Resource and Performance Committee, with the business development content covered within Part 2 due to commercial sensitivity.	**Consider for Action**	✓
	Approval	
	Assurance	✓
	Information	✓

Strategic goals this report relates to:			
To deliver high quality care	**To support people to live independently at home**	**To deliver integrated care**	**To develop sustainable community services**
✓	✓	✓	✓

Summary of key points in report

- Appended is the Future Fit Senior Responsible Officer report for November, which includes an update on the status of the revised programme for the acute options.
- The report provides a summary of Community Fit and describes what Phase 1 of the project is seeking to achieve.
- The Full Business Case (FBC) for the EPR project is still with the TDA, having been submitted on the 26th August 2015. This causes a further delay in the project timeline; the main impact of which will be further condensing of the project deployment phase.
- The terms of reference of the Trust's Transformation Board are being revised and the report includes a description of the new scope and objectives of that group.
- Commissioning intention summaries are appended to the report. Board members are asked to review the documents and to highlight any particular observations or perceived risks.

Key Recommendations
The Board is asked to: • Review the Future Fit Senior Responsible Officer report and note particularly the status of the revised programme timeframe for the acute options. • Consider the update provided on Community Fit and the implications of this for the Trust • Note the current status of the Electronic Patient Record (EPR) business case • Receive the summary from the Transformation Programme Board • Review and provide feedback on the commissioning intentions summary documents.

Is this report relevant to compliance with any key standards? YES OR NO		**State specific standard or BAF risk**
CQC	NO	
IG Governance Toolkit	NO	
Board Assurance Framework	YES	Trust sustainability (ref 5-2014)

Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient safety & experience	NO	
Financial (revenue & capital)	YES	Variable according to value of individual development schemes
OD/ Workforce	YES	As above
Legal	NO	

Transformation Report

1. Introduction

This report updates the Board on significant transformation initiatives, some of which have transitioned from business developments having entered the implementation phase. It includes an update on major strategic projects in particular the Electronic Patient Record project and Future Fit initiative.

The content is aligned with trust corporate objectives, which are used as sub-headings as relevant.

2. Service Transformation

2.1 'Increased range of services'

2.1.1 Future Fit

Attached to this report as Appendix 1 is the Senior Responsible Officer report for November.

Board members are referred in particular to the update given on the revised programme timeframe. Since the October FF Programme Board meeting the Core Group has held a number of discussions, including with representatives of NHS England and NHS Trust Development Authority.

> 'Advice has also been received from NHS England's Project Appraisal Unit which supports the national Oversight Group for Service Change and Reconfiguration. These conversations highlight the difficulty in setting a comprehensive timetable to consultation in advance of the Department of Health and HM Treasury confirming the acceptability of the deficit reduction plan. They also note the limited availability of capital funds for which a number of schemes may find themselves competing.
>
> In the light of the advice received, the proposed revised critical path sets out the key pieces of work for the next phase and notes the risks around external approvals which are not within the Programme's control.'

Key to the development of a plan for the next phase are two critical interdependencies:

a) Developing a deficit reduction plan for the Local Health Economy, and;
b) Completing a revised Strategic Outline Case for acute services which prioritises the most pressing clinical challenges.

An overview of how the programme proposes to manage these independencies and the proposed revised programme timeline are scheduled as items for discussion at the November Future Fit Programme Board.

2.1.2 Community Fit

Community Fit has been set up as an independent programme from Future Fit. The project aims to enable safe transition from the current care model, which is heavily inpatient based, covering all aspects of care. Phase One of the project is underway and will produce a view of the activity that is currently being provided by linking health and social care data sets. Using the data from Future Fit modelling, overlaid on the Community Fit data, the programme will attempt to predict the future level of community activity necessary to support Future Fit.

Phase One of Community Fit is set to deliver the following outputs by February/ March 2016:

- A description of activity currently taking place in primary care, community services, mental health and social care across Shropshire and Telford and Wrekin.
- An agreed taxonomy (classification) of care packages delivered by each of these sectors
- An agreed estimate the impact of demographic change on activity levels within these sectors
- A linked health and social care dataset, identifying patients receiving care from two or more sectors and describing they care they receive
- A description of the activity that the Future Fit 1 models anticipate will move out of SaTH and therefore may have an impact on primary care, community services, mental health and social care services.

This work will be overseen by a steering group, chaired by Mike Innes (chair of Telford and Wrekin CCG). The steering group, which has met on three occasions, formally reports into the boards of Shropshire and Telford and Wrekin CCGs, who commissioned the work. It includes representatives from across health, social care and the voluntary sector involving a combination of local clinicians, patient representatives, Healthwatch and members from the sponsoring organisations. Midlands and Lancashire Commissioning Support Unit (CSU) are providing project management and oversight.

At this moment, Community Fit has not been commissioned beyond Phase One. There is a significant risk that the fully quantified and measured impact of the shift of care out of hospital under Future Fit, combined with the growing demand due to demography, will create an expectation amongst patients and providers that there will be future phases of the programme to respond to the anticipated rise in demand for community health and social care services. Sponsor boards are therefore being asked to take a view on the future requirements of this programme of work.

Community Fit is potentially very important for the Trust and its future development; so it is critical that Trust staff are closely engaged as the work progresses. Board members are asked to note that a specific workshop is being arranged in December; the aims of this will be to review and contribute to the discussion regarding how data extracted from the Community Trust is used to inform the overall modelling for phase one. The workshop will consist of an introduction and overview, followed by a first cut descriptive analysis of what the data is telling us. The CSU will then ask for feedback and also discuss how we account for some of the other factors which are likely to impact on workloads going forward. The workshop will be attended by managers and senior clinicians.

It is suggested that a further update is provided to the Board at the January meeting.

2.1.3 Community Hospitals Strategy

At the October informal board meeting, an hour long session was held on the community hospital strategy, facilitated by Andrew Ferguson, Director of Strategy. The content included an overview of the costs, estate utilisation, services provided, activity volumes and income for each of the hospitals. A connection was then made with the trust clinical strategy, recognising that clear inter-dependencies exist between the two. The final part of the session was an evaluation of potential areas for development.

The next key milestone is to complete a high level plan for the December board meeting, which is intended to be structured as follows:

- Exec summary
- Introduction
- Local Health Economy Strategic Plans
- Current trust provision
    - Description of 4 community hospitals
    - Activity/ finance
    - Facility impact
- Future potential trust provision
    - Trust board overview
    - Market position analysis
- Next steps/ Implications for further work

2.2 'Making the best use of technology'

2.2.1 Electronic Patient Record project

The Full Business Case (FBC) for the EPR project remains with the TDA, having been submitted on the 26th August 2015. The Trust has been receiving and dealing with queries over that time period. As stated previously, the TDA has said that they will attempt to use 'delegated responsibility' to approve the FBC once they are satisfied with the Trust's responses to these queries. This causes a further delay in the project timeline; the main impact of which will be further condensing of the project deployment phase. Members of the Project Team and Operations Directorate have met and reviewed the project approach and how to accommodate the delays in the project timetable; the detail and planning is still being worked through.

In the interim period, the shortlisted suppliers have all been advised about the delay in the notification of the tender outcome.

2.3 'Well led'

2.3.1 Transformation Programme Board

This is one of the internal forums which reports to the Resource and Performance Committee. At the October meeting of this group, it was agreed to focus the discussion on the terms of reference and the future direction the group should take to best meet the requirements of the organisation. The summary points from this discussion are outlined as follows:

- There should be a set of strategies driving estates, IM&T etc which would then link back to the Trust's 'strategy on a page'. This would also include Clinical, Quality and Workforce Strategies. This group would then, as part of a transformation discussion, consider how these strategies align with the current business plans, the 5 year plan and any business cases and tenders that have been submitted.
- The programme board would then provide a steer on which operational elements of the above need to be focussed on, via the most appropriate sub-group(s).
- The group will also enable the opportunity for members to provide intelligence on issues they have identified so that consideration can be given to how these are best responded to.
- The trust strategy on a page will be structure the agenda for future meetings and provide a point of reference.
- People who are not members of the board will be invited to present projects and other 'big ticket items' with emphasis placed on key outcomes and learning points. This has worked well in the past for items such as Health Visitor mobile working and Oswestry MIU.
- The membership of the board will be broadened to include professional leads from nursing (and possibly psychology), along with Dr Karen Stringer to enable a primary care perspective.
- Terms of Reference will be revised to reflect the agreed areas of focus and to include a diagram illustrating how everything links together.

2.4 'Responsive'

2.4.1 Commissioning Intentions for 2016/ 17

This time of year is traditionally when CCGs publicise their commissioning intentions to notify providers as to what services they intend to commission for the following year and perhaps most importantly, what changes they intend to introduce. Commissioning intention summaries have recently been completed by the two local CCGs and are attached as Appendices 2a and 2b. Whilst acknowledging the content is high level, they will nonetheless aid the Trust in its 2016/ 17 business planning process.

Board members are asked to review the documents and to highlight any particular observations or perceived risks.

3. Recommendations

3.1 The Board is asked to:

- Review the Future Fit Senior Responsible Officer report and note particularly the status of the revised programme timeframe for the acute options.
- Consider the update provided on Community Fit and the implications of this for the Trust
- Note the current status of the Electronic Patient Record (EPR) business case
- Receive the summary from the Transformation Programme Board
- Review and provide feedback on the commissioning intentions summary documents.

SRO Update Report

19th November 2015

The purpose of this report is to provide Board members with a brief update on recent Programme progress and to summarise the activities in the next phase.

Appended to the report (see Appendix One) are the action notes from the last Core Group meeting.

1 PROGRAMME TIMELINE

At the last Board meeting it was agreed that the Core Group should agree a new programme timetable which reflected the implications of the Board's decision to defer any conclusion on reaching a preferred option until there is an approvable case for investment.

Since that meeting the Core Group has held a number of discussions, including with representatives of NHS England and NHS Trust Development Authority. Advice has also been received from NHS England's Project Appraisal Unit which supports the national Oversight Group for Service Change and Reconfiguration. These conversations highlight the difficulty in setting a comprehensive timetable to consultation in advance of the Department of Health and HM Treasury confirming the acceptability of the deficit reduction plan. They also note the limited availability of capital funds for which a number of schemes may find themselves competing.

In the light of the advice received, the proposed revised critical path sets out the key pieces of work for the next phase and notes the risks around external approvals which are not within the Programme's control. The proposed timeline is a separate item on the agenda.

Key to the development of a plan for the next phase are two critical interdependencies:

a) Developing a deficit reduction plan for the Local Health Economy, and;

b) Completing a revised Strategic Outline Case for acute services which prioritises the most pressing clinical challenges.

An overview of how the programme proposes to manage these independencies, and of the scope and timing of these two pieces of work, also form separate items on the agenda.

2 RURAL URGENT CARE

Following receipt in October of the sub-group's report on rural urgent care, plans have been developed to:

a) Get further clarity on how urban Urgent Care Centres could work and on what support they will require from the wider Health Economy, and;

b) Further explore how best to provide enhanced urgent care services in rural localities.

A separate report provides more detail about these two pieces of work.

In addition, the Workforce workstream is considering the requirements for an urgent care workforce, and the Communication and Engagement workstream has developed a plan for enabling a greater public understanding of urgent care provision.

3 COMMUNITY FIT

The NHS Community Fit programme (formally outside the scope of the Future Fit Programme) is progressing well and, by 13th November, expects to have received data from all partners

The terms of reference of the NHS Community Fit steering group and a paper setting out the potential broader scope of the overarching programme of work have been submitted to CCG boards for approval and to agree any future phases.

A paper setting out more detail on progress is an agenda item

4 CLINICAL DESIGN

The workstream will be collaborating with the Communications Team to shape plans for communicating with the public about the case for change, the clinical model and the urgent care offer. This includes a document summarising where patients would attend with a variety of conditions – both currently and as a result of Programme proposals. Plans for the ongoing engagement of clinical staff will also be considered.

In addition, the workstream will begin preparations for presenting Programme proposals to the West Midlands Clinical Senate for assurance around the clinical evidence base prior to Public Consultation.

5 IMPACT ASSESSMENT

The next phase of Integrated Impact Assessment (IIA) work will run in parallel with public consultation. Nearer that time, the workstream's plans for the required activity will be finalised (in the light of the exact scope of the proposals to be consulted on). Until that time is reached the activity of this workstream has been paused.

6 WORKFORCE

Board reviewed the draft Workforce Case for Change at its last meeting and asked for the scope of the document to be extended beyond hospital staff, and for an update to be brought to the November meeting.

The Workstream has since expanded its membership to reflect the wider health and social care economy, and this larger group has started to take an overview of local challenges faced by all providers. The requested update appears elsewhere on the agenda.

The workstream's other main focus has been the workforce requirements for urgent care centres. Information has been sought both from the pilot UCCs at PRH and RSH and from a range of other UCCs in the region and beyond.

7 ASSURANCE

The Assurance workstream's next meeting was scheduled for 17th November, at which the proposed new timeline, the process for managing interdependencies and the communications plan for the next phase of activity were due to be discussed. A verbal update will be provided at the Board meeting.

The workstream was also due to review the updated reconfiguration guidance from NHS England - *Planning, Assuring and Delivering Service Change for Patients.* This does not replace the 2013 guidance but seeks to add clarity around assurance processes and decision making levels. It also sets out the requirements for Pre Consultation and Decision Making Business Cases for the first time. Key points include in the guidance include:

a) The planning and development of reconfiguration proposals are rarely linear. The most successful proposals ensure continuous discussion and involvement of the local population and key stakeholders throughout the process.

b) There must be clear and early confidence that a proposal satisfies the four tests and is affordable in capital and revenue terms.

c) Proposals affecting services valued under £350m may be determined by the NHSE Regional Director rather than the Chief Financial Officer or Investment Committee.

d) CCGs should assure themselves that those proposals have the support of their member practices.

e) Schemes have struggled to build public support where they have not adequately addressed public concerns that:

- The proposals are perceived to be purely financially driven.
- Patients and their carers will need to make journeys that may reduce access.
- Emergency services will be too far away, putting people at risk.

f) Until approval for the SOC is in place organisations should not incur material costs progressing to the next formal stages of the scheme (OBCs and FBCs).

g) Commissioner decision making involving two or more CCGs can be based on two models – committee in common or joint committees.

8 ENGAGEMENT AND COMMUNICATIONS

Following the board meeting at the beginning of October, the consultation, originally planned for December, has been put back while further work continues into the options and to reduce the deficit. An announcement and a more detailed statement was shared with the public and stakeholders about the reasons for this delay.

In the meantime, engagement continues with on-going statements and media briefings, and a newsletter is being used to provide updates to key stakeholders and a range of engagement events continue to take place, with members of the team presenting at Local Joint Committees, Parish Councils, Community Groups, Patient Groups and GP surgeries. A comprehensive engagement programme is also speaking to specific groups, including the homeless, older people and Eastern European workers. Politicians continue to be updated on a regular basis through MP briefings by the SROs and there are plans to hold further pop-up shops out in the community.

The website has been updated to improve document access. Presentations to workforce groups have been taking place and more are planned in the months ahead.

A summary document containing the Programme's key outputs to date has been published on the website.

A plan for the next phase of work appears elsewhere on the agenda.

9 FINANCE

The Finance workstream met on 5th November. Although the work to develop a deficit reduction plan is outside of the scope of the Programme, the meeting provided a helpful opportunity for discussion of the scope and approach of the work to be undertaken. The need for external support was highlighted. A report on the scope and timing of this work appears elsewhere on the agenda.

The Programme is also facilitating a meeting of Finance Directors and Chief Officers which will take place in early December to take this work forward.

10 PROGRAMME RISKS

The Risk Register continues to be comprehensively reviewed by the Programme Team each month, and by the Core Group, after which it is published on the Programme website. All workstreams may raise new risks or recommend revision of existing risks at any point.

The Board has previously agreed that all red-rated risks (both pre- and post-mitigation) should be reported to it. The current list of red-rated risks is attached to this report (see Appendix Two).

There are currently a significant number of risks for which the post-mitigation rating remains above the indicated risk appetite of the Programme. The view of Programme Team is that, whilst the appetite to reduce certain risks further is appropriate, it is also to be expected that a Programme of this scale and complexity will carry a significant degree of risk.

11 PROGRAMME EXECUTION PLAN

An update of the PEP will be produced following agreement by the Board on the scope and timing of the next phase of Programme work.

12 PROGRAMME MANAGEMENT

At the inception of the Programme, Commissioners sought the support of The Strategy Unit from NHS Midlands and Lancashire Commissioning Support Unit to provide the Programme Management Office. It was expected that this support would run until 2016 after which the later phases of the Programme could be managed locally (though still with access to support from The Strategy Unit).

To avoid undue disruption, a managed transition is proposed which would take place during 2016. First, the responsibilities of Programme Director would be brought in-house by local Commissioners but with other Programme Office functions remaining in place. Then, at a

later date, these other functions can also be adjusted to reflect the changing needs of the Programme.

Further details will be provided verbally during the meeting.

13 RECOMMENDATIONS

Programme Board is asked to receive this report, and to confirm the proposed timeline.

David Evans & Brigid Stacey

Senior Responsible Officers

APPENDIX ONE – CORE GROUP ACTION NOTES

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Core Group

Action Notes

Friday 23rd October | 4 p.m | Meeting Room One, Oak Lodge, WFH

Present: Brigid Stacey, David Evans, Hayley Thomas (for Carol Shillabeer), Simon Wright, Jan Ditheridge, Paul Tulley, Mike Sharon & David Frith

	Item	Action
1.	**Issues Log** Updated log reviewed and confirmed. All Sponsor organisations to highlight the need for continued attendance at Programme meetings.	***ALL***
2.	**Approach to Deficit Reduction Planning** a) Draft document from Andrew Nash to be circulated to Group.. b) Chief Officers/DoFs to meet for a day and a half in early December. Facilitation to be agreed. *[Post meeting note: Away day scheduled for 7th December.]* c) Scope scale of financial challenge in advance. d) Confirm asap whether RJAH/SSSFT to be included	***DE*** ***MS*** ***DoFs*** ***SROs***
3.	**Confirming scope and timing of SaTH Business Case Work** SW confirmed SaTH working on business case with two options with a range of variations which phase ambitions. An update paper will be prepared by 12th November. Programme Office to set up a workshop to refine and test the model, activity and dependencies for urban Urgent Care Centres. *[Post meeting note: workshop scheduled for 3rd December.]*	***SW*** ***MS***
4.	**Managing Interdependencies** The proposed approach was endorsed for consideration by Programme Board.	
5.	**Programme Timeline** It was agreed that there was a need to talk with NHSE/TDA about the	***MS***

	Item	Action
	potential to depart from standard process. Core Group preference was to have clear view of way ahead before engaging NHSE/TDA – probably early December when A&E continuity plan completed. *[Post meeting note: NHSE now require timetable by 13th November. Call with NHSE/TDA scheduled for 12th November.]*	
6.	**Programme Resourcing** MS advised of his appointment as Director of Strategy at Royal Wolverhampton Hospitals NHS Trust. The potential for CCGs to appoint an in-house Programme Director would be explored, and the November Board advised of the intended approach.	***SROs***
7.	**Date of Next Meeting** *20th November, 9-10am, Somerby Suite, William Farr House.*	

APPENDIX TWO – RED RATED RISKS

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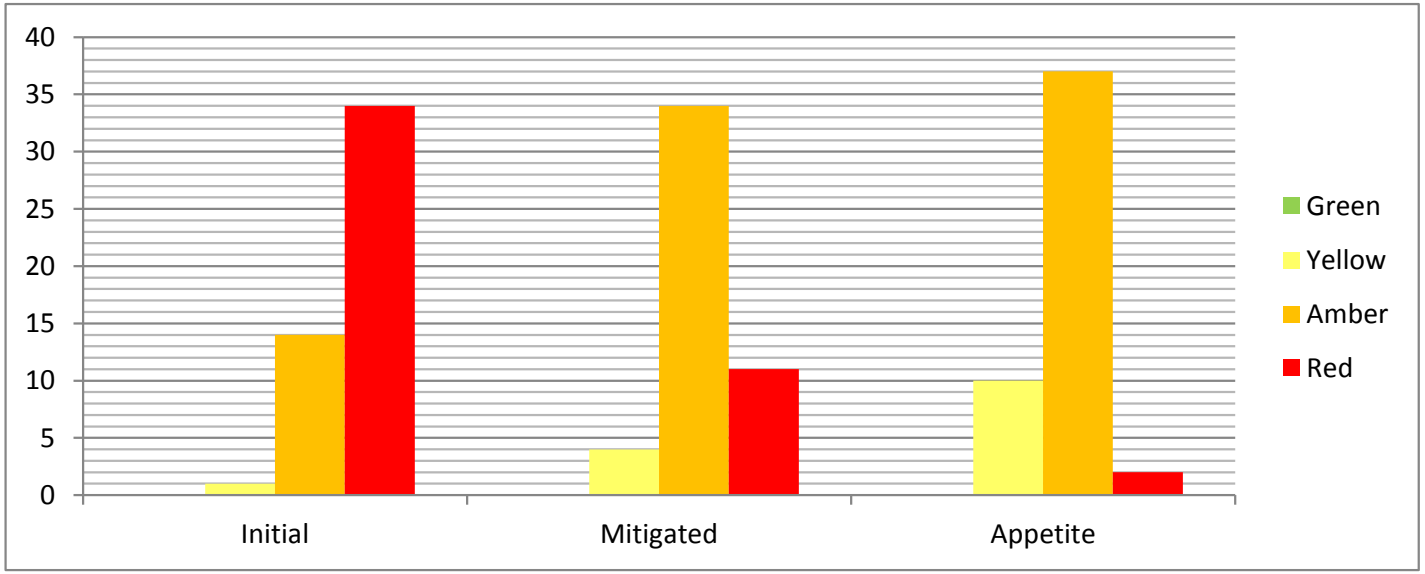
PROGRAMME RISK REGISTER

The NHS Future Fit programme has developed this register which, in line with best practice, sets out the areas which could adversely impact the development and/or implementation of programme proposals. This uses qualitative and quantitative measures to calculate the overall level of risk according to likelihood of occurrence and potential impact.

Each risk is given an initial Red/Amber/Green rating, and a summary of how the risk is being mitigated by the programme is also provided. Where further action is needed, this is also set out. The Risk Register is formally reviewed and updated on a monthly basis by the Programme Team. Risks rated 'red' (either before or after mitigation) will be reported to the Programme Board.



	Initial	Mitigated	Appetite
Green	0	0	0
Yellow	1	4	10
Amber	14	34	37
Red	34	11	2
Totals	**49**	**49**	**49**

NOTES

- Risks are generally causes rather than consequences of an adverse event.
- Mitigation actions must be accurate, timely and owned. They may be significant enough to warrant a task within a programme plan.
- All risks and actions should be updated regularly and the owners of mitigation actions called to account for progress or lack thereof.
- All programme members have a duty to identify and report risks to the programme office.
- The programme appetite for risk (i.e. what risk overall can the programme tolerate) must be clearly articulated by the programme team.
- In general, only those risks that require defined Programme Board action should be formally raised to, and discussed with, the Programme Board
- Risks should be managed as low down the programme structure as possible.
- Issues are essentially Risks with a probability of 100% (i.e. they have materialised and are thus in need of urgent action).
- If a defined risk or issue does not threaten the success of the programme, it need not be entered in the risk

SCORING

Likelihood	Narrative	Probability
1	Rare	<20%
2	Unlikely	20-40%
3	Possible	40-60%
4	Likely	60-80%
5	Very likely to occur	>80%
Consequence	**Narrative**	**Possible Quantification**
1	Insignificant	Revenue impact <£20,000; Capital impact <£0.5m; Delay <1 month
2	Minor	Revenue impact >£20k <£100k; Capital impact >£0.5m <£1.0m; Delay >1 month <3 months
3	Moderate	Revenue impact >£100k <£500k; Capital impact >£1.0m <£3.0m; Delay >3 months <9 months
4	Severe/Major	Revenue impact >£500k <£2.0m; Capital impact >£3.0m <£6.0m; Delay >9 months <24 months
5	Catastrophic	Revenue impact >£2.0m; Capital impact >£6.0m; Delay >24 months

Likelihood	**Consequence**				
	1 – Insignificant	**2 - Minor**	**3 - Moderate**	**4 - Severe/Major**	**5 - Catastrophic**
5 - Almost Certain	**5**	**10**	**15**	**20**	**25**
4 - Likely	**4**	**8**	**12**	**16**	**20**
3 - Possible	**3**	**6**	**9**	**12**	**15**
2 - Unlikely	**2**	**4**	**6**	**8**	**10**
1 - Rare	**1**	**2**	**3**	**4**	**5**

								Initial Rating				Post Mitigation Rating				Risk Appetite		
No.	Date Added	Date Last Revised	Main Register	Work-stream	Risk Name	Description	Risk Owner	C	L	Score	Mitigating Actions	C	L	Score	Further Actions (if required) to reduce risk to acceptable level	C	L	Score
1	27/03/2014	20/03/2015	Y	FI CD	**Key Staff Time**	Inability of stakeholder organisations to release key staff for the Programme leading to adverse impact on programme deliverability	SROs	4	4	**16**	Use of multi-site meetings increased. Evening meetings scheduled to support clinical involvement in design phase. Portable video-conferencing capability implemented. Critical path communicated to highlight consequences of any delay. Finance meetings moved to support attendance.	4	3	**12**	Programme Director to keep under review and to escalate to sponsors as required.	4	2	**8**
2	27/03/2014	24/08/2015	Y	CD	**Clinical Engagement**	Inadequate clinical engagement leads to lack of support for clinical model	BG	5	3	**15**	Extensive clinical engagement in developing model. Model approved by CRG and Board. GPs engaged on development of rural urgent care and 'Community Fit' plans. Staff engagement through sponsor organisations (including Trade Unions)	5	2	**10**	Further meetings of Clinical Reference Group to be held. Ongoing staff engagement.	5	1	**5**
4	27/03/2014	04/08/2015	Y	AS EC	**Engagement Assurance**	Inadequate patient and public engagement may lead to failure to meet assurance tests re: due process, contributing to Independent Reconfiguration Panel referral or Judicial Review	AO	5	3	**15**	Comprehensive engagement & comunications strategy and plans developed and being implemented. Ongoing support from Consultation Institute. Activity log to be shared every quarter with workstream and Programme Office updates shared bi-monthly.	5	2	**10**	No further action required.	5	2	**10**
5	27/03/2014	05/11/2015	Y	EC	**Public Support for Plans**	Public resistance and objections to plans leading to lack of support for preferred clinical model	AO	4	4	**16**	Communication and engagement plans to be implemented including extensive pre-consultation public engagement around the case for change/clinical model (supported by NHSE funding).	4	3	**12**	No further action required.	4	3	**12**
6	24/11/2014	04/08/2015	Y	EC	**Negative Presence in Media**	Risk includes distraction to the process including utilisation of resources; it may undermine confidence in the programme which may lead to a financial impact	AO	4	4	**16**	To implement the Engagement and Communication Strategy and subsequent plans. To undertake more proactive communications including media training with Core Group. Increased SRO engagement with press.	4	2	**8**	No further action required.	4	2	**8**
10	24/11/2014	04/08/2015	Y	EC IIA	**Powys engagement**	Confusion due to a number of programmes impacting Powys healthcare leads to reduced Powys engagement in Future Fit activities and potential challenge	AO	4	4	**16**	E&C workstream and PtHB E&C leads have met and agreed plan of action including tactics to clarify FF Powys engagement plans. E&C workstream will monitor progress on plan over next few months and report to Programme Team . Regular meetings to continue.	4	3	**12**	No further action proposed.	4	3	**12**

								Initial Rating				Post Mitigation Rating				Risk Appetite		
No.	Date Added	Date Last Revised	Main Register	Work-stream	Risk Name	Description	Risk Owner	C	L	Score	Mitigating Actions	C	L	Score	Further Actions (if required) to reduce risk to acceptable level	C	L	Score
12	24/11/2014	04/08/2015	Y	EC	**Clinical leadership**	Failure to gain and sustain support from clinicians to be visibly leading the programme. Consequences may include dwindling public support and undue burden on small number of leaders.	AO	5	4	**20**	To implement the Engagement and Communication Strategy and subsequent plans. Particular emphasis on 1. Repositioning leadership in public 2. Changing the message from 'no news' to 'we have achieved...'. Messaging workshops to be held to engage and develop clinical leaders.	5	3	**15**	Escalate to Core Group to ensure clinical leaders are able to be support programme activities.	5	2	**10**
14	24/11/2014	04/08/2015	Y	EC	**Divergence off proactive plan**	Failure to implement a process to agree a plan and all programme to comply appropriately. Risk includes inability to implement a timely plan to meet best practice standards with no subsequent ownership	AO	5	4	**20**	To implement the Engagement and Communication Strategy and subsequent plans. Additional focus includes creation and maintenance of risk register.	5	3	**15**	Review and update the plan and risk register	5	2	**10**
17	04/08/2015	04/08/2015	Y	EC	**Failure to comply with Gunning Principles**	Inadequate time allowed for consultation fails to comply with Gunning Principles leading to legal challenge	AO	5	4	**20**	Programme Board to approve plan which complies with Gunning Principles.	5	2	**10**	No further action proposed.	5	2	**10**
19	24/11/2014	04/08/2015	Y	EC	**Inadequate workforce engagement**	Failure to effectively engage with health and care staff thus raising risk for negative PR, workforce disengagement and 'on ground' lack of support / champions. This applies across commissioners, providers, and Welsh Healthboard	Key partners	4	4	**16**	Executives to take lead, fully supported by the E&C team. HJ to draw up initial opportunities starting with both CCGs and SaTh then draw out to all others including colleagues in Powys. Each organisation to provide quarterly update on workforce engagement to workstream.	4	3	**12**	No further action proposed.	4	3	**12**
21	30/10/2014	09/06/2015	Y		**Approval Requirements**	Lack of clarity about the nature and alignment of external approval processes prevents agreement of a robust timetable.	MS	4	5	**20**	NHSE/TDA proactively engaged re: approval process requirements and interrelationships.	4	4	**16**	TDA & NHSE to confirm common view on pre-consultation approval requirements.	4	2	**8**
23	27/03/2014	30/10/2014	Y	AS	**Stakeholder Strategies**	Development of stakeholder strategies and plans constrains or conflicts with the Programme	SROs	4	4	**16**	Programme model underpins 5 year plans. Stakeholders to check routinely whether plans fit Programme objectives.	4	2	**8**	No further action proposed.	4	2	**8**
24	29/05/2014	24/08/2015	Y	FI	**Sponsor Financial Risk**	The need to address short term financial risks in individual sponsor organisations compromises programme progress and/or outcome.	SROs	4	4	**16**	Programme financial model developed in alignment with sponsor 2 and 5 year plans.	4	3	**12**	Alignment to be kept under review in case of any change to long term plans.	4	2	**8**
25	27/03/2014	24/08/2015	Y		**Political Support for Plans**	Lack of political support for large-scale service changes resulting in challenge to preferred option	SROs	4	4	**16**	Regular engagement with HOSC & MPs, presentations to Local Joint Committees and workshops with Councillors. Further evidence gathered to support case for change, especially re: workforce challenges.	4	3	**12**	Local Assurance Panel to be considered.	4	2	**8**

								Initial Rating				Post Mitigation Rating				Risk Appetite		
No.	Date Added	Date Last Revised	Main Register	Work-stream	Risk Name	Description	Risk Owner	C	L	Score	Mitigating Actions	C	L	Score	Further Actions (if required) to reduce risk to acceptable level	C	L	Score
26	04/08/2014	04/08/2015	Y	WF	**Interim A&E Plans (SaTH Risk Register)**	Inability to safely staff the Emergency Department with medical workforce. Potential adverse impact on quality and safety of care for patients. Poorer patient flow into and within hospital. Inability to meet national guidance in relation to levels of senior cover. An increase in costs if there is a reliance on internal locum shifts. possible mismanagement of patient care. Difficulty meeting Trauma Network standards for Consultant cover.	SaTH Board	5	5	25	Attempts to recruit Locum/ Substantive Consultants ongoing. Recruitment and training of Advanced Practitioners. Additional SHO shift allocated to PRH on late shift to support flow and safety to avoid the night shift being left with a backlog leaving the department vulnerable. Negotiation ongoing to cover Trauma Rota and Job Planning to make best use of Consultant resource. We have recruited a fixed-term Locum to cover our ED Consultant who is away on a sabbatical; and a Locum Consultant to work with us until February 2016. Ad hoc consultant on site cover over the weekends to support the department when in extreme difficulties.	5	4	20	Business continuity planning underway and key stakeholders engaged. Options provided to execs however no requirement for change agreed at this point. Need to implement interim plan for sustaining A&E services. Complete job planning process. Development of ED staffing strategy. Gap analysis, development of business case to support recruitment of additional consultants.	5	3	15
27	04/08/2015	04/08/2015	Y	WF	**Non compliance with Critical Care Standards for Intensivist Cover within ITU (SaTH Risk Register)**	Critical care standards set out that ITU should have Intensivist cover 24/7 and that Intensivists should undertake twice daily ward rounds. Guidelines from the Faculty of Intensive Care Medicine (FICM) state that there is clear evidence that units with dedicated intensivists are the safest and most clinically effective way to deliver Intensive Care with reduced ICU and hospital mortalities and reduced ICU and hospital lengths-of-stay. In general, the consultant/patient ratio must not exceed a range between 1:8 to 1:15 and the ICU resident/patient ratio should not exceed 1:8. At both sites, these ratios are significantly exceeded. The risk has been exacerbated at PRH due to a high level of medical staff sickness and an imminent retirement.	SaTH Board	5	5	25	In order to safely staff ITU, the Trust may need to stop elective work and shift sessions to Critical Care. This will affect our ability to staff all elective lists, which will have an impact on waiting lists and patient care unless a timely solution is found as the service and the team are highly vulnerable to further vacancies or unexpected absences. Splitting the Rota at RSH means we can ensure 24/7 cover of both intensive care, by intensivists and also take care of emergency activity. Critical Care is being provided with a mix of general anaesthetists and the small number of intensivists available but consultant presence is still well below recommended levels.	5	4	20	The case has now been presented to Trust Board. The case for further recruitment has been supported. Efforts to recruit will be expedited and prioritised. A business case needs to be drafted and submitted for funding for medical capacity increase. Anaesthetic job planning needs to be completed in conjunction with management team and lead anaesthetists. Business case will be presented on 22 April. A decision will be awaited and then progressed.	5	3	15

								Initial Rating				Post Mitigation Rating				Risk Appetite		
No.	Date Added	Date Last Revised	Main Register	Work-stream	Risk Name	Description	Risk Owner	C	L	Score	Mitigating Actions	C	L	Score	Further Actions (if required) to reduce risk to acceptable level	C	L	Score
28	27/03/2014	26/02/2015	Y		**Interim A&E Plans**	The need to implement interim plan for sustaining A&E services over the interim period adversely affects Programme	DV	4	4	**16**	Key partners agree to engage with Programme Board on decisions which may impact on remit of Programme. Communications and engagement plan to be provided to all key stakeholders on necessary actions should interim plans be initiated. 5 year and 2 year plans submitted. ED business continuity plan supplied to with commissioners and TDA and actions to mitigate being implemented re: recruitment of consultant and middle grade staff.	4	3	**12**	Seek identification of preferred option at the earliest opportunity, taking account of work required to reach robust decision.	4	2	**8**
29	01/07/2014	05/11/2015	Y	AS	**Inter-dependencies**	Failure to effectively manage programme interdependencies adversely impacts the implementation of the preferred option	SROs	4	4	**16**	Sponsors to initiate further pieces of work to develop and implement plans to address interdependencies. Monitoring process agreed for the review of sponsor plans by the Programme's Assurance workstream. Document drafted for Board identifying all major interdependencies and setting out governance linkages and the alignment of key outputs.	4	3	**12**	Board to receive progress reports on Community Fit and IT Project activities, and to monitor development of the Powys SDM programme. Approach to managing additional interdependencies of deficit planning and acute business cases to be considered at November Board.	4	2	**8**
30	26/02/2015	05/11/2015	Y	EC	**Urgent Care Centre Offer**	Inability to adequately define UCC offer leads to lack of support for single Emergency Centre.	MS	4	4	**16**	Workshops held and initial report completed in September. Additional workshops to be held re: urban UCCs	4	4	**16**	Focused communication and engagement activities to take place around current and future urgent care offer by locality. Workshop to take place to clarify urban UCC model	4	2	**8**
31	24/08/2015	05/11/2015	Y	EC	**Urgent Care Proposals**	Failure to articulate rural urgent care offer before consultation adversely affects consultation	MS	4	5	**20**	Urban UCCs proposed for RSH and PRH at shortlisting. First phase of work to develop additional rural urgent care solutions nearing completion; next phase to actively involve local practices and patient groups to build proposals around local asset base. Scope of proposals in public consultation to be confined to EC, DTC and urban UCCs with no reduction in existing rural urgent care services. Further engagement planned around urban UCCs.	4	4	**16**	Further engagement to take place around potential rural urgent care offer aligned to the development of a primary care strategy	4	2	**8**
32	23/02/2015	20/03/2015	Y		**Out of Hospital Services**	Lack of clarity on plans for out of hospital services impacts public support for acute and community hospital proposals	SROs	4	4	**16**	Scope and initial activities of 'Community Fit' programme agreed.	4	3	**12**	Initial Community Fit work to be undertaken and reported to Future Fit Board.	4	2	**8**

								Initial Rating				Post Mitigation Rating				Risk Appetite		
No.	Date Added	Date Last Revised	Main Register	Work-stream	Risk Name	Description	Risk Owner	C	L	Score	Mitigating Actions	C	L	Score	Further Actions (if required) to reduce risk to acceptable level	C	L	Score
33	23/03/2015	09/06/2015	Y	WF	**Workforce Deliverability**	Difficulties in recruiting in line with workforce plan (including new roles) adversely impacts implementation of programme proposals	tbc	4	4	**16**	Workforce workstream to identify new roles and to liaise with HEE and education providers to ensure supply of required roles. Develop a more comprehensive "work in Shropshire" offer.	4	3	**12**	Further actions to be defined once workforce plan developed.	4	2	**8**
34	23/03/2015	09/06/2015	Y	WF	**Resistance to Workforce Change**	Lack of appetite for change/new roles locally and from Royal Colleges and others adversely impacts definition of a deliverable workforce plan	tbc	4	4	**16**	Workforce workstream to liaise with Royal Colleges and others to engender support.	4	3	**12**	Further actions to be defined once workforce plan developed.	4	2	**8**
35	27/03/2014	24/08/2015	Y		**Option Appraisal**	The number and/or complexity of shortlisted options identified for appraisal delays the Programme	MS	4	4	**16**	Shortlist of 6 agreed in line with national guidance. Number of options reduced on affordability grounds.	4	2	**8**	No further action required.	4	2	**8**
36	26/02/2015	05/11/2015	Y	FI	**SaTH Affordability**	Financial analysis demonstrates that one or more shortlisted options are not affordable, potentially leading to reconsidering shortlisting decision and significant delay.	NN	4	5	**20**	Phase 2 assumptions agreed by SaTH. Financial costs and benefits of options to be set out by Technical Team. A number of options excluded on affordability grounds. Remaining options potentially affordable to SaTH.	4	4	**16**	Option costs to be reassessed as revised SOC developed, and scope of SOC to be confirmed.	4	2	**8**
38	27/03/2014	27/07/2015	Y	FI	**Capital Availability**	Lack of availability of capital to fund preferred option delays implementation	AN	4	5	**20**	Discussion with TDA/DH re: availability of funding. PF2 to be explored if necessary.	4	4	**16**	Phased approach to implementation could be considered, and potential sources of funding clarified.	4	2	**8**
39	29/05/2014	05/11/2015	Y	FI	**Commissioner Affordability**	Lack of revenue affordability to Local Health Economy of capital requirement and of whole system change adversely impacts identification of the preferred option	AN	5	5 ↑	**25**	Affordability assessments to form part of appraisal processes. Extensive work undertaken to reconcile 5 year plans with Phase 2 assumptions and to allow for community investment.	5	5 ↑	**25**	5 year plans to be kept under review. CCGs to develop community investment plans. Impact of deficit reduction plans to be assessed.	5	2	**10**
40	05/11/2015	05/11/2015	Y	FI	**Local Health Economy Deficit**	LHE deficit undermines viability of business cases	SROs	4	5	**20**	Commissioners and providers to set out nature and scale of deficit and to develop a deficit reduction plan acceptable to regulators.	4	4	**16**	FDs scoping scale of challenge. FDs/CEOs to participate in planning workshop in early December.	4	3	**12**

								Initial Rating				Post Mitigation Rating				Risk Appetite		
No.	Date Added	Date Last Revised	Main Register	Work-stream	Risk Name	Description	Risk Owner	C	L	Score	Mitigating Actions	C	L	Score	Further Actions (if required) to reduce risk to acceptable level	C	L	Score
42	23/03/2015	09/06/2015	Y	WF FI	**Dual Workforce Costs**	Sufficient resources are not available to support double-running costs associated with introducing new roles, leading to delayed implementation	VM	4	4	**16**	Workforce workstream to set out requirements and to liaise with Finance workstream on resourcing.	4	3	**12**	Further actions to be defined once workforce plan developed.	4	2	**8**
45	27/03/2014	29/01/2015	Y	FI	**Programme Resources**	Programme resources / staffing inadequate leading to difficulties in running Programme to agreed timelines	SROs	4	4	**16**	CoreProgramme Budget agreed. Additional requirements for each phase to be identified. Budget for 2015-16 agreed.	4	2	**8**	No further action required.	4	2	**8**
49	27/03/2014	09/06/2015	Y	AS	**NHS Approvals**	Failure to secure necessary NHS approvals at key milestones delays the programme	MS	4	4	**16**	Engagement with NHSTDA, NHSE Project Appraisal Unit and NHSE Regional Team to clarify requirements and duration of approval processes. Sense Check Action Plan monitored monthly by Programme Team and evidence against the Four Tests being assembled. Stage 2 assurance being planned.	4	3	**12**	NHSE/TDA to provide common view on pre-consultation approval requirements.	4	2	**8**
50	09/03/2015	05/11/2015	Y	AS	**Government Approvals**	Uncertainty about timescales for DH/HMT approvals leads to flawed assumptions being made in the Programme Plan and to delay (including to the start of consultation).	MS	4	5	**20**	Programme Plan contains estimated approval periods for DH/HMT. Advice sought from NHSE Project Appraisal Unit.	4	4	**16**	Revised plan to take account of advice from Project Appraisal Unit, NHSE & TDA.	4	2	**8**
51	09/03/2015	05/11/2015	Y	AS	**Decision making**	Lack of an agreed process for reaching a final commissioner decision (including clarifying the role of Powys tHB) prevents a final decision being agreed	SROs	5	4	**20**	Commissioners to agree approach to final decision making in advance of Stage 2 Assurance. Proposal draft for CCG boards. Legal advice received.	5	3	**15**	All relevant commisioners to agree process. SROs to arrange Board-to-Board.	5	2	**10**

NHS Shropshire CCG

COMMISSIONING INTENTIONS 2016/17

1 Introduction

The purpose of Shropshire CCG's local Commissioning Intentions is to notify providers as to what services the CCG intends to commission for 2016/17.

The key themes of the intentions are to bring about change in the way the local health and social care system meets the health needs of local people, while at the same time obtaining better value. In summary we intend to

- Change the way in which services are delivered to patients focusing on patient safety, quality, sustainability and effectiveness, improving value for money
- Take out cost and eliminate waste
- Design and deliver more effective and efficient models of care
- Pay attention to the supporting infrastructure and other enablers of change
- Be clear about what needs to be done and doing it in partnership with Providers
- Maintain a continuous focus on improving outcomes and
- Explore new contracting models including Prime Provider and Alliance contacting
- Manage the transition

We have taken a whole system approach by which we mean understanding the interdependencies that exist and working with all of our providers especially where patient pathways cross organisational boundaries to deliver the services that our patients require whilst at the same time recognising that the level of resource that we collectively have is less than the current cost of service delivery.

The plans outlined in these commissioning intentions are the first step in our commitment to support and lead the change in the way in which services are delivered in order to ensure that every pound we spend delivers the biggest health benefit possible.

Intentions in respect of counting and coding changes for 2016/17 are set out in full in appendix A1.1 and constitute formal notice in accordance with Service Condition 28 of the Contract.

We will apply NHS business rules to the management of all Provider contracts and services, these and outline directions are covered in Appendix A2.

2 Context

2.1 Managing demand for services

The context in which we operate has been a major factor in drawing up our plans. Nationally and locally health and social care services face increasing challenges to meet a rising demand for services from an ageing population, whilst at the same time improving outcomes and reducing health inequalities, all against a backdrop of tightening financial constraint. This means we have a duty to ensure even more value is achieved from every pound invested in health care.

2.2 Financial constraints and opportunities

Shropshire is moving from a position of modest surplus, to one where there is a serious risk of significant financial deficit at CCG level. Our key Providers are facing similar pressure. Against this background, the focus must be on delivering a sustainable health system that is able to deliver better outcomes at lower cost.

This will not be easy and requires providers and commissioners to work together to redesign services and take cost out of the system. The NHS 5 year forward view published in October 2014 presents a significant opportunity to change our system through the adoption of new provider models and associated reimbursement systems, and with our local partners we will seek to exploit these fully for the benefit of local people.

The CCGs will therefore seek support from all their Providers to align QIPP and CIP plans for 2016/17 and will use the contract negotiation period to confirm a manageable set of jointly agreed priorities that will deliver significant beneficial cost reductions and changes to services which will benefit both providers and commissioners.

The single biggest and most discussed challenge facing the NHS is the necessity to meet the healthcare needs of our population both now and in the future within the affordability constraints specified by the Department of Health and enforced through the national oversight bodies.

For our NHS to remain strong and affordable both now and in the future we must all share in the delivery of £20bn of efficiency improvements over the next 5 years and the realisation of the vision shared in the five year forward view.

However it is important to bear in mind that Shropshire CCG alone spends over £350m on meeting the health care needs of local people Getting the best value from this spend is crucial.

Initiatives such as the Better Care Fund provide the opportunities to drive new approaches to commissioning and new ways of working which provide alternatives to hospital admission, we would welcome your continued commitment to work with the Shropshire County Council and Telford and Wrekin Council and our partner CCGs to realise these benefits.

2.3 Financial Planning Assumptions

Where we believe it is possible and necessary to reduce secondary care activity we will work collaboratively with providers to test assumptions and agree triggers for providers to reduce their capacity. Without this, history informs us that under a PbR contract activity will not actually reduce as new activity will fill its place, particularly in urgent care, thus adding to overall system cost.

2.4 National tariff

In most cases national PbR tariffs will continue to apply to most elements of acute service expenditure in 2016/17. We expect these unit tariffs will again be deflated by an efficiency factor and while they are, with the exception of the market forces factor, set at national average price levels, we wish to explore ideas for risk sharing and different contractual mechanisms. In addition we wish to explore the uses of contract flexibilities including use of capitated budgets and year of care tariffs to realign incentives.

2.5 Services not subject to national tariff arrangements

We intend to renegotiate agreements for services and/or service lines where we have evidence that services are being procured at above benchmark prices, for example some community services, mental health services and individual packages of care.

This approach will be important in supporting CCGs in working to rebalance their expenditure from the acute to community /primary care based models of care, with reduced reliance on secondary care services.

3 Delivering our Commitment to Quality & Safety

In line with our principles while we need to make financial savings we must not lose sight of the needs of service users. It is necessary that services are sustainable and affordable but we also want all of the services we commission to be of optimal quality.

We need to hold onto the significant gains that have been made in quality and safety, ensuring for example that improvements made through non recurrent investment through CQUINs are at least maintained. However we recognise also that the system needs to do something very different to deliver better performance against key constitutional targets. In bringing this about we recognise that good collaboration is imperative both across Shropshire and Telford & Wrekin CCGs, with our key providers and stakeholders. In respect of some of the changes we wish to see a greater degree of joint working to build flexible approaches to workforces, managing culture, capacity and capability to deliver transformed services which can respond to patient's needs 24 hours across 7 days, across health and social care sectors.

Services face a challenge to meet increasing expectations and to embrace a different way of interacting with patients and future patients. The use of enabling technologies and significant cultural change are necessary to underpin this.

Commissioning decisions for new, redesigned or disinvested services will continue to be subject to quality and risk impact assessments. It is important that this is transparent and that there is an open and continuing dialogue with the public to inform these decisions.

Appendix A3 outlines further key quality improvement priorities.

4 Working in collaboration and partnership

Underlying macro-economic conditions will continue to provide a major challenge for some years to come. It is only by working closely with providers to identify and jointly agree affordable, local solutions that we can maintain high quality patient care and a strong local health economy.

"We will continue to work with providers, partners and patients to change the way that services are provided and delivered, working towards to the vision for health and care services in Shropshire described in our 5 Year Plan and the Clinical Model developed through NHS Future Fit. Key partnerships through which this work is being taken forward include:

- NHS Future Fit
- Better Care Fund transformation programmes
- System Resilience Group (linking also with the Urgent & Emergency Care Network)

All providers are expected to engage effectively in such collaborative partnerships to improve services for the benefit of the whole health and social care system.

5 Priorities for 16/17

The CCG's Operational and Financial Recovery Plans identify a number of key priorities for 2016/17 in the pursuit of high quality, sustainable and affordable services for the people we serve across Shropshire and are structured into the following areas of focus;

Commissioning High Value Interventions

- Decommissioning and disinvestment from interventions and services of limited clinical value
- Providing patients with support to stop smoking or lose weight prior to elective surgery in order to improve outcomes

Elective Services

- Pathway redesign reducing the level of inappropriate and unnecessary elective referrals
- Community based assessment & treatment services
- GP referral review
- consultant to consultant referral review
- fundamental redesign of follow up care

Reconfiguration of the urgent and emergency care system

- Enhancing the potential of prototype urban urgent care centres
- reducing unnecessary and avoidable emergency admissions
- Maximising the contribution of community hospitals and MIUs to reducing acute service utilization

Frail Older People

- Building on the improvements we have made in care for patients with dementia and the elderly with frail and complex needs

Long Term Conditions

- Transform services for those with long term conditions improving quality, co-ordination of care and efficiency
- Strengthening approaches to risk stratification and case management
- Scaling up self-management and use of technology

Appendix A1 - Accounting and Coding Changes

This appendix constitutes formal notice of Commissioners intentions with regard to counting and coding changes for 16/17 in accordance with Service Condition 28 of the Contract.

1. The CCG will seek assurance that all CMU and PAS prices are applied to drugs monitoring and are effective immediately after their release date
2. The Trust is required to outline any drug or device uplift over and above the unit price paid
3. The Trust is required to outline any drugs where VAT is not being paid
4. Locally agreed or non-tariff prices will be reviewed
5. Commissioners would like to carry out a review of any day-case activity with a view to working with the Trust to move this activity to outpatient settings where clinically appropriate to do so
6. The Trust must work to report in line with schedule 6 requirements with the support of commissioners. The data will be at patient level and will be submitted via the Midlands and Lancashire DSCRO. A template must be agreed for each service type before contract sign off
7. Commissioners would like to undertake a review of any activity being recorded as day-case that could be coded as a home visit
8. A review of non-consultant led outpatient tariffs
9. Commissioners expect that the correct treatment function code must be used for outpatient activity
10. Providers must be able to demonstrate contract positions prior to any adjustments made to the specialised IR
11. Lucentis (Ranibizumab): Charging is being reviewed by commissioners and a mechanism for charging needs to be agreed with Providers.
12. Outpatient telephone consultations: Where clinically appropriate Providers will be expected to move to telephone consultations. This activity must replace face-to-face follow up attendances. They will not be paid as additional activity
13. Outpatient Nurse Led activity – Commissioners would expect any Outpatient activity seen by a nurse to be coded and charged via a locally agreed price
14. Planned procedure not carried out – Commissioners will only pay a locally agreed tariff for activity that is cancelled for medical or patient reasons.

In addition to the counting and coding changes listed above, Commissioners will also be expecting the following additional information items to be included in the contract for 16/17:

1. Additional information will be required from patient level monitoring, therefore commissioners request the following SUS data fields are completed:
    a. All admissions should be time stamped including a discharge ready date
    b. Outpatient appointment should be time stamped
    c. All critical care admissions must include a discharge ready date
    d. All critical care admissions must display the number of organs supported per day
2. A timetable must be agreed during the contract negotiation process for SLAM and non-SUS patient level information submissions to commissioners (Recommended working day 20)
3. Maternity antenatal and postnatal pathway: patient level data will be required to be submitted to the Midlands and Lancashire DSCRO using a standard template that will be sent to providers. Where a patient has been charged by more than one provider, only the provider who carried out the initial midwifery assessment will be paid by commissioners in accordance with PbR guidance.
4. Best practice tariffs: All activity flagged as best practice tariff where all compliance cannot be demonstrated through SUS will require additional local data feeds and information requirements to be made in order for payment to be validated and then processed

Appendix A2 - Business Rules and Directions to Providers

Services subject to National tariff

Acute Providers will be expected to deliver the national tariff under the PbR contract.

All other Providers including Community and Mental Health Providers and the Private and Independent sector will be expected to find the same national efficiencies plus additional efficiencies as either reference costs or benchmarking demonstrate.

SUS data will be used for payment in line with national guidance and national mandatory tariffs applied where they exist.

Non-PbR tariffs will be adjusted in line with PbR inflation/deflation except where the CCG has found the local tariffs to be excessive compared to national comparators and/or do not represent value for money. For avoidance of doubt the CCG will not pay local tariffs which are in excess of national reference costs.

The CCGs will work with their Clinical Priorities Groups to review the evidence base of their high volume and high cost elective treatments. This may lead to changes in existing referral policies or the introduction of new policies. Providers are expected to accept these policies as reviews are completed.

Managing Demand

Demand management was central to the CCG QIPP Programmes in 2015/16 and where benchmarked activity levels of elective procedures are high, it is the CCG's intention to prioritise work in order to bring elective activity back to comparable levels, and this approach will be maintained in 2016/17

The CCGs starting assumptions in application of NHS business rules and for the activity (or demand) planning process are set out below. It is the CCGs intention that the application of the business rules and process for activity planning will ensure the development of an agreed contract and activity plan that supports delivery of the local health and social care economy's objectives including delivery of QIPP, CQUIN, Future Fit, and Better Care Fund schemes.

The CCGs will utilise all available contractual levers and business rules when working with providers as required under their mandate from NHSE. These include levers such as financial adjustments for readmissions and not meeting NHS Constitution targets such as the 18 week referral to treatment target. CCGs will also expect providers to adopt Best Practice Tariffs where best practice is certified and to jointly plan for their introduction through the activity planning process.

Activity and Capacity planning

CCGs will adopt the following principles for activity planning:

- Start at agreed forecast outturn based on Month 6 Final reconciliation point activity, reflecting necessary adjustments to cover seasonal variation and incorporating patterns of demand through months 9 to 12.

Activity adjustments will be made on the following basis:

- Application of growth funding in agreed areas under pressure to buy additional activity
- Add activity for confirmed investments in new services
- Adjust activity for the impact of CCG QIPP and Better Care Fund plans.
- Adjust activity in line with national productivity metrics e.g. less inpatient surgery and more day cases, fewer outpatient follow ups
- Ensure accurate allocation (by commissioner) of specialist activity
- Mandated Best Practice Tariffs (BPT) must be included in the activity plans
- Demonstrate agreed changes to Local Pricing Structures

Pricing adjustments will be made on the following basis:

- By ensuring that local prices relating to activity growth reflect actual marginal cost of delivering services
- Appling differential pricing adjustments to tariff (tariff minus) where providers restrict the patient complexity that they treat
- Applying differential pricing adjustments to tariff (tariff plus) where providers are impacted by the above
- Ensuring Best practice is certified prior to agreement to BPT payments

Detailed intentions regarding the use of contracts and application of business rules (all Providers)

The CCGs intend to use the NHS standard contract for all contracts and where appropriate, to support service quality and efficiency improvements, the CCGs intend to make use of the flexibilities allowed within the standard contract and will consider the use of incentives where there is a supporting business case.

CCGs will expect Providers to absorb all internal cost pressures within existing funding levels (including the national tariff deflation adjustment). All local prices must be made explicit, with full definitions, and agreed at the point of agreement of the contract. Such prices are subject to Monitor rules of disclosure and agreement. CCGs will seek to ensure that local prices relating to activity growth reflect actual marginal cost of delivering services

CCGs will not pay for inherited or transferred costs that are not explicitly related to the services commissioned. Unless otherwise stated (explicitly) for 2016/17, providers are expected to deliver all NICE Quality Standards within the tariff costs.

CCGs will not accept any coding and counting changes that have not had the appropriate notice periods attached. Where counting and coding changes are agreed during the negotiation process, a commissioner based risk assessment will be required from providers prior to entering into any discussions regarding implementation. In addition, commissioners expect that any such coding changes will be under pinned by an appropriate in year risk share arrangement to protect both providers and commissioners from unanticipated financial risk.

CCGs will not fund activity at full or part day case tariff where such activity is clinically appropriate to be undertaken in an outpatient setting.

CCGs will clinically review activity that is being charged as an out-patient procedure to ensure that this is an appropriate tariff.

CCGs will work with Trusts to identify areas of activity which could be covered by a local tariff which supports innovative pathways that incentivise providers to reduce the number of emergency admissions and to reduce the average length of stay.

CCGs will be developing an appropriate set of metrics (or activity planning assumptions) on key indicators of non-elective efficiency which will reflect a sharing of financial risk between the commissioners (in relation to commissioner-induced demand) and the provider (in relation to provider-induced demand).

CCGs will seek to apply differential pricing adjustments to tariff (tariff minus) where providers restrict the patient complexity that they treat.

Commissioners expect that any service changes or developments are supported by a business case and approved by the CCGs before services commence. Where this process is not followed Commissioners do not expect to be charged for such change or development.

Monthly data challenges will continue to be raised and the commissioner expect a timely response to them in accordance with contracted timescales.

Where a patient attends separately for Diagnostic or Nurse treatment that would have otherwise been part of the original attendance, these attendances should not be charged unless part of an agreed pathway or is a nationally tariff-defined unbundled diagnostic test.
Commissioners expect Trusts to adhere to the data dictionary definition of Consultant and Non-Consultant activity. Activity carried out by Allied Health Professionals, e.g. physiotherapy, Occupational Therapy et al are to be classified and charged as "Non consultant Led Activity".

Unless otherwise explicitly agreed for certain treatment programmes, patients attending for minor and repeat procedures on a serial basis over a short period of time, should be classified as regular day attenders and charged at an agreed local price reflective of the resources expended and the substance of their treatment.

Planned Care

The CCGs already have plural markets and good choice options for patients and are not seeking to extend the range of providers or the portfolios of existing providers. CCGs are aware that providers may seek to increase their market share and the CCG position will remain that whilst shifts between providers are a natural part of patient choice, the CCGs will expect to be party to any discussions for significant in year changes to capacity where the intent is to gain market share so as to prevent over supply and financial risk to the health system. Where this occurs the CCGs may only agree to support additional capacity on a risk share basis since overall capacity for the expected demand and delivery of waiting time requirements will have already been commissioned across the portfolio of providers.

The CCGs will actively pursue discussions between clinicians to look at threshold levels for surgical intervention. Too often there is over intervention resulting in procedures when the impact on future life is minimal. CCGs will want to look at procedures which may require prior approval or further discussion between the GP and consultant.

As part of demand and capacity modelling the CCGs will review all areas of growth, looking at how demand can be managed differently and ensuring thresholds for intervention are clear in order to support a balance between demand and supply and to continue to offer patients treatment times in accordance with the NHS Constitution .Commissioners will initiate project work to investigate and address identified variations in activity utilisation for planned (elective) care services using a variety of tools to mitigate activity growth beyond epidemiological expectations. This will be further developed through the QIPP planning.

Outpatients

The CCGs will be pursuing opportunities to reduce face-to-face follow-ups. The CCGs will seek to work with providers to consider redesign to the traditional method of outpatient care delivery using both alternative settings of care as well as alternatives to face to face contact. The CCGs will agree a plan with providers which will form part of the Service Development and Improvement Plan schedule within contracts for 16/17.
The CCGs will promote clinical discussions between GPs and secondary care consultants to create patient centric, efficient pathways

Mental health

The CCGs will review PICU charges and benchmarking values against existing contracts and in particular where a CCG is charged for what is described as ‘specialing’ in PICU. Commissioners assert that this additional nursing input is already funded via the bed cost of PICU, and that this is custom and practice in other health economies. The Commissioners’ intention is to no longer separately recognise and fund ‘specialling’ from mental health providers

Appendix A3 - Further Key Quality Improvement priorities

Include:

National Enquiries – Francis et al and Kirkley/ Lampton/Goddard Reports

- The Francis, Keogh & Berwick recommendations for organisational integrity are now fully established within CCGs operations and surveillance regimes for providers. To implement the commissioning implications of the Kirkley report for safe maternity services acknowledging the local context this has for provider mergers. The CCGs will need to take account through service specifications the recommendations in the Lampton /Goddard /Saville reviews to reinforce safe guarding systems and reduce the risks to vulnerable patients from contact with non statutory personnel.

New CQC inspection Regime

- To work with providers and lead commissioners to address the findings and common themes from recent provider inspections around those services. Particularly areas either graded as inadequate or requiring improvement. To maintain a continuing dialogue between CCGs and CQC Inspectors to enable earlier warning and proactive work to be undertaken. To promote public understanding of the new CQC inspection regime and the local context to the public.

Intelligence and Information Sharing

- As the new models of care and pathways develop across traditional service boundaries there will be a need to ensure that the intelligence systems and information systems are able to support the front line practitioner delivering care and the Commissioner requiring assurance of quality and safety. This is also an issue for transitioned services and where providers have merged.

Quality & Risk Impact Assessments

- To consolidate the developments and improvements made through automated processes and routine practice that demonstrate transparency and organisational integrity. To promote standardised QIA system across CCGs to underpin integrated commissioning governance.

Nursing Homes

- To consolidate infra structure initiatives developed during 2014/15; to improve the both quality of care delivered in Nursing Homes, the quality and appropriateness of Nursing Home placements and market development of the Nursing Home sector. This includes the CCGs integrated governance framework, a web based quality and safety reporting tool and an electronic procurement system. When fully established they will enable ongoing assessment of the quality status of each Nursing Home and the common themes and trends across this market sector.

CHC

- To improve the responsiveness of the CHC service and reduce the backlog of reviews the CCGs has agreed new service specifications. To conduct a gap analysis against the outcomes for each CHC programme around standards, processes and thresholds to identify where there are improvement gaps and to agree actions to address them.

Primary Care

- To develop a quality assurance system that supports the work towards level three co-commissioning of general medical services. To consolidate the governance and monitoring processes for non GMS services commissioned from Primary care. To provide leadership and support for the revalidation process for nurses working in general practice to ensure that they are able to continue to practice.

NHS
Telford and Wrekin
Clinical Commissioning Group

Agenda Item 9.4

CLINICAL COMMISSIONING GOVERNANCE BOARD
EXECUTIVE SUMMARY SHEET

DATE:	10th November 2015
TITLE OF PAPER:	'Healthier, Happier Longer' - CCG priorities and work programme for 2016/17
CLINICAL LEAD:	Dr Jim Hudson
EXECUTIVE RESPONSIBLE: **Contact Details:**	Fran Beck Executive Lead Commissioner Ext: 2497 Email:Fran.Beck@telfordccg.nhs.uk
AUTHOR (if different from above) **Contact Details:**	
CCG OBJECTIVE:	Setting clear priorities allows the CCG to allocate resources on the most critical work programmes to deliver the CCG objectives.
☐ For Information ☒ For decision ☐ For performance monitoring	
EXECUTIVE SUMMARY (Key points in report)	The CCG is adopting a 'Programme Management Office' approach to delivering organisational objectives, to meet the requirements of the NHS Outcomes Framework, which can be summarised as to; i. Prevent premature death – Cancer/CVD ii. Improve the Quality of Life for people with LTC iii. Help people recover from episodes of ill health/injuries iv. Ensure people have a true experience of care v. Treat and care for people in a safe environment and prevention from harm. This paper recognises that there is work to do to improve each and every one of these outcomes for our patients. The CCG is committed to our strongly held view that 'Quality Drives Efficiency'. Rather than have a separate savings or 'QIPP' Plan we need a work programme that supports delivery of both our 2 and 5 year plans and achieves the savings in our medium and long term Financial Plans . No one single project can address each of the multi-faceted problems that lie behind, for example current cancer outcomes for our population. Neither is it likely that one project will only

	solve a single issue. Benefits from, for example, developing a sustainable model of Primary Care will contribute to a range of improvements. The solutions require a 'Performance Management Approach' to ensure we embed the 'Quality Drives Efficiency' concept into the day to day work of the CCG. The paper proposes four key programmes, each with a series of projects discussed and agreed with the Patient Roundtable and GP Forum. The four proposed programmes are:- 1. **'Change the dynamic'** To strengthen communities and individuals ability to 'self-care'; 2. **'Patients at the centre'** To sustain and improve primary care including strengthening integrated multi-disciplinary working in line with current BCF pilots; 3. **'Streamlined care - robust pathways'** To ensure we commission sufficient capacity for planned care and improve the patient experience of appointments and treatment. 4. **'Support people in a crisis with the right care, right place'** To make sure people can 'navigate' a simplified 'Urgent Care System' to meet both physical and mental health needs. There will be cross over between schemes. Outcomes for patients will improve through the combined outputs of several initiatives being delivered simultaneously. Implicit in each programme is the drive to:- 1. Improve the quality and safety of care for all Telford & Wrekin people receiving NHS care, by empowering individuals, strengthening communities and ensuring safeguarding vulnerable people is a strong theme in every project. 2. Ensure all NHS constitution targets are met, specifically; a. 95% of people in Emergency Department treated within 4 hours by March 2016 b. 92% of patients on incomplete pathways receive treatment within 18 weeks of referral from GP to consultant c. All cancer targets for assessment, diagnosis and treatment met sustainably, and Cancer survivorship increased. 3. Meet Quality Premium targets, particularly designed, for

	example to; a. Reduce Potential Years of Life Lost (PYLL) by 3.2% per annum – 15/16 target of 2450.8 b. Reduce the difference between the Health related Quality of Life (HQoL) for people with a LTC compared to those with a mental health LTC (baseline GP survey Sept 15) c. Reduce smoking prevalence, particularly for mothers smoking at time of delivery from 20.4% in Q4 of 14/15 to <20% by Q4 15/16, and people with Mental Health problems. 4. Achieve QIPP savings in line with the CCG Financial plan and the need to deliver Value for Money for taxpayers. The QiPP plan although derived from these priorities is not part of this paper, but will be presented at a later date.
FINANCIAL IMPLICATIONS	The CCG needs to identify at least £4m of QIPP savings for 2016/17. Rather than develop a detailed separate savings plan the aim is to ensure 'Quality drives Efficiency' and that savings are identified from each project in the four proposed work programmes.
EQUALITY & DIVERSITY	Each project will complete equality and diversity, and quality impact assessments.
PATIENT & PUBLIC ENGAGEMENT	To date there has been varying degrees of engagement for different projects. CCG Executive leads have held a workshop with the Roundtable to determine the contribution the group can make. Each programme will ensure robust engagement with relevant stakeholders, particularly patients is undertaken.
LEGAL IMPACT:	There will be particular legal requirements for specific projects, for example a statutory duty to consult where substantial change is proposed. This will be addressed through each project.
RECOMMENDATIONS:	The Clinical Commissioning Group Board is asked to:- 1. Approve the proposed programmes to ensure the CCG is able to meet its priorities to improve outcomes, quality of care and performance of services while simultaneously ensuring we meet our saving targets.

Is there a need to consider inclusion in the Corporate Risk Register?	No

'Healthier, Happier Longer' - CCG priorities and work programme for 2016/17

1.0 Introduction

1.1 The CCG has been commissioning services for the Telford & Wrekin populations since 2012/13. We have made considerable progress in improving quality, performance and cost effectiveness. There is still much to be done to reduce health inequalities, improve patient experience, achieve optimal value for money, and ensure our providers, including primary care operate as part of an effective sustainable health economy.

1.2 Over recent months a new structure strengthening capacity to improve our commissioning, finance and quality functions has been implemented. We have made some excellent appointments and, the organisation has been increasingly focused on establishing the key priorities to deliver the CCG vision:-

"Working with our patients, Telford & Wrekin CCG aspires to have the healthiest population in England. Healthier, Happier, Longer."

1.3 How are we doing? - There has been some progress in extending life expectancy in Telford & Wrekin, BUT the current population health status summary at *Appendix A* demonstrates persistent enduring gaps, particularly for women, and particularly for lifestyle related illnesses – CVD and Cancer.

1.4 While the CCG must focus increasingly on improving health outcomes, we also must continue to drive better performance of commissioned services which in several notable instances e.g. the 95% access target to Accident and Emergency Services are not delivering essential NHS Constitution targets.

1.5 Similarly we are committed to deliver our contribution towards the NHS England savings target via our QIPP programme. Rather than that be a stand-alone plan the CCG is striving to use our strongly held view that 'Quality Drives Efficiency' is reflected in the priorities we set. In other words our ambition has been to identify priorities and work programmes that will improve outcomes, quality, performance and efficiencies simultaneously.

1.6 For many of the problems we are trying to solve it is clear there is no single solution. For example, improving survival rates for people suffering with cancer requires adoption of better lifestyles across whole communities; better awareness of signs and symptoms; effective screening; earlier access to diagnostics, and well performing cancer services to provide effective clinical treatment post diagnosis. Evidence from benchmarking information suggests that improving the way we do all of this could result in efficiency savings.

2.0 Development of proposals

2.1 Commissioners are keen to adopt a Programme Management Approach which helps provide a clear structure for the essential projects needed but which also reflects the need for schemes to be cross cutting. Setting up a programme management office and a consistent set of project management documents is a relatively straightforward administrative process – the key challenge has been identifying 'what' programmes should be prioritised to achieve the improvements required?

2.2 Commissioners have been determined to ensure the ‘what’ question has been informed not only by outcome and performance data, but both patient and clinical engagement. To that end there have been two key discussions with the GP Forum on 15th September and 20th October 2015, and a workshop with the Roundtable on 15th October 2015.

2.3 Public health and other Local Authority colleagues have also made valuable contributions as there is clearly synergy between our shared objectives and the emerging Health and Well Being Board priorities.

3.0 Programmes

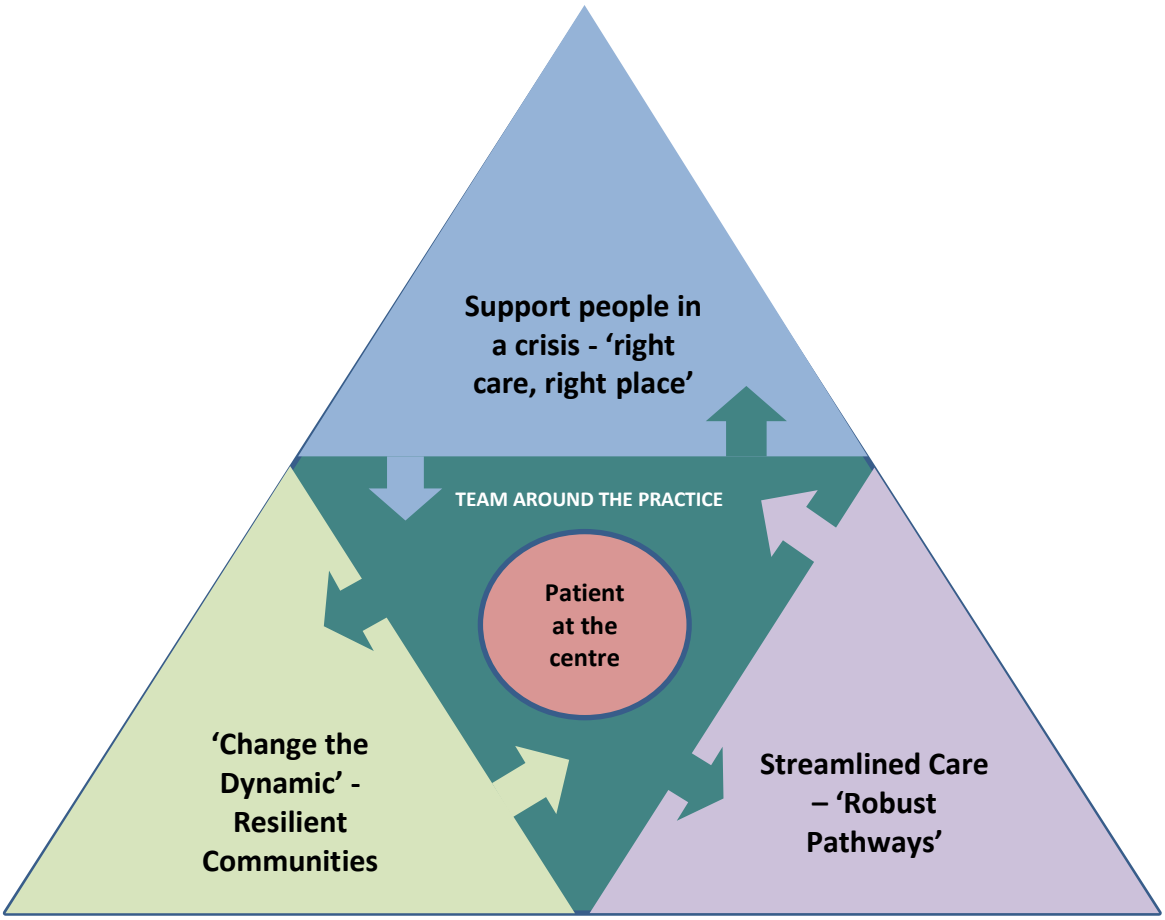
3.1 As a result we are now proposing that the CCG agrees to focus on adopting four key programmes which if developed together would support a system wide healthcare transformation in Telford & Wrekin. A summary of these is at *Appendix B*.

3.2 The detailed work in each programme will be delivered through interconnected projects. Some of these are already well established and close to completion, others have yet to start. The ongoing process will be dynamic - as projects are completed others will be started.

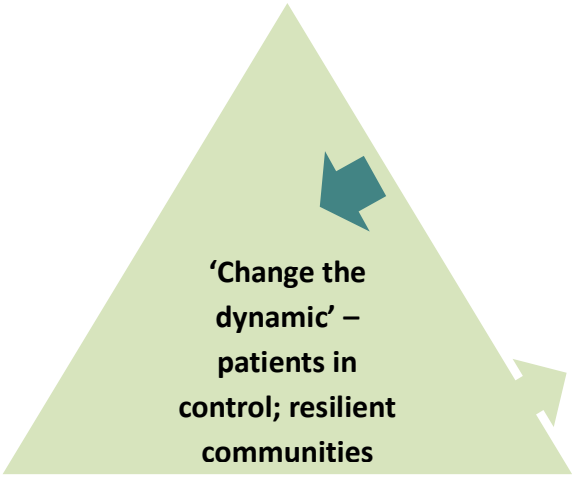
3.3 The four programmes will be :-

1. **'Change the dynamic'** To strengthen communities and individuals ability to ‘self-care’;
2. **'Patients at the centre'** To sustain and improve primary care including strengthening integrated multi-disciplinary working in line with current BCF pilots;
3. **'Streamlined care - robust pathways'** To ensure we commission sufficient capacity for planned care and improve the patient experience of appointments and treatment.
4. **'Support people in a crisis with the right care, right place'** To make sure people can 'navigate' a simplified 'Urgent Care System' to meet both physical and mental health needs.

3.4 The ‘triangle’ diagram emphasises the centrality of the patient, and the way we need to simultaneously deliver all these programmes:-

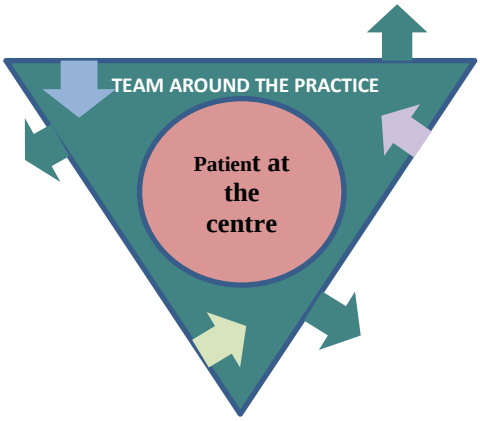


3.5 The current specific projects so far identified and to be discussed with key stakeholders are:-



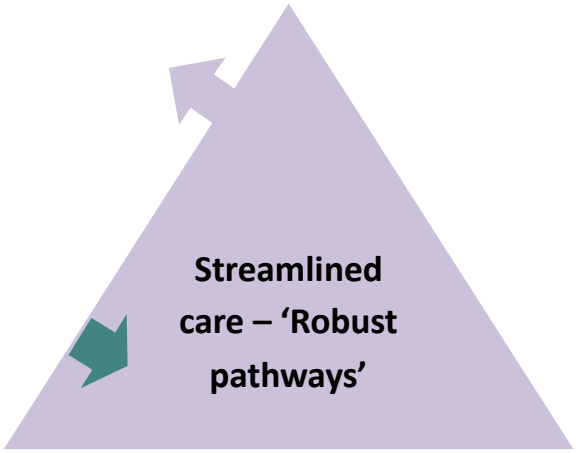
C1 Develop a joint strategy with Telford & Wrekin Council for 'Building Resilient Communities' (*likely to reflect a key Health & Well being Priority*)
C2 Implement a Joint Grant framework for voluntary organisations with the Council.
C3 Redesign model of care for people with Learning Disabilities with the council.
C4 Produce & deliver a joint Care/ Nursing Home Strategy with the council.
C5 Develop and implement an End of Life strategy – 'A Good Death'

3.6



T1 Design a new sustainable model with and for Primary Care
T2 Design and implement effective multidisciplinary 'Case Management' for our most complex patients
T3 Design and implement a model for 'Locality Working/ structures' (Team Around the Practice - TAP)

3.7



P1 Complete the implementation of the new MSK model
P2 Ensure sufficient capacity for 'Planned Care' and redesign booking systems to improve access and reduce waits for Diagnostics, Out-patient care & Elective & Cancer treatment.
P3 Deliver a Cancer project - 'One Stop Shop'/Fit for 2020 by 2017'
P4 Redesign the IAPT model
P5 Redesign the MH model (inc CAMHS & Dementia)

3.8

R1 Improve Mental Health crisis management as part of the Mental Health project.
R2 Procure new model for 111 & OOH to 'fit' our emerging model of 'Urgent Care'.
R3 Design and implement Ambulatory Care model
R4 Redesign Intermediate Care

3.9 We propose to allocate each work programmes to a Deputy Executive lead, with the expectation that collaboration is essential to ensure models of care are designed across primary, secondary and mental health.

3.10 In addition we expect a focus on the role that individuals and communities can contribute, for example by working in collaboration with Public Health and the council on making the concept of 'Resilient Communities' a reality.

3.11 The programme names are 'high level' – each lead will work up the detail of what specific schemes and projects are needed to deliver required outcomes. A set of shared principles is required and *Appendix C* includes suggestions for:-

- Programme principles
- The Enablers
- Programme Management Office (PMO) approach to ensure organisational rigour about delivering programmes at pace.

4.0 Commissioning intentions and contractual processes

4.1 The CSU has already written to our key providers setting out how we intend to negotiate contracts for next year. We will be implementing national requirements for NHS Contracts including deflators, national targets including CQUINs. There will be a particular focus on how trusts code and count activity.

4.2 The CCG will continue to participate in the ongoing work to ensure the Local Health Economy is financially sustainable (Future Fit), and it is important that saving schemes represent 'system' savings.

5.0 Conclusion

5.1 In conclusion the CCG is now in a position to adopt a more focused programme management approach to delivering its priorities and to ensure we can make a major impact on health outcomes, service performance, quality and efficiency. This paper summarised the proposals for a set of four key interrelated programmes all with the patient at the centre. Each programme will include a number of projects and the next step is to organise our staff and resources to making it happen!

6.0 Recommendation

6.1 The Clinical Commissioning Group Board is asked to:-

- Approve the proposed programmes to ensure the CCG is able to meet its priorities to improve outcomes, quality of care and performance of services while simultaneously ensuring we meet our saving targets.

Joint Strategic Needs Assessment Headlines

Life Expectancy

- In Telford & Wrekin life expectancy in men has improved in recent years but fallen in women. Life expectancy in both men and women is lower than the national average but the gap has narrowed in men and widened in women.
- Cancer and cardiovascular disease are the biggest components of the gap in life expectancy between Telford & Wrekin and the national average.
- **Early death rates from CVD have declined significantly over the past decade but still remain significantly worse that the national average.**
- In 2011-13 the rates of preventable early death from CVD were not significantly different to the England average for men, women or persons.
- **Early death rates from all cancers have been relatively static over the past decade although there are recent signs of a downward trend in men.**
- **The early death rates from all cancers for persons and women remain significantly worse than the England average.**
- **The 2013 Potential Years of Life Lost (PYLL) amenable to healthcare for the CCG is higher than the national average.**
- In Telford & Wrekin 80% of the total Potential Years of Life Lost (PYLL) amenable to healthcare during 2011-13 were caused by cardiovascular diseases, cancers and respiratory diseases with:
    - Cardiovascular diseases (heart disease and stroke) accounting for 30% and 13% of the total PYLLs respectively
    - Cancers accounting for 31% of the total PYLLs (the top three cancers with the greatest number of early deaths which are amenable to healthcare are bowel cancers, breast cancers and bladder cancers)
    - Respiratory disease accounting for 6% of the total PYLLs.

Key Health Problems

- The top 4 burdens of ill-health nationally as measured using Disability Adjusted Life Years are Cancer (17%), Cardiovascular disease (16%), Mental Health conditions (15%), Musculoskeletal disease (15%).
- This measure from the Global burdens of disease study 2010 uses a measure that combines years of life lost and years of life in disability. Mental health and musculoskeletal disease are significant because of the years of life spent in disability or ill-health for our population.

Multiple long-term conditions

- It is estimated that 23% of people have more than one long term condition. Prevalence of multiple morbidity increases with age and onset of multiple conditions occurs around 10-15 years earlier in those living in deprived localities. Having a mental health condition in addition to a physical health condition is more prevalent in more deprived populations. People with a multiple number of conditions are driving use of high cost health & social care. (*Source: Scottish Multiple Morbidity Study*)

Programme	'Change the dynamic'	'Patients at the Centre of Care'	Streamlined care – 'Robust pathways'	'Support people in a crisis with the right care, right place'
Goal	To change the traditional reliance on the NHS and Social Care by promoting 'self-care' and creating supportive, confident and connected communities.	To put patients at the centre of a supportive infrastructure of services organised at locality level with a multi-disciplinary 'Team around the Practice' (TAP)	To get rid of inefficiencies for both patients and clinicians; and improve access to tests and reduce waits for treatment.	To make sure people can 'navigate' a simplified 'Urgent Care System' to meet both physical and mental health needs.
Current Projects	C1 Develop a joint strategy for 'Building Resilient Communities' C2 Implement a Joint Grant framework with T&W Council. C3 Redesign model of care for people with Learning Disabilities. C4 Produce & deliver a joint Care/ Nursing Home Strategy. C5 Develop and implement an End of Life strategy – 'A Good Death'	T1 Design a new sustainable model with and for Primary Care T2 Design and implement effective multidisciplinary 'Case Management' for our most complex patients T3 Design and implement a model for 'Locality Working/ structures' (TAP)	P1 Implement the MSK model P2 Ensure sufficient capacity for 'Planned & Cancer Care' & redesign booking systems to improve access/reduce waits. P3 Deliver a Cancer project - 'One Stop Shop'/Fit for 2020 by 2017' P4 Redesign the IAPT model P5 Redesign the MH model (inc CAMHS & Dementia)	R1 Improve MH crisis management (as part of the MH redesign). R2 Procure new model for 111 & OOH to 'fit' our emerging model of 'Urgent Care'. R3 Design and implement Ambulatory Care model R4 Redesign Intermediate Care
Key programme measures **NB each project will have its own set.**	1. Healthy life expectancy to improve from 60 to 63.4 for men and 58.7 to 62.1 for women 2. The percentage of inactive adults to fall from 70.2% to 63.8% or better 3. More people die in the place they chose – target tbc.	1. Increase in patient satisfaction from annual GP survey, from 71% in 14/15 to 75% in 16/17 2. 500 more anticipatory plans	1. IAPT recovery 50% by Q1 2016/17 *2* Dementia diagnosis of 67% 3 92% incomplete target 4 All cancer targets met.	1 Zero delays in ED for people with Mental Health crises. 2 Reduction in use of out of area/PICU beds for mental health patients 3 95% access target met by April 2016 & no 12 hour breaches. 4 Reduction in AEC admissions >1 day tbc

Cross cutting ***Enablers*** common to all programmes:-

1. Ensuring high quality care - what will change to improve quality and patient experience? - **Quality strategy and framework.**
2. Information sharing is essential for patients and to improve communication between clinicians and organisations - **Information Sharing Agreement**s need to be established between key partners
3. Obtaining best value - how will we spend the money differently? How do we get more for it? - **Medium and long term Financial Plan**.
4. What needs to be communicated? - **Communication and Engagement strategy**.
5. What are the workforce and training implications? - **Workforce strategy**

Principles for programme delivery:-

1. Patient centred, clinically driven
2. Quality, quality, quality.
3. Collaboration & system leadership
4. Holistic approach - minimise impact of silo working
5. Externally facing - learn from others, bring in good practice, cut corners for the right result
6. Ensure project management capacity identified to successfully deliver programmes

Programme Management Office Approach (PMO)

- All programmes to identify the key projects required
- Each project to be clearly defined in a 'Project initiation documents' (PID)
- The PID to identify what specific outcomes and outputs will be achieved, plus actions, milestones and metrics for progress monitoring
- QIPP sub-committee to approve all PIDs and monitor progress - confirm & challenge
- QIPP agenda for reminder of 15/16 to be divided into 2 parts:-
    - This year 15/16
    - Plans for delivery next year - 16/17