Agenda Item No.6

Health and Wellbeing Board 26th March 2014

Report of the Chief Accountable Officer, Dudley Clinical Commissioning Group

Dudley CCG Operational Plan 2014/2015 – 2016/2017 and Strategic Plan 2014/2015 – 2018/2019

Purpose of Report

1. To review the CCG's draft Operational Plan for 2014/15 - 2016/17 and the development of the Strategic Plan for 2014/15 - 2018/19.

Background

2. The national planning guidance "Everyone Counts - Planning for Patients 2014/15 - 2018/19" sets out a process whereby CCGs are expected to develop a detailed 2 year operational plan for 2014/15 - 2015/16 and a higher level, 5 year, strategic plan for 2014/15 - 2018/19.

3. These plans are expected to set out how CCGs will meet a series of national planning requirements and targets.

4. At its meeting in January 2014, the Board noted the broad outline of the planning guidance. This report sets out how the CCG's Operational Plan has been developed in the context of both our existing strategies and plans and the national planning guidance.

Existing Strategy and Plans

5. The Board will recall that the CCG's existing strategic vision "to promote good health and Wellbeing and ensure high quality services for the people of Dudley" is based upon 3 objectives:-

   - reduce health inequalities
   - deliver the best possible outcomes
   - improve quality and safety

6. In addition, our agreed strategic intent describes four particular types of care which patients may require, all of which are designed to deliver the objectives above:-

   - planned care
   - urgent care
   - reablement care
   - preventative care

7. In addition we commission care for vulnerable groups - children, the elderly, people with mental health problems and people with learning disabilities.

8. The CCG's commissioning intentions for 2014/15 were constructed around this strategic intent focussing on:-

   - delivering efficiencies for planned care pathways;
   - improving urgent care through the development of a new urgent care centre and an enhanced care pathway for the frail elderly;

- aligning health and social care capacity to support the reduction of dependency;
- integrating services across health and social care;
- creating a strong primary care system as a key element of our approach to prevention;
- creating new mechanisms for engaging with patients and the public through our patient participation groups and our mutualist organisational model.

9. Our existing plans are also informed by and consistent with both the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS). They reflect the JHWS's priorities of:-

    - making our services healthy;
    - making our lifestyles healthy;
    - making our minds healthy;
    - making our children healthy;
    - making our neighbourhoods healthy.

National Planning Guidance

10. The national guidance is based upon 5 domains, 7 ambitions and 3 measures:-

    a. Domains

    - preventing premature death
    - best quality of life for people with long term conditions;
    - recovery following periods of ill health;
    - patient experience;
    - keeping patients safe and protected from harm.

    b. Ambitions

    - additional years of life for people with mental health problems/long term conditions;
    - improved quality of life for people with long term conditions;
    - reducing the time people spend in hospital through integrated care;
    - increasing the number of older people living independently at home;
    - increasing the number of people having a positive experience of hospital care;
    - increasing the number of people having a positive experience of care outside hospital, in the community and with their GP;
    - eliminating avoidable hospital deaths.

    c. Measures

    - Improving health - commissioning for prevention and tackling the wider determinants of health;
    - reducing health inequalities with better care and services for the most vulnerable;
    - parity of esteem for physical and mental health problems.

11. These are expected to be delivered whilst maintaining the essential system characteristics of:-

    - Quality
    - Innovation
    - Access
    - Value for Money

12. There are two key targets that CCGs are expected to deliver:-

    - 15 % reduction in emergency admissions;
    - 20 % increase in productivity for planned care

13. The guidance describes the 6 key system characteristics that are required to deliver transformational change:-

    - citizen participation and empowerment;
    - wider primary care, provided at scale;
    - a modern model of integrated care;
    - access to the highest quality urgent and emergency care;
    - a step change in the productivity of elective care;
    - specialised services concentrated in centres of excellence.

CCG Operational Plan

14. The CCG's draft Operational Plan for 2014/15 - 2015/16 is attached as Annex 1.

15. This has been developed to both reflect the CCG's existing priorities and build on these against the background of the new planning requirements.

16. The plan:-

    - reaffirms and develops the CCG's objectives;
    - identifies the health and financial challenges faced;
    - demonstrates how the commissioning priorities will create a health system which reflects the 6 key system characteristics;
    - demonstrates how we will meet the highest standards of quality and patient safety.

Issues for the Board to Consider

17. The plan reviews the JSNA and other tools which focus on particular aspects of **health need and health inequalities (pp. 8 – 9). Is the Board satisfied that the areas of focus shown on pp. 9 – 10 are appropriate?**

18. The CCG is expected to set out its **"outcome ambitions"** in relation to those areas identified in paragraph 4.1 above. These are shown at pp. 11 – 12. Other required indicators have been grouped under the appropriate ambition headings. **Is the Board satisfied that the levels of ambition are appropriate?**

19. The Board will recall that for 2013/14, 3 **local quality premium targets** were agreed in relation to atrial fibrillation, dementia diagnosis and hypertension diagnosis. These will all be achieved for 2013/14. The CCG is required to choose one indicator (to be agreed with the Health and Wellbeing Board) for 2014/15. It is suggested that, given the intelligence from the JSNA, **hypertension** (see p. 12) is chosen for 2014/15. **Is this appropriate?**

20. **Dementia diagnosis rate** is a supporting measure for the outcome ambitions. Given current performance, it is proposed that this also be used as a local performance measure for **the Better Care Fund (see p. 11 and p. 21).**

21. Are the actions described in relation to **commissioning for quality and safety appropriate?**

22. **Parity of esteem** for people with mental health problems is a key national priority**. Are the actions set out at pp. 14 – 15 supported?**

23. Are the proposed priorities of **urgent care, planned care, integrated care and primary care development** (p.15) relevant?

24. Specific actions are identified to develop a local system that meets the **6 system characteristics for transformation** (pp. 16 – 24)**. Does the Board regard these as sufficient?**

Next Steps and Timetable

25. The next planning submission must be made to NHS England by 4th April 2014.

Finance

26. See pp 7 – 8 of the draft plan.

Equality Impact

27. Equality impact assessments will be carried out on all planned initiatives.

Recommendation

28. That the draft Operational Plan for 2014/15 – 2015-16 be noted.

29. That consideration be given to those issues identified above in paragraphs 17 – 24.

30. That the Board confirm that the plan is consistent with the JHWS.

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Thinking Differently

Appendix 1

NHS
Dudley
Clinical Commissioning Group

From: Dependency, Hierarchy and Modernism

To: Autonomy, Networks and Mutualism

Operational Plan 2014/2016

Dudley Clinical Commissioning Group

From: Dependency, Hierarchy and Modernism To: Autonomy, Networks and Mutualism

Operational Plan 2014/2016

Background

In February 2013, the CCG approved its strategic commissioning plan for 2012/2015. In line with NHS England's guidance "Everyone One Counts: Planning For Patients 2014/15. This Operational Plan represents a progression from our existing plan to a five year strategic plan form the period 2014 – 2019.

This plan is designed to:-

- build on the objectives developed by the CCG in the period building up to formal authorisation as a statutory body;
- reflect the work we have done as the local leader of the NHS in conjunction with our NHS providers, our local government partners and the voluntary/community sector;
- fulfil the expectations placed upon us through the national planning system;
- take us to the next step in our development as a clinically led commissioning body responding to the significant clinical, service and financial challenges of the coming years.

We have already engaged our stakeholders in the planning process through:-

- discussing proposals with our GP membership;
- involving patients and public through our Health Care Forum and our Patient Participation Groups;
- sharing the key requirements of the planning guidance with the Health and Wellbeing Board;
- seeking the Health and Wellbeing Board's support for key system changes including our plans for primary care, the Better Care Fund and urgent care.

This engagement lies at the heart of our value system and will continue as our plans are developed and implemented.

In the sections below we have:-

- reaffirmed and developed our objectives;
- identified the financial and health challenges we face;

- explained how our commissioning priorities will position us to have a local health and care system which reflects the 6 key system characteristics and the actions we will take to deliver them;
- demonstrated how we will ensure we meet the highest standards of quality and patient safety.

NHS
Dudley
Clinical Commissioning Group

To promote good health and wellbeing; and ensure high quality health services for the people of Dudley

From: Dependency, Hierarchy and Modernism To: Autonomy, Networks and Mutualism

Objective: System Effectiveness
Reduce Emergency admissions by 15%
Achieve Better Care Fund Measures
Improve system productivity
Improve elective efficiency by 20%

Objective: Reduced Health Inequalities:
- Reducing premature mortality
- Reducing emergency hospital admissions due to alcohol
- Reducing Childhood Obesity
- Reducing CVD mortality

Objective: Best Possible Outcomes
- Improved patient experience and value-added outcomes of healthcare
- Increased early detection of dementia
- Improved individual autonomy
- Improve access and choice of services

Objective: Improved Quality and Safety
- Reduce incidence of pressure ulcers
- Reduce unwarranted variations
- Reduce incidence of Clostridium difficile
- Zero tolerance of MRSA bacteraemia
- Safeguarding children and adults

Initiative: Citizen Empowerment and Engagement.
Creating opportunities for active citizenship in vibrant communities

Initiative: Systematic Management of Long Term Conditions. Through primary care and community services delivered in response to health inequalities in our localities

Initiative: Primary Care Strategy
Delivering modern primary care at scale within a federated locality model.

Initiative: Integrated Care
Aligned health & social care teams providing proactive care operating in practices, localities and borough-wide.

Initiative: Community Rapid Response
Providing a real alternative to ambulance intervention and hospital admission, where unnecessary admission to hospital or care homes is seen as a system failure.

Initiative: Market Shaping and Development.
To create responsive Integrated community services.

Initiative: Integrated Urgent Care
A new integrated urgent care centre, providing a single point of access 24/7 and commissioning.

Initiative: Quality Programme
CQUINs and quality initiatives to reduce patient harm and improve outcomes.
7 day working across acute and community services.

Initiative: Elective Pathway modernisation
Streamlined elective pathways.

Enabler: A mutualist based relationship with member practices and responsible local citizens – developing PPGs and an autonomous registered membership

Enabler: Network leadership, training and OD programmes.

Enabler: Joint Commissioning of Primary Care with NHS England.

Enabler: Integrated GP and mobile community IT systems.

Enabler: Developing community service and provision choice through AQP.

Enabler: Risk stratification to target resources based upon patient risk profiling and service utilisation across health and social care.

monitoring of systems to evaluate efficiency and outcomes.

Enabler: PSIAMS – personalised patient-driven reporting on the value of care and implementation of personal health budgets.

Enabler: Joint governance and performance and commissioning frameworks with all partners. Memorandum of Understanding with the Office of Public Health

Vision and Objectives

Our Vision

“To promote good health and wellbeing and ensure high quality health services for the people of Dudley”

Our objectives which underpin this are to:-

- reduce health inequalities;
- deliver the best quality outcomes;
- improve quality and safety;
- secure system effectiveness.

Strategic Intent

Our strategic intent is based around four particular types of care which patients may require, each of which displays separate characteristics but for which the ultimate objective is to contribute to the objectives above. These are:-

- **planned care** – to deliver quick, reliable, value added interventions at a time and place of the patient’s choice;
- **urgent care** – to deliver value added interventions in a crisis, where the capacity available is appropriate to the presenting need and each part of the system has a clear, distinct and exclusive role;
- **reablement care** – to deliver an integrated system, where people regain independence in the least restrictive setting possible;
- **preventative care** – to empower people to take as much care of themselves as possible, in partnership with appropriate professionals, so that their level of clinical risk is reduced and their overall wellbeing enhanced.

<table>
<tr><td colspan="2"><u>Planned Care</u>

• Short Term
• Quick
• Empowered/ Choice
• Proactive
• Multiple Providers
• Performance Measure – Waiting Times</td><td colspan="2"><u>Urgent Care</u>

• Short Term
• Quick
• Disempowered/ Ltd Choice
• Reactive
• Unique Providers
• Performance Measure – Response Times</td></tr>
<tr><td colspan="2"><u>Preventative Care</u>

• Medium and Long Term
• Empowered
• Proactive
• Integrated Providers Including Social Care
• Performance Measure – Risk Reduction

NHS Outcome Framework Domains 1 and 2</td><td colspan="2"><u>Reablement Care</u>

• Medium Term
• Empowered
• Reactive
• Integrated Providers Including Social Care
• Performance Measure – Dependency Reduction

NHS Outcome Framework Domain 3</td></tr>
<tr><td>Reduced Health Inequalities

NHS Outcome Framework Domain 1</td><td colspan="2">Better Outcomes

NHS Outcome Framework Domain 4</td><td>Improved Quality and Safety

NHS Outcome Framework Domains 4 and 5</td></tr>
<tr><td colspan="4">Best Use of Resources – Effective, Economic, Efficient</td></tr>
</table>

In addition, we commission care for certain vulnerable groups – children, the elderly, people with mental health problems and people with learning difficulties. Their needs tend to be complex, variable over time, involve the input of social care, the third sector and other bodies. Such services have a focus on health and wellbeing.

This represents our strategic intent and is reflected in our plan. Our vision will be to create a health and care system characterised by ten key features:-

- a strong, clinically led CCG fulfilling its role as system leader through a mutualist based relationship with its member practices and local citizens;

- a distributed style of clinical leadership, where, community health, mental health and social care practitioners will be aligned to the same population base, providing responsive interventions for patients and service users, enabling them to retain their independence within local communities, where

active citizenship and autonomy from healthcare is encouraged and facilitated;

- new style organisational models delivering community services aligned to our locality based service integration model, including a proper alignment between health and social care activity, where the system of admission and discharge is in equilibrium;

- community rapid response services providing a real alternative to ambulance intervention and hospital admission, driving down emergency admissions and creating a climate where unnecessary admission to hospital or care homes will be seen as a system failure;

- health inequalities addressed through the systematic management of long term conditions, both in general practice and through our community health services, working in partnership with NHS England and the Office of Public Health, providing a differential response on the basis of need; parity of esteem for patients with mental health problems

- a distinctive, primary care led, urgent care service, provided at scale which is easy to access and is capable of ensuring the right intervention, in the most appropriate setting;

- measures of improvement ensuring patient safety and the quality of the patient experience are paramount, including compassion in practice, staff satisfaction, seven day services and safeguarding;

- the most economic and effective system of planned care, where the value of every service is transparent, unwarranted variation is eliminated and outcomes are clear;

- all services commissioned are evidence based and patient-value focussed and service delivery is intelligence driven, using risk stratification and other methods;

- IT integration, mobile IT and other enablers are the basis for delivering service efficiency;

- a premium being placed upon continual organisational development as the key feature of sustained transformation;

- our locality based service model provides real accountability for service delivery at the appropriate geographic level and a building block for future CCG development. The implementation of the Better Care Fund delivers closer alignment between and improved outcomes from, health and social care commissioning.

The Challenge

The key challenges facing the Dudley health and care economy are:-

- growing demand for healthcare from a population where over the next two decades the number of people over 65 will grow by 25,100 and the number over 85 by 9,900;
- financial sustainability of Dudley Group NHS FT as the main provider of acute hospital and community health services;
- budgetary challenges facing Dudley MBC in relation to adult social care and children's services;
- specific issue of budgetary pressures in adult social care and potential effect on system equilibrium with ability to secure safe and effective discharges from hospital;
- inflexible organisational forms, incapable of providing a responsive and integrated response to local need;
- poor access to community services;
- need to reshape the market and create choice through alternative procurement routes such as AQP;
- need to secure effective transformation in leadership and cultural terms at a local level to ensure our planned model of service integration is capable of delivery;
- need to secure full clinical engagement from clinicians across primary, community and secondary care;
- need for a system wide approach to IT implementation and shared records.

Financial

The CCG's financial plan for 2014/15 to 2018/19 has been constructed to deliver a sustainable NHS in Dudley. The delivery of a financially sound health economy is, however, not without its challenges.

The CCG will meet its statutory and local financial duties, delivering a planned surplus of £5.4m per annum. To achieve this, however, a QIPP programme has been developed that provides real, cash releasing savings as well as delivering improvements in outcomes and quality. The value of the internal QIPP programme (excluding provider tariff deflator) is £29.4m. The main focus of initiatives in 2014/2015 and 2015/2016 is a reduction in emergency/A and E activity. This will be twofold – by introducing a community rapid response service to reduce admissions to hospital through the Better Care Fund and the redesign of urgent care with the establishment of an urgent care centre that will reduce A and E attendances. There are also a number of separate qualitative schemes within the programme.

It is assumed within the financial plan that running costs will remain at 2013/2014 levels in 2014/2015 and reduce by 10% in 2015/2016. A review of all corporate

services is underway with the intent of reducing costs from internal structures, commissioning support and non-pay as appropriate.

A key task for the CCG and our providers, over the next 2 years is securing value for our patients. Our commissioning intentions for 2014/2015 stated that we will only procure services from providers that actively demonstrate the value they provide for the patients they treat. We will support providers in doing so and expect to fulfil this obligation over the next year. This is to ensure a continuous assessment of the efficiency of services used by GPs when making referral decisions.

In summary, the CCG is expected to meet its financial objectives over the planning period but will need to manage a number of key risks, the main one being the potential for not receiving the full Better Care Fund allocation in 2015/2016.

Mitigations have been identified to make sure the CCG meets its duties but the CCG intends to manage its finances to allow investment in the services outlined in our strategic plan over the next 5 years.

Health Status and Health Inequalities

Dudley is characterised by significant health outcome differences between the most and least deprived parts of the Borough and bears the legacy of post industrialisation.

Our JSNA sets out a number of key messages which have informed our plans and outcome ambitions as follows:-

- the gap in life expectancy for the least and most deprived areas of Dudley has widened, mostly due to CHD, COPD and lung cancer in men;
- mortality rate in 60 -74 age band is significantly higher for males;
- nearly a quarter of deaths in the 40 – 59 age band are due to cardiovascular disease, smoking, obesity and physical activity;
- mortality from respiratory disease is significantly higher than the national average. Lower respiratory tract infection is the major condition;
- the next two decades are forecast to see an additional 25,100 more people over the age of 65 and an extra 9,900 over 85;
- nearly one fifth of 40-59 year olds are living with a long term limiting illness;
- the next two decades are forecast to see an additional 25,100 more people over the age of 65 and an extra 9,900 over 85;
- nearly one fifth of 40-59 year olds are living with a long term limiting illness;
- disease prevalence rates as determined by primary care disease registers are low compared to modelled prevalence;
- the rate of delayed hospital discharge attributable to social care is higher than the national rate;
- emergency admissions for gastroenteritis and lower respiratory disease are increasing for the 60 – 74 age band;

- emergency admissions for gastroenteritis in the 75+ age band are increasing;
- hospital admission rates for 40 – 59 year olds suffering from alcohol specific conditions are rising, particularly from the deprived quintiles of the population. 20% of single person households are in the 60+ age group;
- 20% of single person households are in the 60+ age group;
- with the ageing population there is an increasing number of older people who are carers of older people, or who are carers of adult children with learning or physical disabilities.

"Commissioning for Prevention" suggests that in Dudley premature death is worse than average for:-

- cancer
- heart disease
- stroke
- liver disease

In addition, our review of the "Commissioning for Value Pack", the "CSU QIPP Opportunities Pack", "Commissioning for Prevention" and the CCG Outcome Indicators Framework, suggests that:-

- gastroenteritis
- cancer and tumours
- CVD
- mental health problems
- musculoskeletal problems
- endocrine, nutritional and metabolic
- vaccine preventable conditions
- falls
- ambulatory care sensitive conditions
- frail elderly
- admissions via A and E with a primary mental health diagnosis
- present opportunities for health status, service and cost improvement.

This means:-

- **We have specific health inequalities for the male population both in terms of mortality rates in the 60 – 74 year age band and alcohol specific problems for the 40-59 year age band.**
- **This is contributing to a widening of life expectancy gap between the most and least deprived parts of our population.**
- **We need to ensure our locality based service delivery model (see below) provides an appropriate, differential intervention at neighbourhood level to respond to local health inequalities.**

- **Interventions in relation to cancer, heart disease, stroke, liver disease and stroke are required.**
- **The systematic management of patients with long term conditions in primary care and community health services will be a major contributor to our success.**
- **We have a growing frail elderly population, we need to improve the care pathway to prevent unnecessary admissions and create the conditions to enable people to be re-abled and retain their independence in their communities.**
- **We require a continued focus on mental health and the relationship between mental health, physical health and the management of long term conditions.**

This is reflected in our plans.

Clinician and Community Engagement

Community Views:-

Our key plans, including our primary care strategy, our detailed proposals for redesigning urgent care and our integrated care model have all been shaped by the views of patients and the public, through specific consultation exercises and through our Patient Participation Groups, our Patient Opportunities Panel and our Healthcare Forum.

We have also been informed by the priorities contained in the Joint Health and Wellbeing Strategy and specific spotlight events run by the Health and Wellbeing Board in relation to urgent care and service integration, mental illness, lifestyle and children's services.

The Joint Health and Wellbeing Strategy's priorities of:-

- healthy services
- healthy lifestyles
- healthy minds
- healthy children
- healthy neighbourhoods

are all reflected in our key service and outcome priorities.

The key messages received from our programme of engagement activities cover a number of themes – the most significant being:-

- improved access to primary care – most patients would rather see their own GP than go to a walk-in centre or ED;
- a simplified approach to emergency and urgent care without multiple points of access or confusion;

- education for people which starts at an early stage which includes what to do in an emergency, how to access healthcare and how to look after yourself at home;
- more support and information to manage conditions, including long term conditions;
- more integrated community health care services which are patient centred and delivered in partnerships with other agencies, including social care;
- improved access in particular for mental health patients and younger patients so they get the right care at the right place at the right time;
- improved engagement and communication so that patients can make informed choices, get involved if they want to and have influence over what the CCG commissions.

Clinician views:-

As a clinically-led organisation, our member GPs play a key role in shaping our plans. GPs have a majority of the voting members on our Board. Key decision making committees which report to the Board are the Clinical Development Committee, the Primary Care Development Committee and the Quality and Safety Committee.

More widely, issues are discussed at monthly locality meetings of GPs with major strategic plans and other issues taken from these locality meetings to bi-monthly borough-wide members' meetings.

Our key interventions in relation to the development of primary care, service integration at locality level and a new system of urgent care have all been developed in partnership with our membership.

Our Outcome Ambitions

Our outcome ambitions reflect our assessment of local health need and key system effectiveness priorities:-

Securing additional years of life for people with treatable conditions:-

- 3.5% reduction in potential years of life lost per annum from 2087/100,000 in 2012/13 to 1943.5/100,000 in 2015/16 and 1685/100,000 in 2018/19.

Improving quality of life for 15m plus people with one or more long term conditions:-

- 70/100 people in 2012/13 to 71.6/100 in 2015/16 and 74/100 people in 2018/19;
- IAPT access level to increase from 15.3% at 31st March 2014 to 18.3% at 31st March 2015 (QP indicator);
- IAPT recovery rate to be 50% by 31st March 2015
- dementia diagnosis rate to increase from 46% at 31st March 2014 to 67% by 31st March 2015 (QP/Local BCF indicator);

- hypertension diagnosis rate to increase by 1% (local QP indicator)
- improve recording of disease in primary care registers, in particular for hypertension, heart failure, chronic kidney disease.

Reducing time spent avoidably in hospital through more integrated community care:-

- avoidable emergency admissions to be reduced from 2481 in 2012/13 to 2419 in 2015/16 and by 2018/19 (QP/BCF indicator).
- **Increasing proportion of older people living independently at home after discharge:-**
- people still at home 91 days after discharge to reablement will increase by 12 people in '14/'15 and a further 11 in '15/'16. (BCF indicator).

Increasing people's positive experience of hospital care:-

- reducing the average number of negative responses per 100 patients from 159.2 in 2012/13 to 153.5 in 2015/16 and 145 in 2018/19;
- plan to be agreed with local providers to address issues identified in the 2013/14 Friends and Family Test results (QP indicator)

Increasing number of people with positive experience of care in general practice and in community:-

- reducing the average number of negative responses per 100 patients from 6.1 in 2012/13 to 5.66 in 2015/16 and 5 in 2018/19.

Progress towards eliminating avoidable deaths in hospital:-

- improving the reporting of medication related safety incidents in a locally selected measure.
- zero tolerance of MRSA;
- C diff reduction from 117 to 108 by March 2015.

Specific actions in relation to these outcome ambitions are set out in our system intervention plans below.

Commissioning for Quality and Safety

We will develop quality initiatives and use the CQUIN process to reduce patient harm and improve patient outcomes.

We will work with our providers to encourage the development of smart dashboards to illustrate the performance of their services and inform patient choice. We will look to work with providers who actively promote their own information to support this.

We expect all providers to develop clear clinical quality standards for their services and measure their performance against these.

The CCG Board will use patient stories as a key mechanism for obtaining feedback from patients and build the lessons learned into the service design process. Our CQUIN process will incentivise this for our providers.

Francis, Berwick and Winterbourne View

Prior to the start of this planning period, we will be seeking assurance from our providers in relation to their Francis/Berwick action plans and reviewing the CCG's own action plan. We will, in turn, look to provide assurance to the Health and Wellbeing Board on this.

We have developed, in conjunction with our social care partners, a Winterbourne View action plan. All actions are on track to be completed and we expect firm plans to be in place for the discharge of clients to appropriate community based services by 1st June 2014.

We are reviewing the commissioning of assessment and treatment services in the light of the report.

Staff Satisfaction

Our AHRQ CQUIN will inform and assist in the understanding of the patient safety culture and which greatly influences staff satisfaction. This will be viewed in conjunction with the staff survey.

Berwick's "ethic of learning" is reflected in our organisational learning CQUIN which will take into account the changes implemented following complex complaints, Internal RAG rated red incidents and serious incidents reported on to the STEIS system. These will be reviewed monthly at clinical quality review meetings and a report submitted quarterly to the Quality and Safety Committee.

Patient Safety

The organisational learning CQUIN will require the organisational to look across the system in a number of areas where there may be flags to a wider issue or problem to be resolved. For example serious incidents, complaints, internal incidents a reported on the internal system, executive walkabouts, patient stories, staff experience data, CQC visits. The discussion of these will allow the understanding of immediate actions, medium and long term plans to secure improvement and prevent harm.

Our tissue viability CQUIN will focus on grade two pressure ulcers and use a short RCA to review all of the pressure ulcers with the aim of maintaining a zero tolerance on grade fours, no increase in grade threes and a reduction in grade twos.

Local KPIs will be developed to address the reporting of medication errors

Seven Day Services

As well as ensuring ourselves that our providers are putting in place appropriate arrangements for safe seven day services our integrated locality service model and

our urgent care model will operate on the basis of a 7 day service. This will be built into the relevant service specifications.

In addition, as a 7 day working transformational pilot site, we will be developing 7 day service standards for community services.

Compassion in Practice

The nursing strategies of our main providers have been developed and assured against the expectations of Compassion in Practice

Parity of Esteem for People with Mental Health Problems

“Healthy minds” is one of our Health and Wellbeing Board’s 5 priorities (see below). Our “Healthy Minds Spotlight” identified an ambition to create a “mental health friendly Dudley, where the social determinants of health and wellbeing are understood and action is taken to tackle inequalities with all partners and stakeholders”.

Our integrated locality service model (see below) is focussed on both physical and mental health. CPNs and other mental health practitioners are just as much key members of our locality teams and as part of our vision of distributed leadership as are community nurses and social workers. This recognises that physical and mental health problems are interrelated. The links with local voluntary and community services and our focus on prevention and independence within asset rich communities is designed to reduce the harmful effects of social isolation.

We will continue with the development of our award winning dementia gateways as a one stop shop for patients and carers. Dementia diagnosis rates will be a key performance metric for the local Better Care Fund.

We will work with our partners in local government to promote mental wellbeing, not only with public health but with leisure and other services.

We will ensure that there is speedy access to primary mental health services and our CCG locality groups will be empowered to monitor, review and hold local services to account for performance.

We will ensure that our new model of urgent care provides an appropriate and timely response to those presenting in crisis. We will ensure that there is appropriate access to a “place of safety”.

We will work with NHS England to improve the recording of patients with mental health problems in primary care disease registers and in turn ensure that these patients enjoy appropriate access to physical health services in primary care.

We will commission services on the basis of a recovery model and work with MIND to develop our Empowering Recovery in the Community service.

Our Key Priorities – 2014/15 and 2015/16

In responding to the challenges we face there are 3 key priorities which need to be delivered in 2014/15 and 2015/16:-

- **urgent care** – implementing the service model we have consulted upon, providing a clearer and consistent response for patients and reducing inappropriate demand;
- **planned care** – the delivery of service efficiencies
- **integrated care** – implementing our model of integrated locality working, transforming the nature of joint working across health and social care and providing a real alternative to hospital admission;
- **primary care development** – working jointly with NHS England to commission a modern system of primary care capable of managing patients systematically supported by appropriate IT.

These are dealt with in detail below.

Impact on Providers

The achievement of these priorities will be dependent on the appetite, ability and speed of providers to react to the change in our commissioned service model.

If providers react in the way we have indicated, then we foresee a reduction in the acute and mental health bed base within Dudley and an increase in the provision of community/primary care services. This will be done in a planned and managed way with our providers to ensure that the cost base within providers reduces in line with potential income reductions.

If providers do not work with us in delivering our service model, then there is a significant risk of financial sustainability for providers, as the CCG will have no choice but to test the market for services. The financial environment for our local NHS providers is already very challenging, so we wish to work collaboratively to ensure that the health economy is financially viable for the foreseeable future. We will not, however, work with providers that do not share our values or vision.

System Characteristics for Transformation

NHS England has identified the six key characteristics which sustainable health and care systems will need to demonstrate in five years. Our key initiatives in relation to these are set out below.

Our priority service changes have been analysed in both financial and activity terms. These are set out on the attached “activity and cost maps” dealing with the impact of these changes.

1. **Citizen Participation and Empowerment**
    - **Each of our practices will have an active Patient Participation Group (PPG) moving from 40/49 to 49/49**
    - **We will deliver a structured programme of training and development for PPG members with at least 100 members being involved in 2014/15.**
    - **We will commission 5 community development workers in our localities to support our service integration model.**
    - **We will ensure our contracted levels of activity meet NHS Constitution requirements.**
    - **Our Building Healthy Partnerships Initiative will support the development of a refreshed community information directory for Dudley citizens.**
    - **1000 assessments over two years leading to the issue of social prescriptions as necessary, through our Age UK partners.**
    - **We will double the size of our citizen contact database to 1500 people who are interested in being actively involved in decisions about their health and care.**
    - **We will work with up to 15 families in exercising their right to have personal health budgets for NHS Continuing Healthcare.**

We have a number of engagement channels which encourage patients and the public to be actively involved in the decision making process on how their health care services are planned, developed and delivered.

These include:-

- a thriving network of Patient Participation Groups. These groups provide a patient voice on the provision on primary care but also a resource which we use to shape wider discussions on commissioning intentions and other health and social care related issues. Our aim for 2014/15 is to develop a locality and borough wide structure, mirroring our GP membership structure, which enables our PPGs to network and share best practice, communicate with each other more effectively and have a stronger voice at board level.

- our Patient Opportunities Panel (POPs) – membership is drawn from PPGs across the borough. The purpose of the POPs is to give patient representatives a direct influence on the strategic commissioning process.
- our Health Care Forum (HCF) – a less formal public meeting held quarterly with an emphasis on information sharing about health care developments and appropriate access to healthcare services.

Our vision to develop more integrated services is also reflected in the joint work on involvement we carry out with our local authority and other partner organisations, which includes:-

- Building Healthy Partnerships – funded piece of work bringing together the NHS, local authority and voluntary sector to promote joined up working to empower local people to make healthy lifestyle choices, support them in making informed choices about health and social care. Specific projects include the development of a Community Information Directory, which will provide a single point of access for information on a wide range of health and social care services;

- in partnership with the local authority, public health and third sector we also hold quarterly Community Engagement Network (CEN) events focussing on engagement techniques and approaches.

- we gather, and act on, patient feedback from a wide variety of sources. That includes data collected from online feedback channels, social media and provider complaints, as well as our own channels including:-

    - service specific consultations;
    - specific pieces of work such as our vox pop ‘Feet on the Street’ videos which are screened to Board meetings in public and other committees;
    - our Patient Participation Groups, Patient Opportunities Panel and Health Care Forum;
    - announced and unannounced visits to providers by the patient experience team;
    - feedback from GP forums including locality and borough wide members’ meetings.

We have scoped those existing NHS continuing healthcare patients who may wish to exercise their right to have a personal health budget and are working with 2 families to pilot our approach. We have agreed our process and governance arrangements and will look to use a direct payment mechanism.

We will use the PSIAMS system of personal and social impact action measurement to commission for value.

2. Wider primary care, provided at scale

- **The consultation rate in Dudley is expected to grow due to demography by less than 1 %.**
- **21,000 urgent care attendances will be redirected to primary care.**
- **The average consultation rate for Dudley is 5.26 per person which equals approximately 1,651,640 per annum, which equates to 31,762 primary care consultations per week.**

Our Primary Care Strategy sets out the priorities for developing primary care in Dudley. The challenges within Dudley are common to those that have been identified nationally through the Call to Action; and we already have extensive support and development in place with our member practices to manage workload, improve access, develop locality based integrated services, reduce unwarranted variation and reward excellence.

We are seeking to bring our responsibility for improving primary care together with NHS England's contractual responsibilities for these services, into a more formalised joint commissioning arrangement from 1st April 2014. In addition, our strategy is for all primary and community based services to integrate in order to deliver better co-ordinated and seamless care, through a single point of contact, in each of our five localities – Entrenching GPs as community health service leaders, at the heart of our service integration process to co-ordinate and deliver comprehensive care in collaboration with community services and expert clinicians.

As well as aligning our community based services with primary care, we are part of a National pilot to commission those services over 7 working days; enhancing our use of risk stratification tools to identify and manage the frail elderly; reducing unplanned admissions, and co-ordinating physical, mental and social care in the community – all services will work with the same group of patients.

We are seeking to expand upon our existing and effective support structure for primary care, bringing together teams of specialist staff whose sole function to maximise the efficiency within our member practices. The support to date has helped practices meet year-on-year rises in demand without the need for additional resources. This is evidenced by that fact that demand for A&E services has not risen over the last few years.

The systematic management of long term conditions in primary care will be a key vehicle for meeting our outcome ambitions. We will incentivise practices to improve recording in their disease registers, particularly in relation to hypertension, heart failure and chronic kidney disease. This will have clear links to our risk stratification system and our model of integrated locality working.

3. A Modern Model of Integrated Care

- **Emergency admissions will be reduced by 4545 by 2015/16**
- **Unnecessary admissions will reduce from 8490 in 2012/13 to 8278 in 2014/15;**
- **delayed days in hospital will reduce by 134 days in 2014/15 and by a further 160 days in 2015/16;**
- **people still at home 91 days after discharge to reablement will increase by 12 people in 2014/15 and a further 11 in 2015/16;**
- **the number of new admissions to nursing homes will reduce by 32 in 2014/15 and by a further 36 in 2015/16.**

Our model of integrated care is designed to ensure that:-

- every Dudley person has a high quality experience of health and care throughout their life journey;
- the health and care system promotes independence;
- prevention and wellbeing are integrated and privileged;
- every unplanned hospital admission is treated as a system failure;
- risk stratification and other tools enable an intelligent approach to service intervention.

Our approach is based upon integrating primary, community, mental health, social care and public health activities to support older people. In addition, our model supports integration with voluntary and community sector services at a neighbourhood level.

Integration will take place at three levels – practice level, locality level within our 5 CCG localities and at Borough wide level. Integrated teams will integrate services from practice to Borough wide level and connect local services more effectively with their local communities.

These services will provide:-

- proactive, preventative support to a common population using risk stratification and other data tools;
- an enhanced community based urgent care service as a real alternative to ED/hospital admission;
- step down for supported discharges from secondary care;
- a consistent response 7 days per week to agreed clinical standards.

A key feature of our model will be a scaled up rapid response service, working in conjunction with the West Midlands Ambulance Service, acting as the first response to patients who may have historically been admitted to hospital.

We will seek to create more resilient community and voluntary services in conjunction with our partners. This will include the development of a social prescribing service and an integrated range of CAB services to support the frail elderly and patients with long term conditions.

General practitioners will act as the lead clinicians for these community teams. A significant OD programme is being rolled out to support their creation and to foster a new way of working across health and social care. The allocation of £5 per head to support this is reflected in our Better Care Fund Plan. A set of agreed performance metrics will be monitored by our GP locality groups where teams will account for their performance. Service delivery will be enabled by a single IT solution.

This will be the prime area of development within the Better Care Fund and will make the main contribution to reducing emergency admissions by 15%.

Success will be measured by:-

- an enhanced service experience for patients and users;
- reduced clinical risk measured by the risk stratification tool;
- reduced levels of dependency;
- reduced social isolation;
- reduced ED attendances and unnecessary admissions;
- better quality of life for patients with long term conditions through efficient management;
- distributed leadership as the norm.

The systematic management of patients with long term conditions will be part of this model this will include:-

- the Dudley Respiratory Assessment Service (DRAS) will be redesigned and aligned to our 5 localities and provide a step down service to the Rapid Response Service. This will be part of a comprehensive approach to managing COPD including a re launch of our LES;
- the implementation of a revision to our diabetes LES and a more community focussed community diabetes team, including appropriate psychological input;
- a more community based approach to anticoagulation services;
- utilising technology following a joint scoping exercise with social care;
- provision of IV antibiotics and IV diuretics;
- familial hyperlipidaemia;
- a systematic approach to self-care programmes.

A specialist community palliative care team will provide further community capacity to intervene early, prevent unnecessary admissions and facilitate preferred place of care for patients.

The development of an integrated community health and social care service for children with complex needs will complement our adult service model and will include the development of a hospital at home service for high risk patients. The paediatric triage service (see below) will contribute to this process.

Our Better Care Fund Plan

The BCF reflects our approach to:-

- citizen engagement and empowerment
- development of primary care at scale
- development of service integration
- development of urgent care

Our plan centres upon the development of our integrated health and social care service model, designed to reduce emergency admissions by 15% through:-

- developing integrated practice and locality based teams led by GPs.;
- investing in a locality based rapid response team as the referral point of choice for patients in crisis;
- reducing admissions to hospital and residential/nursing home care as a result of this;
- creating strong links to local community and voluntary services , reducing social isolation and supporting people to be as independent as possible in their local communities.

The Better Care Fund will invest in the development of our rapid response service and the leadership role of local GPs.

In terms of the key performance metrics:-

- Service efficiencies will provide the recurrent investment for the rapid response service and the GP leadership role for the over 75s;
- 15% reduction in emergency admissions by 2015/16 (£7.5m)
- unnecessary admissions will reduce from 8490 in 2012/13 to 8278 in 2014/15;
- delayed days in hospital will reduce by 134 days in 2014/15 and by a further 160 days in 2015/16;
- people still at home 91 days after discharge to reablement will increase by 12 people in 2014/15 and a further 11 in 2015/16;
- the number of new admissions to nursing homes will reduce by 32 in 2014/15 and by a further 36 in 2014/15 and 2015/16.
- The dementia diagnosis rate will increase from 46% to 67%.

4. Access to highest quality urgent and emergency care

- **A 21,000 reduction in A and E attendances by 2015/16 resulting from this and the rapid response team.**
- **Ambulance conveyances reduced by 3556 by 2015/16.**

The CCG has recently completed a public consultation process on a proposed new urgent care system for Dudley, in line with national recommendations on urgent and emergency care.

Our proposed service model was informed by the outcome of a "spotlight event" led by the Health and Wellbeing Board and specifically focussed on urgent care as part of the development of the Joint Health and Wellbeing Strategy's priority "making our services healthy"; as well as discussions that took place through our own Health Care Forum and our "feet on the street initiative" (see above).

Two key features of this engagement was a preference expressed for:-

- improved access to primary care – patients preferred to see their own GP rather than go to a walk in centre or to ED;
- a simplified approach to access without confusing multiple entry points.

Therefore, the system we have consulted upon envisages:-

- general practice being the first place that patients go for urgent care during normal surgery hours;
- patients ringing 111 for out of hours advice, potentially resulting in an urgent GP appointment the next day, a visit to a new urgent care centre (see below) or potentially a home visit;
- patients being able to visit an urgent care centre at the Russells Hall hospital when their usual surgery is closed, being treated or triaged for ED.

A more effective urgent care system, complementing our approach to integrated services described above, will be a major contributor to our planned reduction in ED attendances.

- Implementation of our new urgent care centre providing 24/7 access through a single portal of entry.
- Implementation of a 24/7 psychiatric liaison service with appropriate medical support, coupled with a review of access to local "place of safety".

We will work with local partners and NHS England to implement any proposals agreed for urgent and emergency care system reconfiguration across the Black Country.

We will work with our partner CCGs across the West Midlands to reconfigure hyper acute stroke services.

Our Urgent Care Working Group, reporting to the Health and Social Care Leadership Group and in turn the Health and Wellbeing Board, has oversight of the urgent care system. We will agree an activity model to show the level of supported and unsupported discharges that we will expect for health and social care services, for a given level of admissions. This will be used by the Urgent Care Working Group to hold the system to account for performance.

The Urgent Care Working Group and a new Urgent Care Centre will manage the system at times of pressure

We will embed our community bed management system to facilitate effective discharges.

Schemes that have been developed to manage demand and facilitate discharge during the winter period will be reviewed and we will invest recurrently in those initiatives which are demonstrably effective.

5. A step change in productivity of elective care

- **To be met by a 20% reduction over 5 years, whilst countering a potential £100,000 cost increase, due to demographic change, per year.**
- **Outpatient 1st appointments to reduce in 2014/15 by 3637.**
- **Outpatient follow up attendances to reduce by 18,587 by 2015/16.**

Planned care represents our largest area of spend. However, there is a significant variation both between services and between providers in the number of steps that a person may go through in the course of treatment. We will expect each provider to determine how they will improve the efficiency of the services they provide. At the end of ‘14/’15 we will publish an efficiency index and share this with our member GP practices when advising on referrals and setting commissioning priorities.

We will invite all providers to demonstrate the effectiveness of the services they provide. Services which demonstrate effective outcomes will be positively promoted. Services where the outcome value cannot be demonstrated will be de-commissioned.

We will build on the pathway model developed for cardiology services to improve the efficiency of pathways for a range of acute specialities.

In particular, we will:-

- extend access to “advice and guidance” services for GPs in gastroenterology, gynaecology, haematology, neurology, paediatrics and rheumatology based on the Taunton model, to reduce outpatient attendances;

- redesign the pathway for musculoskeletal services, including the contribution of physiotherapy;
- dermatology – seek further provision of activity in the community;
- Orthopaedic Assessment Service – reducing number of inappropriate referrals to secondary care;
- ophthalmology – transfer to community;
- pain services – transfer to community;
- neurology – email triage service to reduce inappropriate referrals;
- heart failure pathway – integrating acute and community teams and moving to 7 day working;
- Improving cardiac rehabilitation pathways and reducing readmission rates;
- decommissioning the community echo service;
- community medical officer service – transferring enuresis and encopresis services to nurse led community clinics;
- paediatric triage – to prevent unnecessary admissions;
- review of short stay admissions for stroke, heart failure and suspected MI;
- specific preventative measures in relation to cancer, heart disease, stroke, lung disease, liver disease and retinopathy.

6. Specialised Services concentrated in centres of excellence

We will work with NHS England on proposals to CCGs to achieve concentration of expertise in a reduced number of centres

Governance and Performance

Our outline planning issues were shared with the CCG Board and the Health and Wellbeing Board in January 2014. This included our outline Better Care Fund Plan, our service integration model and our urgent care model. All parties involved in the Health and Wellbeing Board approved our primary care strategy in October 2014.

Key issues already identified in our commissioning intentions will be contained in our contracts with our main providers to be agreed by 28th February 2014.

Our final plans, including our outcome ambitions, key metrics and quality premium targets will be considered by the Health and Wellbeing Board in March 2014 and the CCG Board in April 2014.

Our system of governance involves the oversight of our main initiatives by 4 key committees:-

- quality and safety – CQUIN performance, assurance from our clinical quality review meetings, safeguarding matters, implementation of Francis and Winterbourne View recommendations and our quality strategy;

- primary care development – implementation of our primary care development strategy;
- clinical development – our key system initiatives, including service integration, urgent care, planned care productivity, as well as health outcome metrics, quality premium indicators and our QIPP initiatives;
- communications and engagement – our plans for citizen engagement and empowerment;
- finance and performance – our financial and QIPP plan and key performance metrics.

Alongside the nationally mandated metrics for the Better Care Fund, we will develop in conjunction with our social care partners, a comprehensive system of performance metrics to manage the development and implementation of our integrated service delivery model. These will be overseen by the Health and Social Care Leadership Group (a chief officer/director level body reporting to the Health and Wellbeing Board), as the governing body of the Section 75 Agreement for the Better Care Fund. This agreement will set out the roles, responsibilities and obligations of all partners with a role in our service integration model – the CCG, Dudley Group NHS FT, Dudley and Walsall Mental Health Partnership NHS Trust and Dudley MBC.

We have described the key functions of the CCG as:-

- setting the vision for our local health system;
- holding our system to account;
- facilitating service improvements;
- engaging with patients and the public;
- supporting quality improvements;
- ensuring good governance and working with our partners.

Our internal governance processes are geared to discharging these functions and ensuring appropriate reporting and accountability arrangements to our Board through our quality and safety, clinical development, primary care development, communications and engagement and finance and performance committees.

As described above we also have a number of mechanisms in place to engage with and hold ourselves accountable to our local community outside our traditional governance processes. Our plans will continue to be developed with and our performance reported to our stakeholders through:-

- our Health Care Forum, Patient Participation Groups and Patient Opportunity Panel;
- our GP Membership meetings and the development of our mutuality model;
- our GP locality meetings – particularly in relation to the delivery of our integrated care model;

- Health watch – who we will encourage to act as a “critical friend” in the development of future plans;
- our partners in the voluntary and community sectors, through our Building Healthy Partnerships initiative.
- the Health and Wellbeing Board, not least as the oversight body for the BCF.

At the heart of our system vision is the development of a new model of integrated working. As described above this will be characterised by locality teams led by GPs, acting as the main mechanism for providing responsive services, capable of enabling people to live independently in strong communities, providing a real alternative to hospital admission. These teams will operate on the basis of distributed leadership, where accountability will be at its strongest within the team itself and performance reported regularly to our GP locality meetings.

Deliverability

A system wide organisational development programme, delivered at pace and scale, will be a key enabler for the implementation of the new service model which lies at the heart of our plan. This will encompass community nurses, CPNs, GPs and social workers and will be aimed at creating a distributed leadership model which places an onus on responsive, integrated service delivery.

The development of our primary care system, through a new joint commissioning framework with NHS England, will create the capacity and capability to support and complement our urgent and planned care systems. This will include the systematic management of patients with long term conditions to meet our outcome ambitions and respond to our assessment of local health need.

We will implement a single IT platform for primary care, capable of developing the capacity to intervene systematically to manage a practice population and link with other systems as part of the integrated response process.