Appendix 1

Thinking Differently

NHS
Dudley
Clinical Commissioning Group

From: Dependency, Hierarchy and Modernism

To: Autonomy, Networks and Mutualism

Operational Plan 2015/2016

Version 2 – For submission to CCG Board/ Health and Wellbeing Board

Contents

Dudley Clinical Commissioning Group

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

Background

Operational Plan 2015/2016

In February 2014, the CCG approved its Operational Plan for 2014/15 – 2015/16. This Operational Plan represents the next year of our overall strategic plan for the period until 2019.

This plan is designed to:-

- build on our achievements in implementing our plan for 2014/15;
- develop our strategic intention of implementing a model of population-based health and wellbeing, establishing integrated health and social care services with primary care at its heart;
- reflect the work we are doing as the local leader of the NHS, in conjunction with our NHS providers, our local government partners and the voluntary/community sector;
- fulfill the expectations placed upon us through the national planning system;
- take us to the next step in our development as a clinically led commissioning organisation, 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 on a regular basis;
- engaging with patients and the public through our Health Care Forum and 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 population health and wellbeing, the Better Care Fund; delegated commissioning of primary medical services and urgent care;
- sharing our plan with our three NHS service providers, our local government partners and the voluntary sector, through our System Resilience Group.

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 comm1ss1oning priorities will position us to have a local health and care system which reflects the "6 key system characteristics" and enables us to fulfill our vision for population health and wellbeing;
- demonstrated how we will ensure we meet the highest standards of quality and patient safety.

DUDLEY CCG OPERATIONAL PLAN

THREE KEY AREAS OF FOCUS FOR THE 15/16 OPERATIONAL PLAN

1. **Integrating services, empowering our multi-disciplinary teams to deliver population health and wellbeing, avoid admissions and retrieve patients from hospital**
2. **Enhancing efficiency of elective care pathways by eliminating unwarranted variation**
3. **Developing a new service model based upon our vision of population health and wellbeing**

ACCESS

All NHS Constitution standards and Mandate commitments to be met

A&E
Urgent care centre commissioned

Winter resilience
Street triage vehicle for mental health patients Discharge to assess pathways Mental health urgent care centre Enhanced Programme for care homes

RTT/Diagnostics/Cancer
Enhancing pathway efficiency for diabetes, ENT, MSK, cardiology, urology, ophthalmology

IAPT
Pathway audit to eliminate unwarranted variation and increase efficiency

Dementia
Community based dementia service

Early intervention in psychosis
Audit to eliminate unwarranted variation and increase efficiency

Primary Care
Saturday opening for primary care

OUTCOMES

Delivery across the five domains and seven outcome measures

Improving health
Joint targets with Dudley Council for smoking, alcohol and diabetes

Reducing health inequalities Young people's health champions Community health champions "Healthy Living" GP practices
"QOF Plus" approach to identifying and managing hypertension in primary care
Workplace health and wellbeing – CCG and its partners

Parity of esteem
"All age" primary care emotional health and wellbeing service
Healthy lifestyles programme for mental health patients

QUALITY

Patient safety
Embedded organisational learning

Patient experience
PSIAMs, patient app and "feet on the street" Extending personal health budgets

Compassion in practice
Provider strategies assured against 6 Cs

Safeguarding
Revised arrangements for safeguarding children's services Assuring safety of all CCG commissioned nursing home placements

Staff satisfaction
Analysis of national staff surveys and follow up action with providers as part of quality intelligence scanning

Seven day services
Development and implementation of service standards for community based services

DELIVERING VALUE

Financial resilience; delivering VFM for taxpayers and patients and procurement
Planned surplus £6.295m
Contingency 0.5%
1% non-recurrent
Elective and non-elective activity plans based on outturn plus demographic growth, adjusted for impact of QIPP schemes
System wide efficiencies being sought across partners on estate/IT/medicines and consumables

TRANSFORMATION PROGRAMMES, RECONFIGURATION PLAND AND REPROCUREMENT

Commissioning a new urgent care centre
Exploiting a system wide common IT platform
Procuring an "all age" primary care emotional health and wellbeing service
Empowering staff to deliver population health and wellbeing through an extensive od programme
Partnership Board to oversee new service model

1. Vision and Objectives

a) Our Vision

Our vision is “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.

b) 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.

The following table shows the relationship between our strategic intent and the 6 key system characteristics for transformation.

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

A step change in the productivity of elected care

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

Access to the highest quality urgent and Emergency care

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

Wider primary care provided at scale

• Medium and Long Term
• Empowered
• Proactive
• Integrated Providers Including Social Care
• Performance Measure – Risk Reduction</td><td colspan="2">Reablement Care

A modern model of integrated care

• Medium Term
• Empowered
• Reactive
• Integrated Providers Including Social Care
• Performance Measure – Dependency Reduced</td></tr>
<tr><td>Reduced Health Inequalities

NHS Outcome Framework Domain 1</td><td>Better Outcome

Citizen participation and empowerment

NHS Outcome Framework Domain 4</td><td colspan="2">Improved Quality and Safety

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

Specialised services concentrated in centres of excellence</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. We will create specific programmes tailored to their needs.

This represents our strategic intent and is reflected in our plan.

c) Our 6 key Principles

Since inception, the following 6 key principles have informed the work of the CCG:-

i) Patient and public involvement

The meaningful involvement of patients and public is of paramount importance. Throughout the NHS the patient is usually the coordinator of their care. It is key that contact with healthcare professionals adds clinical value. We believe this contact must be re-aligned, from a hierarchical dialogue 'expert to receptive patient', to a horizontal dialogue 'expert to expert'. Patients/families are most knowledgeable about their symptoms, bodies and psychological and social state. This self-expertise remains an under-tapped resource that if accessed will transform healthcare and well-being. Supporting autonomous living is of paramount importance. However when people do use healthcare we want them to have clearer information about the quality of services in order to inform their choices; and we want them to be better able to share whether services are working for them.

ii) Clinically Led

The public register with their GP and it is through the coordination that their GP provides, that they are able to best access the healthcare that they need. So our future health system will be organised around this key relationship between patient and their GP; providing a personalised service. Similarly, all population-based healthcare will be commissioned on a registered-population basis and will be organised in accordance with our GP and CCG structures (so around practices, localities and borough-wide) in order to enable a clear clinically-led approach to healthcare delivery.

iii) Primary Care at our heart

The vast majority of care is either delivered by General Practice or is accessed through it. The success of primary care is therefore central to the future success of our health services locally. We have already developed a primary care strategy, in conjunction with the Health and Wellbeing Board and NHS England. There are significant recruitment and retention challenges for our primary care services so development of primary care infrastructure and workforce will be central components to our on-going work – we want Dudley to have a national reputation as the best place to work for GPs along with their extended primary care and community staff. We will further enhance our shared commissioning of primary care with NHS England in order to ensure that this can be achieved.

iv) Working with partners in our communities

Our locality-based approach to the Better Care Fund initiative recognises the need to network our GPs, patients and associated primary care/community services, social care and the voluntary sector in order to respond to the variable needs of different communities across our population. Health inequalities can only be addressed through a jointly targeted community-based approach. We will build our partnership relationships through the organisation of all of our services for all of our populations based on clinical need.

v) Focus on quality and continuous improvement

We will take a predominantly developmental approach to quality improvement that encourages transparency by all our service providers to reduce variations in care and outcomes; and to aim for best practice performance. We will expect every service to be able to demonstrate the value and quality that it provides to patients. We will utilise a continuous evaluation process that will ultimately ensure that we do not commission any service that cannot demonstrate value; and will actively promote those that can demonstrate best outcomes for patients.

vi) Live within available resources

Dudley CCG will meet its financial responsibilities to address the reasonable needs of our population within available resources. This necessitates a drive for continuous efficiency and improvement given the economic constraints we face. Our emphasis will always be to maximise the effectiveness and availability of front-line services.

d) 5 Year Vision

In our 5 year strategic plan we have applied these principles to establish a new vision for healthcare which is characterised by:-

- **A Mutualist Culture** – which recognises the mutual relationship between GP and patient and the associated rights and responsibilities in an organisation of member practices and registered patients.
- **The Structure of The System** – where we move away from traditional organisational boundaries and service categorisations to recognise the needs of individual patients in a modern world.
- **Population Health and Wellbeing Services** – commissioning proactive population based healthcare.
- **Health and Wellbeing Centres for the 21st Century** – providing the capacity to needed to deliver our vision of population health and wellbeing services.
- **Innovation and Learning** – investing in research, technology and information systems as a basis for improving our organisational performance and the effectiveness of the system.

2. The Challenges

a) System Challenges

The key challenges facing the Dudley health and social 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;
- the financial sustainability of our NHS partners;
- budgetary challenges facing Dudley MBC, in particular adult social care and children's services;
- the specific issue of budgetary pressures in adult social care and the potential impact on system equilibrium, affecting the ability to secure safe and timely 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 Any Qualified Provider (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, shared records and data sharing.

b) Financial Challenges

The CCG's financial plan for 2015/16 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 £6.3m per annum. To achieve this, 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) for 2015/16 is £7.2m. The main focus of initiatives in 2015/16 is a reduction in emergency activity. This will be twofold: -

- expanding the community rapid response service to reduce admissions to hospital through the Better Care Fund; and
- the redesign of urgent care with the opening of an urgent care centre on the 1st April 2015 that will reduce emergency department attendances.

There are also a number of separate qualitative schemes within the programme with a particular focus on better prescribing and more efficient elective pathways

Within the financial plan, running costs for 2015/16 have reduced by 10%. A review of all corporate services was carried out in 2014/15 in preparation for the reduction in allocation and savings were identified from internal structures, commissioning support contracts and other non-pay areas.

A key task for the CCG and its providers over the coming year is securing value for its patients. The CCG's commissioning intentions for 2015/16 stated that we will only procure services from providers that actively demonstrate the value they provide for the patients they treat. The CCG 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 challenging financial objectives over the planning period but will need to manage a number of key risks, the main ones being:

- not realising the full transfer of care (through the BCF) from hospital through to social care;
- the over performance of Acute contracts;
- the potential under delivery of identified QIPP schemes; and
- prescribing spend risk given the volatility of prescribing costs in 2014/15.

Mitigations have been identified, but given the challenging financial year ahead, the CCG may be in a position where it would need to decommission services to meet its statutory financial duties. If faced with these circumstances any process would be clinically led and involve all appropriate stakeholders, including dialogue with the CCG's population on how it will get best value from the resources available to it as a public body. For example, in the case of end of life care, the start point for any discussion would be the public views around the fact the CCG spends a significant proportion of an individual's lifetime care costs in the last year of life. If the CCG were faced with financial issues during the life of this plan, these discussions will be accelerated.

c) Performance Challenges

In 2014/15, we are on track to meet our key performance targets for referral to treatment time (RTT) and the Emergency Department (ED) waiting time. Nevertheless, performance challenges will remain in relation to:-

- referral to treatment times for urology, trauma and orthopaedics, opthalomology and oral surgery;
- The impact of delayed transfers of care on the ED 4 hour target;
- waiting times for some community services including physiotherapy, phlebotomy and counseling.

Our contracts for 2015/16 are designed to ensure that all NHS Constitution targets are met in terms of contracted activity levels. It should be noted that historically referral to treatment targets have been met.

The ED 4 hour wait remains the biggest performance challenge to the health and social care system. In response to this the CCG has taken action that deals with the current performance issues and ensure that the system is capable of sustaining performance in the future.

The System Resilience Group (SRG) will review the impact of those schemes put in place to sustain the system over the winter period and following the Group's agreement, the CCG will look to re-commission validates services on a recurrent basis.

This review will be concluded in early March. Schemes that are likely to be sustained include:-

- discharge to assess pathways;
- mental health street triage service;
- mental health urgent care centre;
- enhanced support for care homes;
- additional intermediate care assessment and therapy capacity;
- 7 day working for intermediate care and NHS Continuing Healthcare assessors.

The System Resilience Group has overseen the implementation of an action plan produced on the advice of the Emergency Care Intensive Support Team (ECIST), this will be embedded in 2015/16.

An agreed reporting mechanism to the SRG on overall performance will ensure that the system is properly held to account at both SRG and Health and Wellbeing Board levels.

As part of the Section 75 Agreement underpinning the Better Care Fund, the Council will be required to reimburse the CCG for excess bed day costs arising from delayed transfers attributable to social care.

Following work carried out with Professor David Oliver, a new care pathway will be developed for the frail elderly with a clear focus on retrieving patients from secondary care by our community teams

Sustained performance will also be achieved through our redesign of urgent care and the implementation of our rapid response service. Both these issues are dealt with below.

d) 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:-

- nearly 20% of our population have a limiting long term illness or disability, this has increased since the 2001 census and is worse than the national average;
- 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;

- the mortality rate in the 60 -74 age band is significantly higher for males;
- female life expectancy is 82.7 years – similar to the national average, whilst male life expectance is 78.5 years – lower than the England average of 78.9;
- male life expectancy varies across Dudley. Halesowen South has the highest at 82.1 years, Netherton, Woodside and St. Andrews have the lowest at 73.9 years – a gap of 8.2 years;
- nearly a quarter of deaths in the 40 – 59 age band are due to cardiovascular disease, smoking, obesity and lack of physical activity;
- mortality from respiratory disease is significantly higher than the national average. Lower respiratory tract infection is the major condition;
- mortality rates for alcohol related diseases are significantly higher than the national rate and the rate is rising for females aged 25-39;
- emergency admissions for alcohol specific conditions increases from the 40-59 age group;
- 12.1 % of adults aged 16+ participate in sport for 30 minutes 3 or more times per week, showing a downward trend and below the national average of 17.4%;
- nearly two thirds of ED attendances are for people living in the 40% most deprived group in Dudley;
- the next two decades are forecast to see an additional 25,100 people over the age of 65 and an extra 9,900 over 85;
- uptake rates for both cervical and breast cancer screening are below the national target of 80%;
- disease prevalence rates as determined by primary care disease registers are low compared to modelled prevalence, however, these have improved – most markedly for COPD;
- 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;
- 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;
- the rate of deaths at home or in care homes remains static and there is a higher percentage of terminal admissions that are emergencies than England.

For our children and young people:-

- the infant mortality rate is 4.5 per 1,000 live births, compared to 4.3 for England and Wales;
- male babies born in the most deprived areas of Dudley are up to 4 times more likely to die than those from the more affluent areas;
- children aged 10-11have a higher rate of obesity than the national average;
- emergency hospital admissions for 0 – 4 year olds have risen. This is particularly prominent for lower respiratory tract infections in the most deprived areas;
- the proportion of 9 and 11 year olds with a high self-esteem score has

risen, though 25% of pupils reported bullying. The proportion of 13-15 year olds reporting being bullied has risen to nearly 20%;
- the looked after children prevalence rate is significantly higher in Dudley and double the national rate;
- smoking at delivery was 14.3% in Dudley, higher than both England and the West Midlands;
- breast feeding initiation rates at birth and at 6-8 weeks are lower than in England. These are also lower in the more deprived parts of Dudley and in younger mothers.

"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.

e) Our Assets

The JSNA identifies the way in which an asset based approach can help improve the resilience and lives of people at neighbourhood level, focusing on people, places, causes and influence.

Building on community assets as a means of creating sustainable communities is an issue the CCG will pursue in its contribution to partnership working and addressing the wider determinants of health. This is recognised in our approach to the development of integrated service provision (see below).

f) JSNA – Key Messages and Actions

The key messages and actions arising from our assessment of the health status of our population are:-

- 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 provides an appropriate, differential intervention at neighbourhood level to respond to local health inequalities.
- Interventions in relation to cancer, heart disease, liver disease and stroke are required.
- We must ensure that our practices perform well in delivering smoking cessation services.
- Improved case finding, uptake of screening services and uptake of vaccination programmes are critical. Exploiting the potential of EMIS will assist this.
- The systematic management of patients with long term conditions in primary care and community health services will be a major contributor to our success, including the management of diabetes.
- The care pathway for COPD requires attention to reduce unnecessary admissions.
- The local alcohol harm strategy needs to be fully implemented by all partners.
- The integration of maternity services with pre-conceptual, health visiting and school nursing services, together with primary care and the voluntary sector will improve outcomes across the life course.
- Child health inequalities can be reduced by promoting the uptake of breast feeding and the prevention of smoking.
- 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.
- The end of life pathway needs review to increase the number of people who die at home and to reduce admission to hospital at the end of life.
- We require a continued focus on mental health and the relationship between mental health, physical health and the management of long term conditions.
- We need to ensure that our approach to prescribing and the input of our practice based pharmacists continues to improve our performance in relation to the use of drugs to reduce cholesterol, reduce blood pressure and manage atrial fibrillation.
- We need to ensure that our work on the systematic management of long term conditions, redesigning urgent and planned care pathways and integrating services in our localities is sensitive to the needs of our child population.
- As part of our approach to the Equality Delivery Scheme, we need to facilitate work with those groups protected by legislation where the difference in health outcome and need is greatest, as well as analyse the barriers to improved patient access and experience for these groups. This will be reflected in our Equality Objectives.
- We will use an asset based approach to our work with partners in addressing the wider determinants of health.

This is reflected in our plans.

3) Prevention

Our approach to prevention will be based on enhancing our existing long term conditions framework to address existing prevalence gaps, reduce health inequalities and embed evidence based practice on a systematic basis. This will be developed jointly with the Office of Public Health, acting also as a critical friend for our proposals.

Our programmes will involve delivery by primary care teams, practice based pharmacists, community pharmacy and primary mental health care. This will be linked to a robust monitoring framework.

The National Audit Office report on health inequalities identified specific high impact interventions which have a direct impact on the life expectancy gap demonstrated in the JSNA. These were:-

- increasing the prescribing of drugs to control blood pressure and cholesterol – there has been a 33% increase since 2008. We have set a local quality premium target to address the diagnosis of hypertension, we will develop a systematic approach to the management of long term conditions in primary care and work with the Office of Public Health and GPs to improve the uptake of vascular checks;

- increasing anticoagulation treatment for atrial fibrillation – our standardised mortality rates for all circulatory diseases have decreased by 12.8 compared to the England and Wales average and the local quality premium target for 2013/14 has been met. We will ensure we have a sustained approach to the prescribing of new oral anti-coagulants;

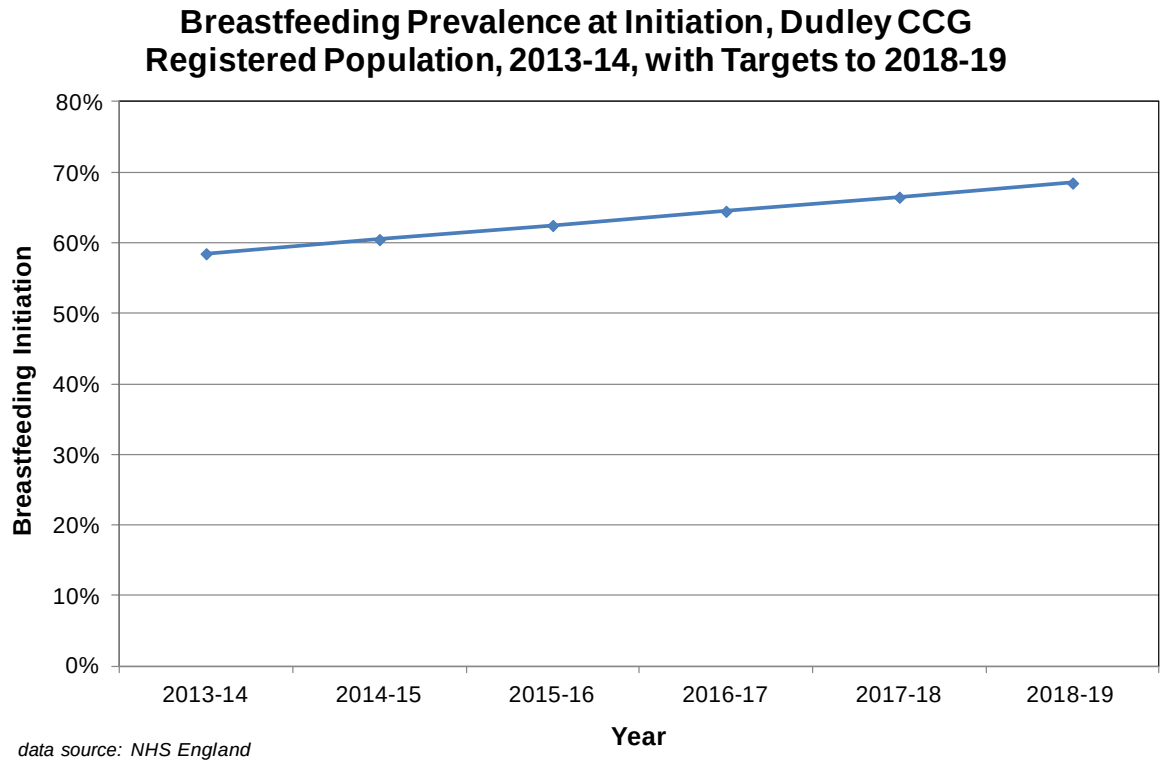
- improving blood sugar control for diabetes – in 2012/13, 62.5% of patients had an HbA1C equal to 7.5%, 71.1% = 8.0% and 81.7% = 9.0%. Our revised LES and the commissioning of a community diabetes service will continue to address this issue;

- increasing smoking cessation services. We will work with the Office of Public Health to encourage improved performance from general practice in delivering these services.

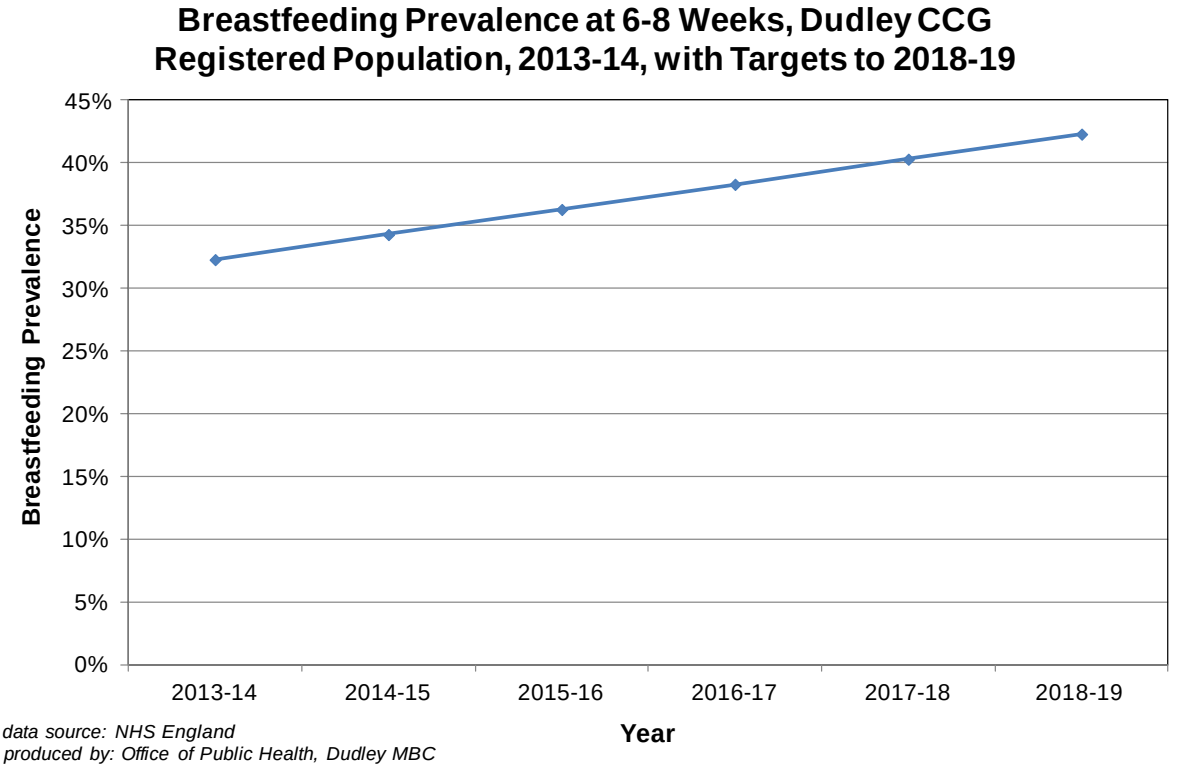
  We have agreed specific targets with the Office of Public Health, broken down by locality and practice for obesity, tobacco control and alcohol. These are shown as below:

a) Obesity

i) Shared breastfeeding targets (baseline 2013-14)

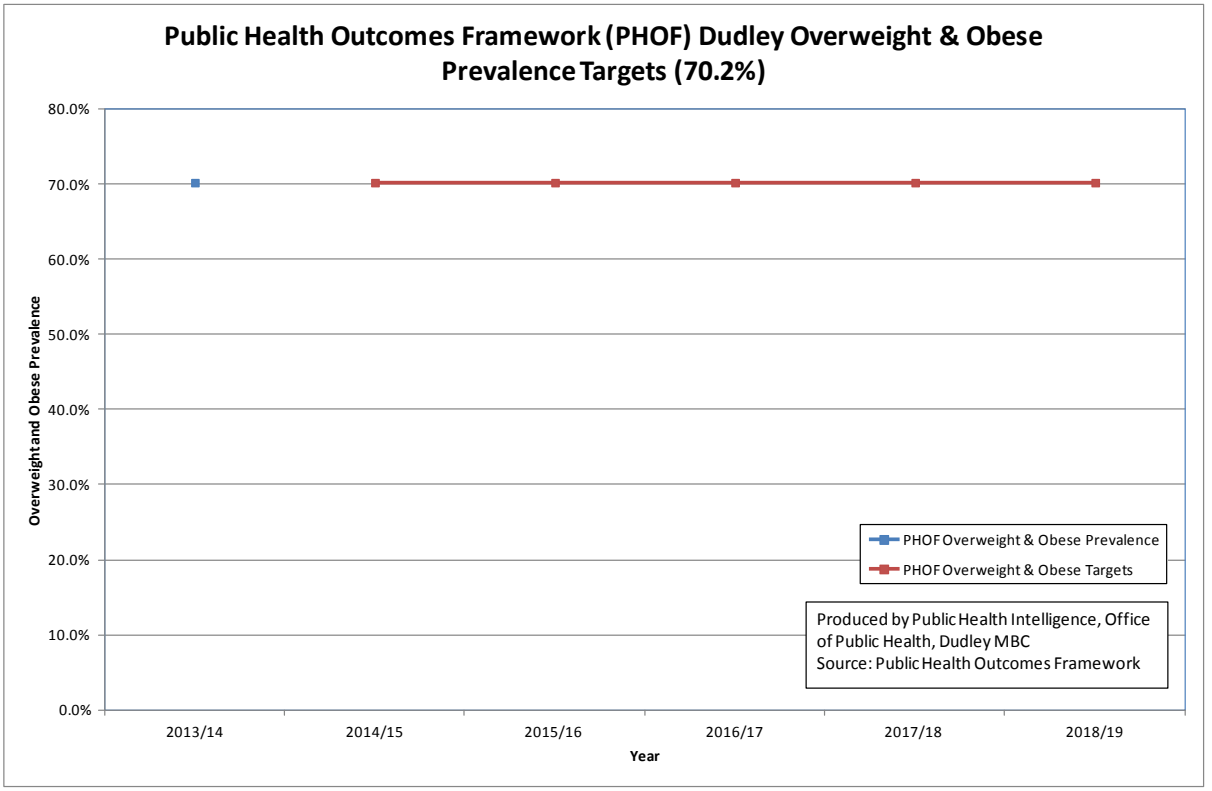


data source: NHS England

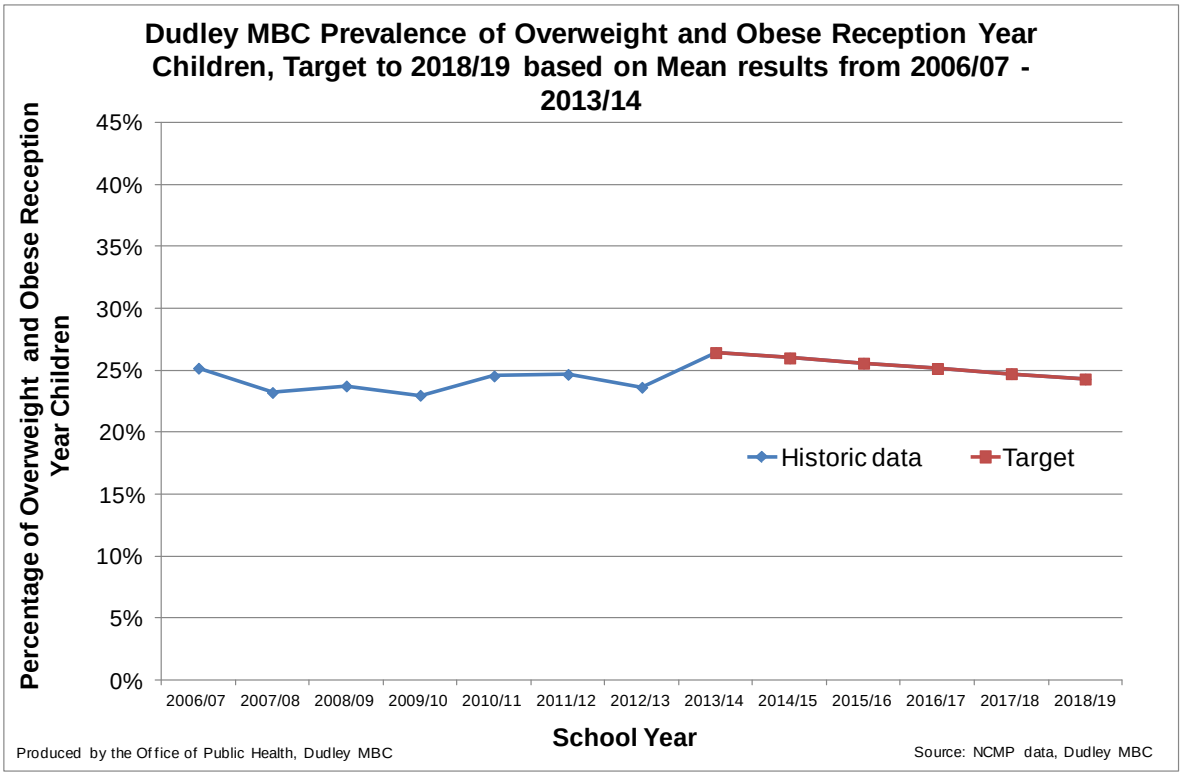


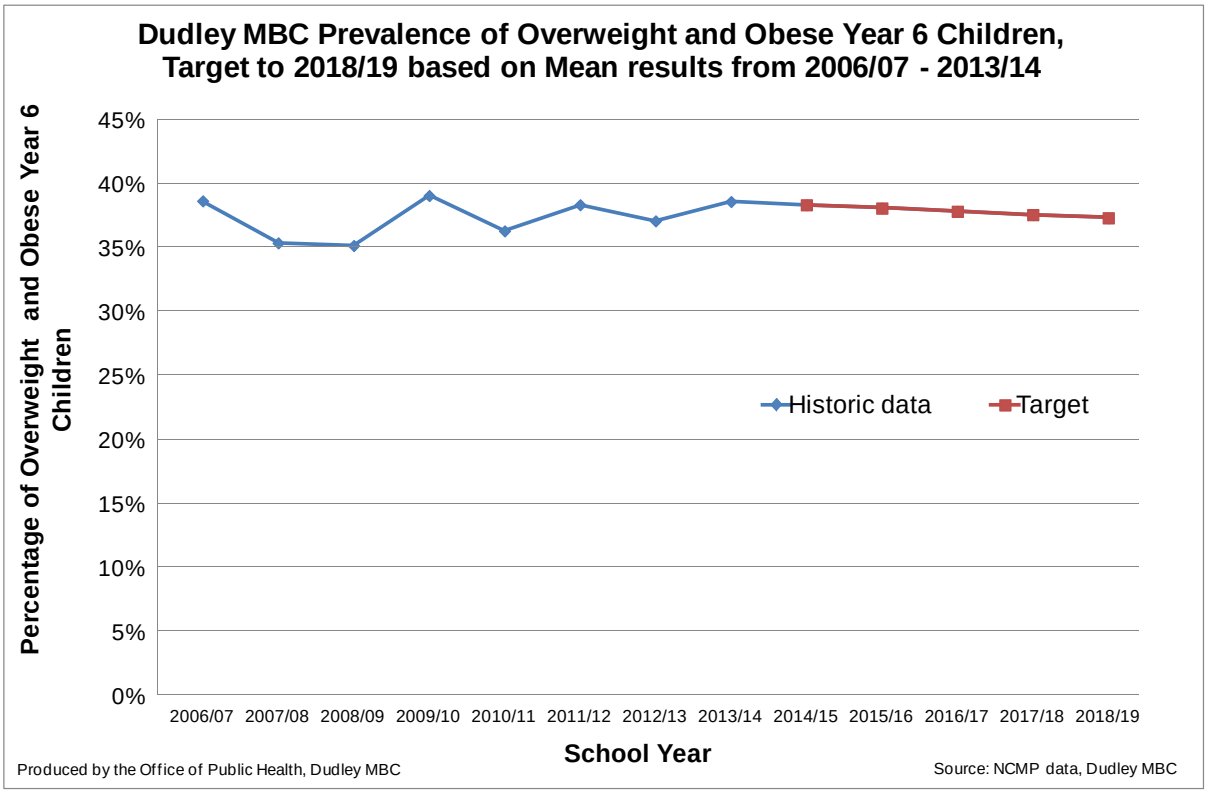
data source: NHS England
produced by: Office of Public Health, Dudley MBC

ii) Shared adult excess weight targets (baseline 2013-14)



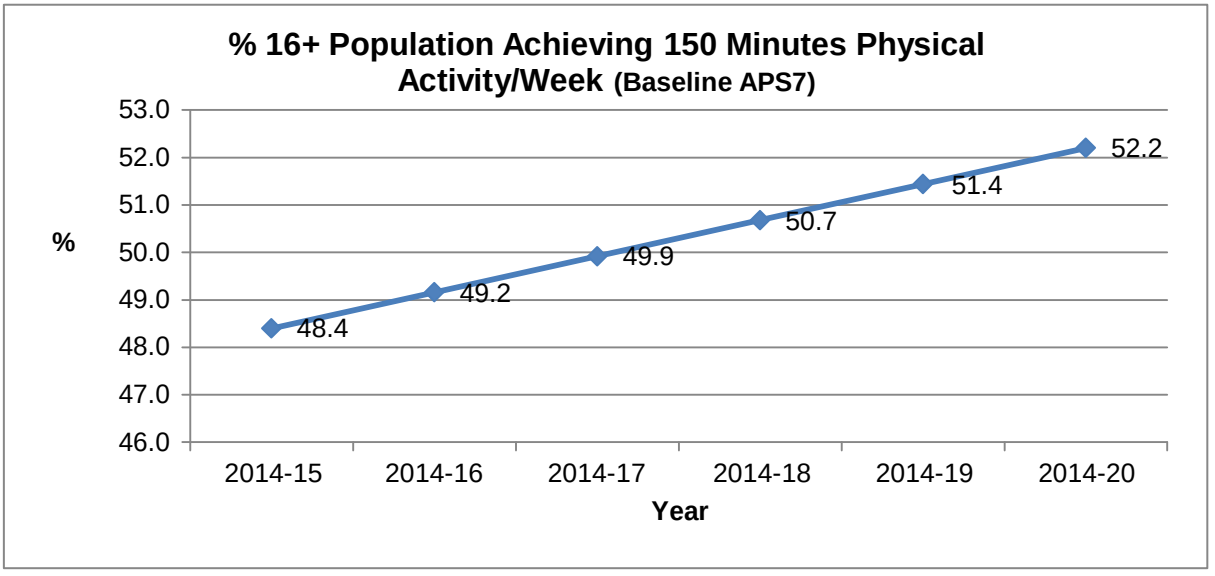
iii) Shared child excess weight targets (baseline 2013-14)





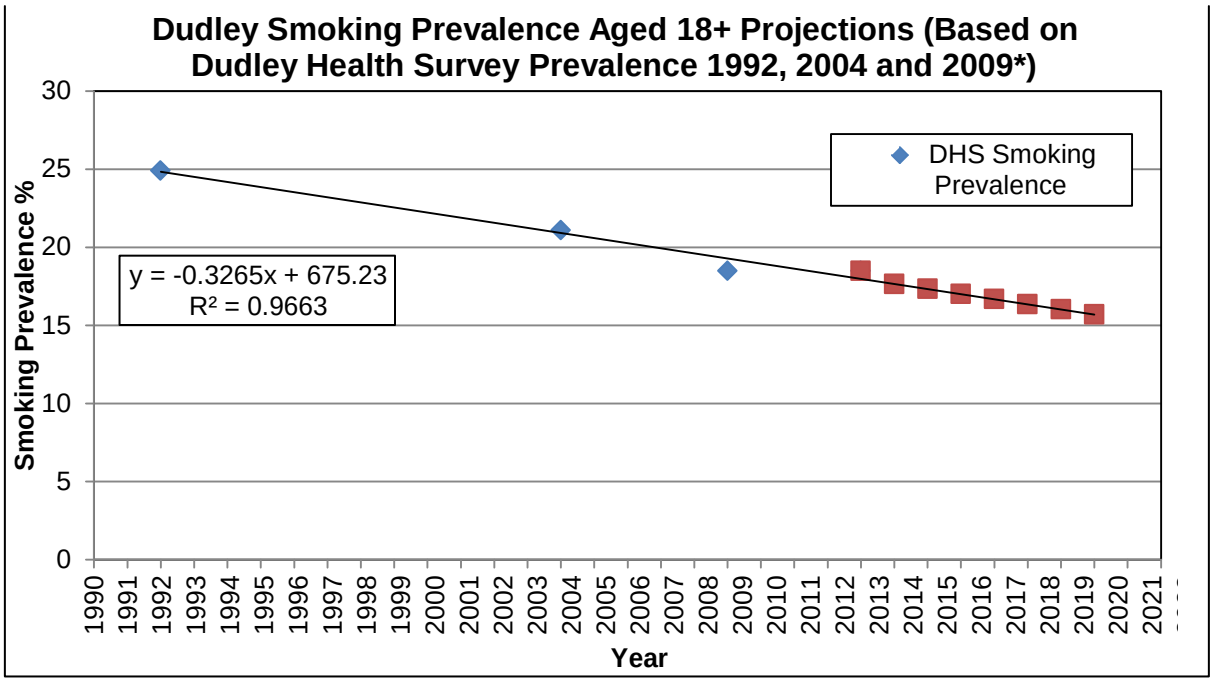
iv) Physical Activity

Percentage of Adults (16+) Taking 150+ Minutes of Physical Activity Per Week (Baseline Active Peoples Survey 7 2014)



b) Tobacco control

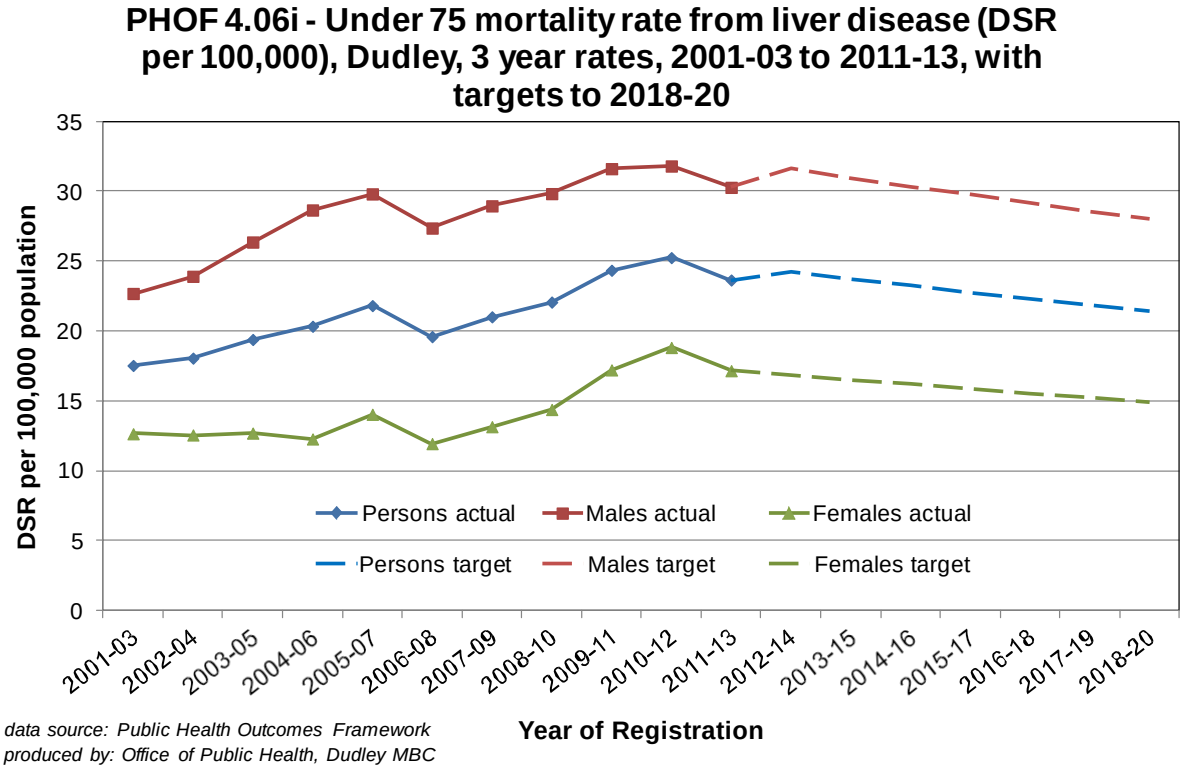
i) Smoking prevalence



* Prevalence was assumed to have remained constant between 2009 and 2013. Based on ONS Integrated Household Survey data

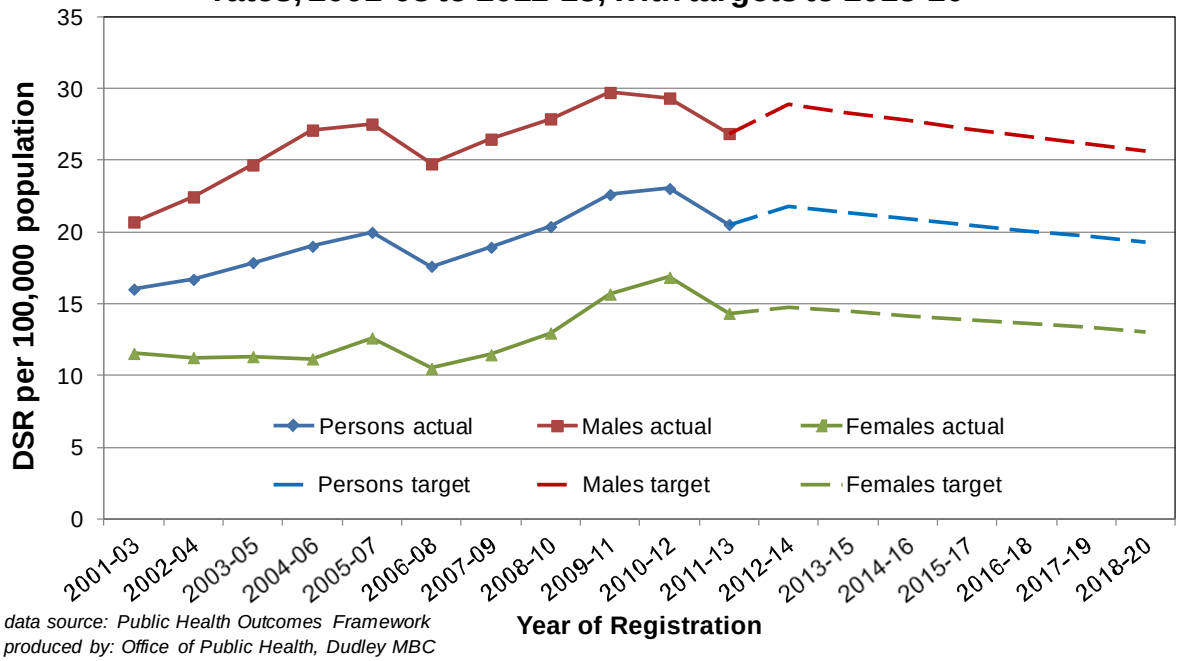
c) Alcohol

i) Alcohol mortality targets



data source: Public Health Outcomes Framework
produced by: Office of Public Health, Dudley MBC

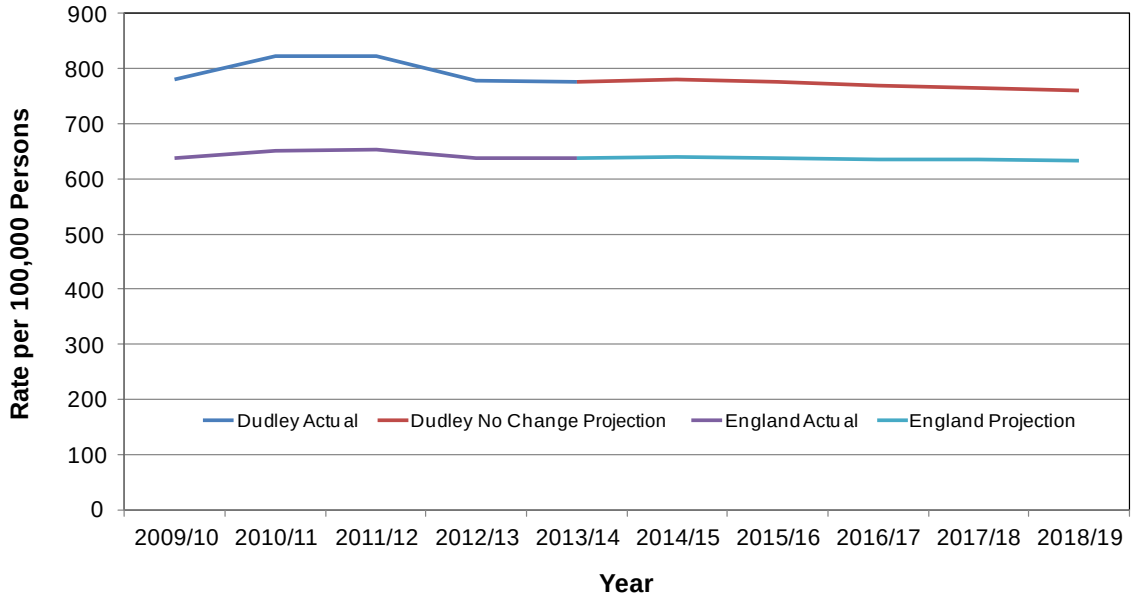
PHOF 4.06ii - Under 75 mortality rate from liver disease considered preventable (DSR per 100,000), Dudley, 3 year rates, 2001-03 to 2011-13, with targets to 2018-20



data source: Public Health Outcomes Framework
produced by: Office of Public Health, Dudley MBC

ii) Alcohol related hospital admissions

Alcohol Related Hospital Admissions per 100,000 Persons, Narrow Indicator, Dudley, 2009/10 to 2013/14 with Projections to 2018/19



data source: Hospital Episode Statistics (HES)
produced by: Office of Public Health, Dudley MBC

We will implement our recently approved physical activity and sport action plan which includes:-

- providing grants to local community groups to increase levels of physical activity;
- Including referral rates to physical activity schemes on our practice scorecard;

- looking to incorporate the inclusion of gyms in future premises development;
- building on our workplace health scheme for CCG employees and holding our providers to account for ensuring their staff have similar access.

We will extend the model of healthy living pharmacies and opticians to general practice. In partnership with the Office of Public Health a delivery framework will be developed and piloted, working with public health and practice staff.

For these practices their local community's health and wellbeing will be at the heart of everything the team does, consistent with our approach to population health and wellbeing. They will promote a healthy living ethos and deliver high quality public health services, such as smoking cessation, sexual health, NHS health checks and advice on alcohol and weight management.

The aim is to improve health and wellbeing and reduce health inequalities by using surgery staff to promote healthy living, provide well-being advice, signposting and services, and support people to self-care and manage long-term conditions. The teams will make every contact count to provide relevant health information.

Surgeries would be awarded the Healthy Living Surgery quality mark following a robust accreditation process.

The model will include:-

- each surgery having a Healthy Living Champion (with a Royal Society of Public Health qualification), who keeps up to date with community health services and spreads this knowledge throughout the team and a practice manager who has undertaken bespoke leadership training;

- a healthy living environment – a healthy living self-assessment and information area, promotion of lifestyle services and behaviour change campaigns.

The systematic management of patients with long term conditions will be part of this model. We have a significant group of patients identified by our risk stratification tool as being in the emergent risk cohort. At present, the approach to managing these patients is disparate and disjointed and the main commissioning vehicles for managing these patients in primary care are the Quality and Outcomes Framework (QOF) and enhanced services for diabetes and COPD. A more systematic approach is required to deliver better patient care, prevent risk escalation and find the 10% of patients that QOF alone fails to reach.

We will develop a new long term conditions framework making best use of the EMIS web system to support a systematised approach; case find; manage call and recall and extract data. The system will be developed in 2015/16, with a view to replacing elements of the QOF and existing enhanced services from April 2016. This will make a significant contribution to the early diagnosis of cancer and our one year survival rate.

Access to services is a major determinant of health status. We will enhance access to services in a number of ways:-

- more systematic case finding and call/recall systems using the EMIS
- system;
- identifying and responding to patients through risk stratification;
- encouraging GP registration for non-registered patients attending the
- Urgent Care Centre; commissioning GP services at weekends and making better use of
- telephone appointments;
- making primary mental health care available in non-stigmatising community venues;
- commissioning a minor ailments scheme from community pharmacy.

We have self-assessed against the "Better health outcomes" and "improved patient access and experience elements of the Equality Delivery System (EDS2). As well as the areas of action identified in this plan to deliver better outcomes and improved access and experience, we will, following a period of stakeholder engagement , review an agreed range of services in relation to these EDS 2 goals.

In addition we will:-

- implement the service specification for the redesigned the Dudley Respiratory Assessment Service (DRAS), aligned to our 5 localities and providing a step down service to the Rapid Response Service;
- reviewing the COPD pathway with a view to reducing emergency admissions;
- implement our diabetes model of care with a single point of access and triage for all referrals; the majority of care being provided in a primary care setting and the de-commissioning of routine type 2 diabetic reviews in secondary care;
- take part in the national Diabetes Prevention Programme;
- carry out further work on hypertension building on the outcome of the 2014/15 local quality premium scheme which has increased recording on primary care disease registers by 1%;
- implement a new pathway for anticoagulation services;
- commission IV antibiotics and IV diuretics in the community;
- implement the agreed familial hyperlipidaemia screening process;
- support a systematic approach to self-care programmes using appropriate technology, particularly in relation to COPD and heart failure;
- implement an integrated heart failure pathway across acute and community services, 7 days a week.

4. Community and Clinician Engagement

a) Community Engagement

Our key plans 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 their priorities.

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 health problems, 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.

b) Clinician Engagement

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.

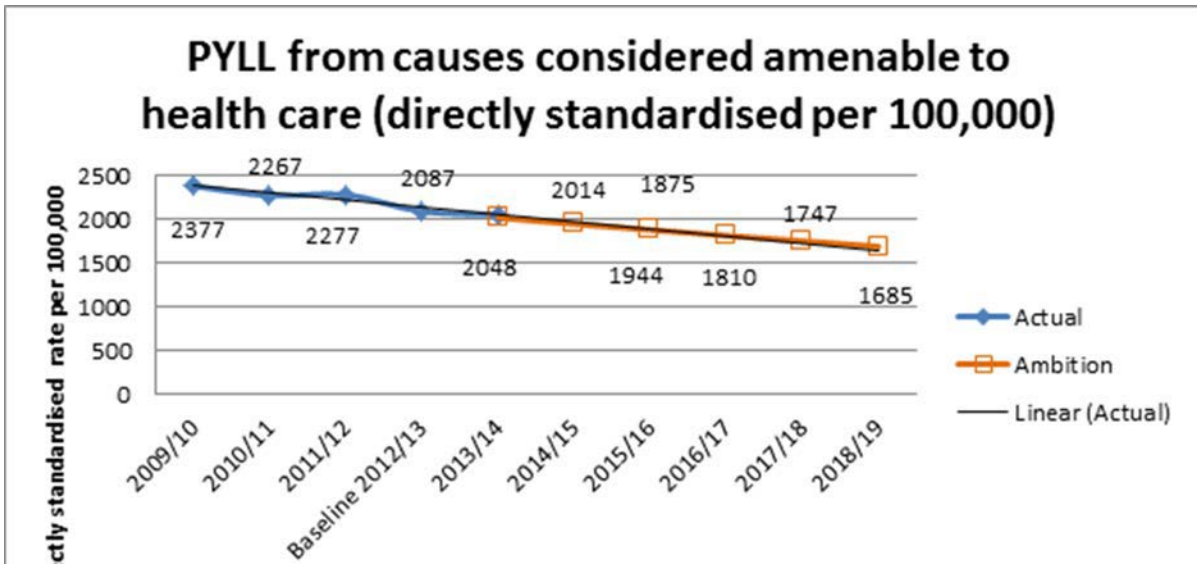
5. Our Outcome Ambitions

Our outcome ambitions reflect our assessment of local health need and key system effectiveness priorities. They have been drawn up with regard to the JSNA and in consultation with the Dudley Office of Public Health. Appendix 1 sets out our

outcome ambitions, their relationship to the JSNA and our initiatives to respond to them:-

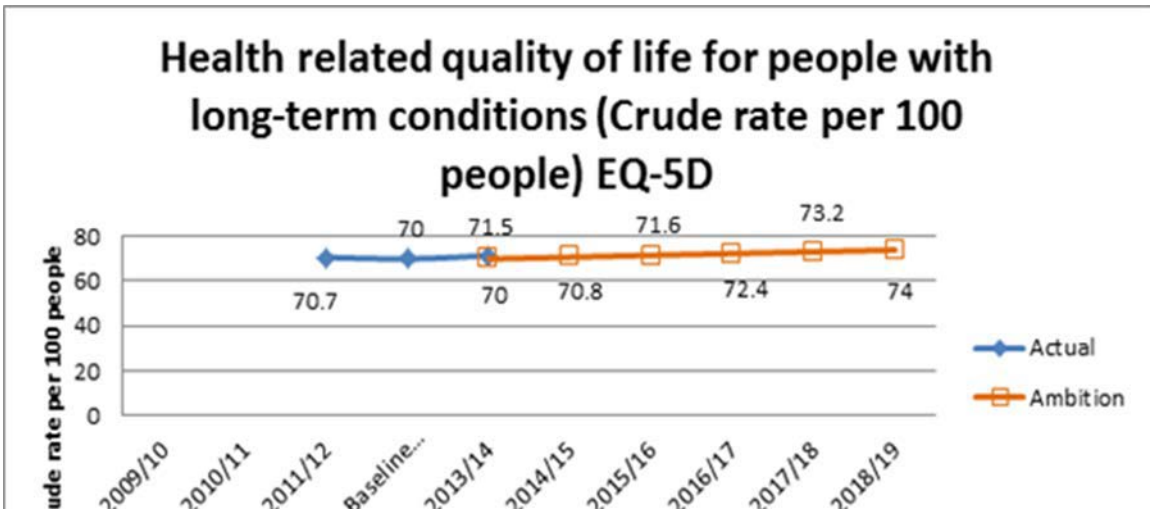
a) Securing additional years of life for people with treatable conditions:-

- 3.5% reduction in potential years of life lost (PYLL) per annum from 2087 per 100,000 in 2012/13 to 1943.5 per 100,000 in 2014/15 and 1685 per 100,000 in 2018/19;
- work with the Office of Public Health to improve the uptake of smoking cessation services in primary care.
- Work with the Black Country Be Active Partnership and Dudley MBC to ensure that general practice contributes to initiatives designed to promote physical activity, as part of our physical activity and sport action plan.



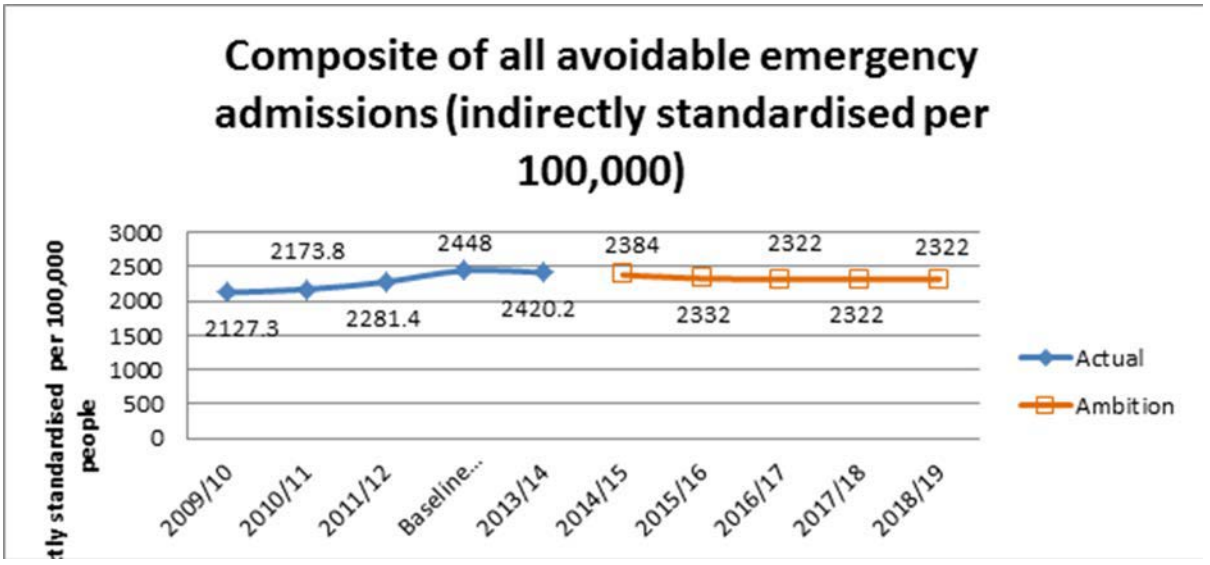
b) **Improving quality of life for 15m plus people nationally with one or more long term conditions:-**

- 70/100 people in 2012/13 reporting improved health status increasing 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% - current register 55,164 to
- 55,716 – an increase of 552 (local QP indicator);
- improve recording of disease in primary care registers, in particular for hypertension, heart failure and chronic kidney disease (recorded prevalence 18,838, modelled prevalence 31,398);
- work with the Office of Public Health and primary care to improve the uptake of vascular checks;
- work with the Office of Public Health on initiatives to reduce childhood obesity towards the England average.



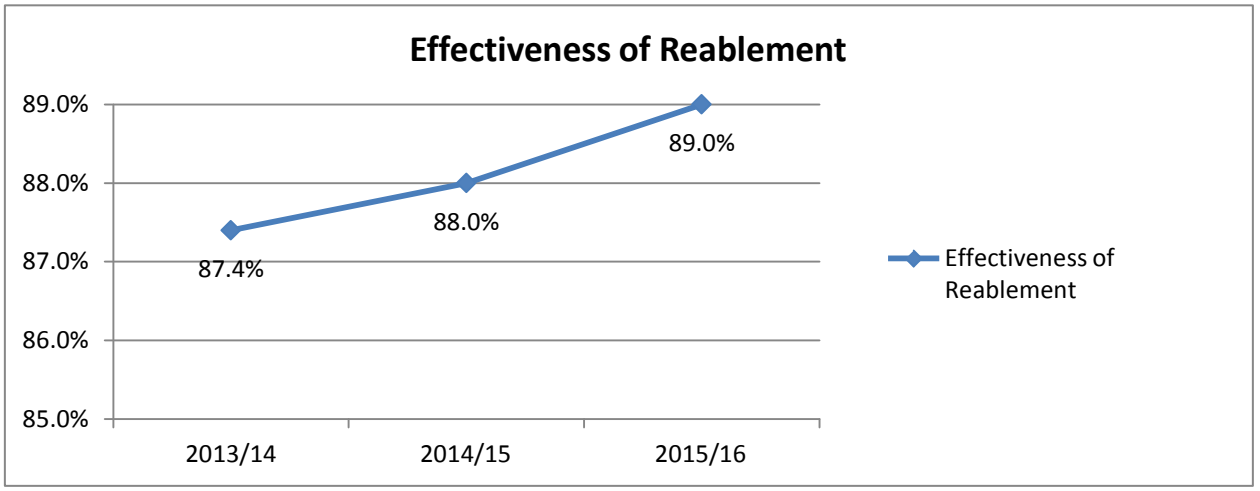
c) **Reducing time spent avoidably in hospital through more integrated community care:-**

- avoidable emergency admissions to be reduced from 2448 per 100,000 in 2012/13 to 2332 per 100,000 in 2015/16 and 2018/19.



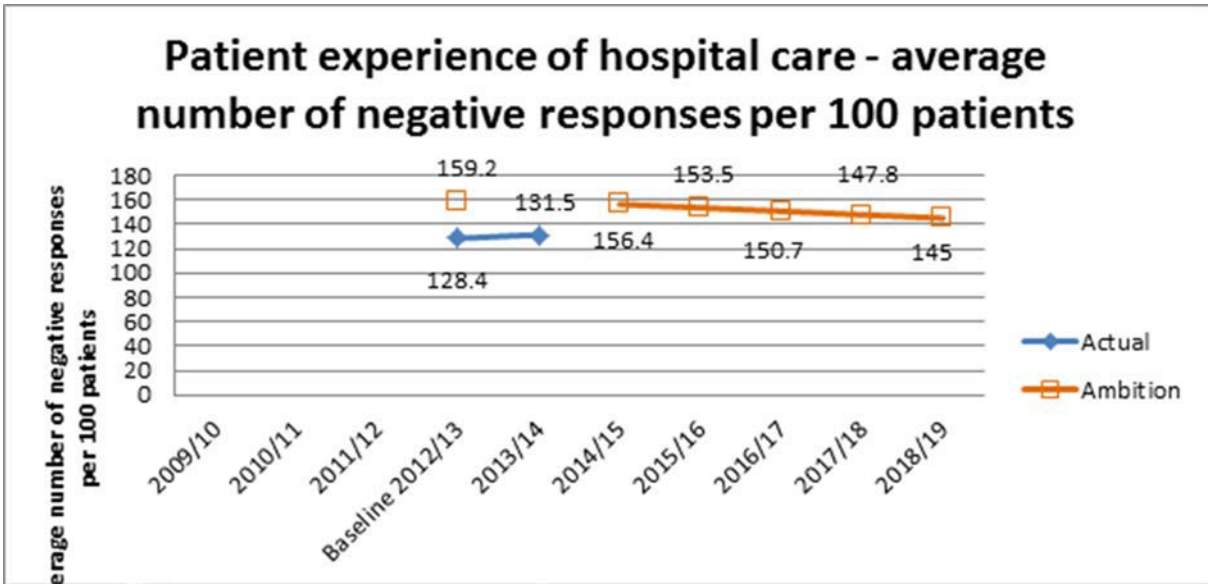
d) Increasing proportion of older people living independently at home after discharge:-

- people still at home 91 days after discharge to reablement will increase by 12 people in 2014/15, from 87.4% as at March 2013 to 88% by March 2015 and a further 11 in 2015/2016 to 89%. (BCF indicator).



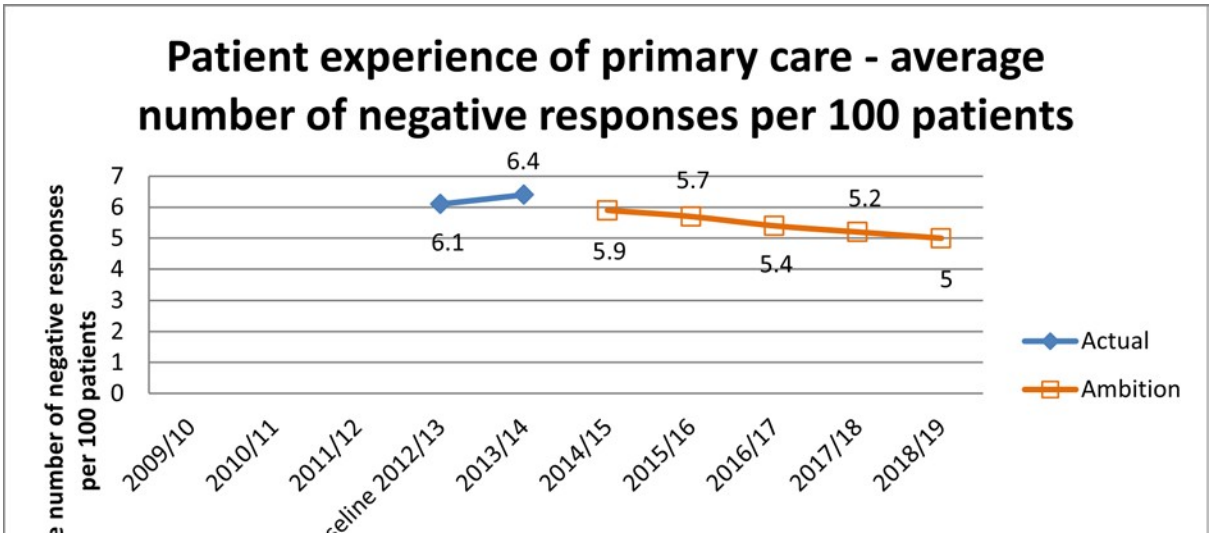
e) Increasing people's positive experience of hospital care:-

- 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;
- agree a plan with local providers to address issues identified in the 2013/14
- Friends and Family Test results (QP indicator);
- reducing the number of pressure ulcers: - zero tolerance of grade 4s, no increase in grade 3s and a reduction in grade 2s.



f) 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.



g) Progress towards eliminating avoidable deaths in hospital:-

- Medication incidents reported through the National Reporting and Learning System – quality of the reported learning to be shared;
- development of a reporting system to support the investigation and remedy of medication related serious incidents for which the medicines management team have received root cause analysis training.
- zero tolerance of MRSA. There have been no MRSA bacteremias in providers to date in 2014/15 , however, there has been one case attributable to the CCG.
- Clostridium difficile reduction from 117 cases to 108 cases by March 2015. This is on target to be delivered - the objective will be reduced further in 2015/16 and will be more challenging to achieve.

6. Commissioning for Quality and Safety

a) Holding providers to account

We will develop quality initiatives and use the Commissioning for Quality and Innovation (CQUIN) process to reduce patient harm and improve patient outcomes. This continues and CQUINs have been refreshed for 2015/16 and national CQUINS are awaited.

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. Progress has been made in giving feedback to the public on quality metrics – e.g. safer staffing levels. This will continue in 2015/16.

We expect all providers to develop clear clinical quality standards for their services and measure their performance against these. In 2015/16 we will focus on outcomes based quality standards for inclusion in contracts and will monitor providers against these mapped to the NHS Outcomes Framework.

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. We have used the CQUIN process to incentivize this for some providers until firmly established.

Mortality data and other variate intelligence continues to be used to triangulate an overall view of deaths. Where there are emergent patterns or themes, these are explored through a quality improvement approach.

We require providers to have in place mortality tracking processes including case note review to provide assurance of safe care and reduce avoidable mortality. Mortality is tracked through the Clinical Quality Review Meeting (CQRM) process, mortality and morbidity meetings, the use of national metrics such as SHMI and other qualitative intelligence such as complaints and incidents. A collaborative approach will continue to identify where acts of omission might have contributed to an avoidable death. We will participate in specialty specific mortality reviews.

From April 2015 the CCG will assume delegated responsibility for the commissioning of primary care. The CCG will put in place a comprehensive quality monitoring programme to ensure safe care.

Our educational programmes for primary care practitioners and community services will be used to share best practice and lessons learnt.

b) Francis, Berwick and Winterbourne View

The recommendations from the Francis report continue to steer service improvements and outcomes focused commissioning specifications.

In 2014/15 CQUINs were used to focus organisations on the Berwick report around organisational learning. The culture of learning climate will continue to be a feature of CQRMs supported by evidential matrices such as professional development, access to learning, learning and sharing from adverse incidents and feedback on what worked well. Organisational learning quality indicators will be further developed in the next twelve months to be included in contract specifications for 2016/17. Francis principles are now built into our business and contract management processes.

We have developed, in conjunction with our social care partners, a Winterbourne View action plan and achieved all actions on time as planned. Patients with a learning disability continue to be a high priority to ensure appropriate and timely placements based on individual assessed need.

We are reviewing the commissioning of assessment and treatment services with a view to commissioning:-

- a community based assessment and treatment service for those patients who would have traditionally been admitted to an inpatient facility;
- a community based "short breaks" service tp prevent placement breakdown and admission.

c) Staff satisfaction

In 2014/15 we used a CQUIN based on the American Association for Healthcare Research and Quality (AHRQ) report to inform and assist in the understanding of the patient safety culture as a means of influencing staff satisfaction. In 2015/16 we will build on this work and use nationally reported staff surveys to focus efforts and engagement.

d) Patient safety

There are robust processes in place to oversee the quality agenda across provider services supported by the Clinical Quality Review meetings between the CCG and each provider, and the CCG Quality & Safety Committee.

The main thrust of the patient safety agenda is to:-

- develop locally sensitive quality indicators and metrics to continually improve the quality outcomes of services;
- provide the governing body with a clear, comprehensive summary on the user view, effectiveness, safety and outcomes of services commissioned;
- monitor the performance of service providers against outcomes of agreed CQUINs and to support the development of future CQUINs;
- support the implementation of improvement plans put in place by service providers in relation to breaches in quality and safety standards, using outcome measures and appropriate time lines;
- review and act upon any notification, advice or instruction issued by the National Regulators or NHS England;
- review and act upon any notification, advice or whistleblowing issued by other agencies or individuals;
- review reports from service providers on progress and outcomes against existing Quality Account work plans, and to review the outcomes of any new work plans;
- monitor and receive reports on incident data (Serious Incidents, Never Events, unexpected deaths);
- quality exceptions reported since the last meeting previous week (such as whistleblowing, serious case review, adverse media reports);
- review safeguarding issues;

- review a suite of key indicators including HCA1 data, complaints, patient experience and a quality dashboard.

e) Seven day services

Our Service Development Improvement Plans set out our plans for implementing seven day standards. As well as assuring ourselves that our providers are putting in place appropriate arrangements for safe 7 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 national 7 day working NHS IQ transformational pilot site, we have developed 7 day service standards for community services which have been shared with NHS England. These standards will be reflected in our service specifications for 2015/16.

f) Compassion in Practice (CIP) and the 6 Cs

The nursing and allied health professional strategies of our main providers have been developed and assured against the expectations of "Compassion in Practice" and the 6Cs.

i) Care

Care is our core business and that of our organisations and the care we deliver helps the individual person and improves the health of the whole community. Caring defines us and our work. People receiving care expect it to be right for them consistently throughout every stage of their life.

ii) Compassion

Compassion is how care is given through relationships based on empathy, respect and dignity. It can also be described as intelligent kindness and is central to how people perceive their care.

iii) Competence

Competence means all those in caring roles must have the ability to understand an individual's health and social needs. It is also about having the expertise, clinical and technical knowledge to deliver effective care and treatments based on research and evidence.

iv) Communication

Communication is central to successful caring relationships and to effective team working. Listening is as important as what we say and do. It is essential for "no decision about me without me". Communication is the key to a good workplace with benefits for those in our care and staff alike.

v) Courage

Courage enables us to do the right thing for the people we care for, to speak up when we have concerns. It means we have the personal strength and vision to innovate and to embrace new ways of working.

vi) Commitment

A commitment to our patients and populations is a cornerstone of what we do. We need to build on our commitment to improve the care and experience of our patients. We need to take action to make this vision and strategy a reality for all and meet the health and social care challenges ahead.

The Next Steps

We will use our practice and community nurse fora to identify how the 6C principles are embedded and ensure our education programmes support this.

g) Provider cost improvement programmes

We continue to require providers to demonstrate a robust impact assessment process related to cost improvement programmes both in terms of qualitative impacts and operational impacts (such as reduced analytical or reporting capacity), and evidence of full reporting to their Boards. These will be considered by the CCG Quality and Safety Committee and appropriate assurance given to the Board.

CIP meetings are held with providers regarding the clinical quality impact of cost improvement programmes and how this translates into workforce plans. Our CIP approach extends to our commissioning plans in relation to creating a modern system of integrated community services, capable of preventing unnecessary admission.

l) Safeguarding children

i) Section 11 audit

Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard for the need to safeguard and promote the welfare of children and young people. As members of Local Safeguarding Children Board, key partner agencies have agreed to ensure that their duty to safeguard and promote the welfare of children is carried out in such a way as to improve outcomes for children and young people in the borough. Wherever possible, evidence of impact on improving outcomes for children should be identified.

For the Local Safeguarding Children Board to maintain oversight of the effectiveness of safeguarding children practice across the borough, and of the extent to which it is continuously improving, the key Section 11 agencies are expected to provide information on the arrangements they have in place to protect and promote the welfare of children and young people. This includes Dudley CCG as a statutory member of the Safeguarding Children Board.

The Designated Senior Nurse has completed the audit on behalf of Dudley CCG and its member practices for the period 2014/15. Overall the CCG is compliant with all of its statutory responsibilities. The CCG has worked hard to raise the profile of safeguarding children within the organisation and is working towards ensuring that

safeguarding is fully embedded in all aspects of CCG business including all contracts and service specifications. The correct governance structures are in place and staff have undertaken appropriate safeguarding children training.

Whilst the CCG has made excellent strides in listening to the voice of the child and determining wishes and feelings of local children and young people, they are not currently involved in service development and redesign. The CCG has plans to develop a cache of young health champions in an attempt to improve local children's and young people's health by: -

- working with other young people to help to set up and support new health projects;
- becoming active and key partners working with health organisations to help develop health services for young people;
- Influencing young people to live healthier and active lives and providing peer support and a voice for young people around health issues.

With regards to safer recruitment processes, whilst all of the managers and HR staff within the CCG have undertaken recruitment training, this does not specifically include the safer element. The Designated Senior Nurse has undertaken safer recruitment training and the issue is currently being addressed in conjunction with the Head of Organisational Development & Human Resources. All appropriate staff will undertake training in 2015 and this will be arranged via a Department for Education e-learning package or delivered face to face from a member of the Dudley Safeguarding Children Board.

The final report of the Midlands Safeguarding Review commissioned by the CCG in 2014 will be presented to the Quality & Safety Committee in April 2015 together with recommendations for action. The Board will be updated at its next meeting.

Safeguarding adults

i) Prevent agenda

The Prevent strategy is a cross-Government policy that forms one of the four strands of the Government's counter terrorism strategy. Prevent strategy was introduced as a specific requirement within the NHS Standard Contract for 2013/14 for provider organisations.

The CCG Safeguarding Team introduced new multi-disciplinary training workshops and has delivered 24 training sessions since April 2014. Training will continue to be offered at regular intervals in the future.

Prevent training is offered to all CCG front-line practitioners, and is promoted via Member News, practice meetings, and other training events.

ii) Care Act and NHS Accountability framework

NHS Accountability Safeguarding Framework has taken into consideration the Care Act which Adult safeguarding is, for the first time, spelt out in the law in the Care Act. Local authorities must make enquiries or ask others if they believe an adult is, or is at risk of being abused or neglected. The legal framework is to enable key organisations

and individuals with responsibilities for adult safeguarding to agree on how they must work together and what roles they must play to keep adults at risk safe. Safeguarding adults board will be a key requirement which includes key stakeholders such as Health and the Police. This board will carry out safeguarding adult reviews when people die as a result of neglect or abuse and there is a concern that the local authority, or its partners, could have done more.

iii) Transforming Care – Next Steps

NHS England has published a system-wide report on transforming services for people with learning disabilities. *Transforming Care – Next Steps* sets out a cross-system programme to transform services for people with learning disabilities and/or autism. The report represents the latest stage in responding to the recommendations of the *Winterbourne View – Time for Change* report. The report was produced jointly by the following organisations:

In particular, the report focuses on the need to provide mental health hospital placements in some circumstances where there is a genuine need and in some cases as an alternative to custody, however a commitment to seeing a substantial shift away from reliance on inpatient care remains. Inter-agency efforts will be focused on:

- a substantial reduction in the number of people placed in inpatient settings;
- reducing the length of stay for all people in inpatient settings;
- better quality of care for people who are in inpatient and community settings;
- better quality of life for people who are in inpatient and community settings.

To achieve those ambitions, a number of work streams will be pursued:

- empowering people and families;
- getting the right care in the right place – both by ensuring that the current care system works for patients and families, and by designing and implementing changes for the future;
- regulation and inspection: tightening regulation and inspection of providers, strengthen providers' corporate accountability and responsibility, and their management, to drive up the quality of care;
- workforce: improving care quality and safety through raising workforce capability;
- data and information: underlying all the work streams above will be a focus on making sure the right information is available at the right time to the people who need it.

The Quality & Safety Committee will consider this report in more detail in April 2015, and make recommendations for further action. This report will also be discussed with providers via the Clinical Quality Review Meeting process and actions taken accordingly in conjunction with commissioning teams.

7. Parity of Esteem for People with Mental Health Problems

“Healthy minds” is one of our Health and Wellbeing Board’s 5 priorities (see above). The Board has 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".

To deliver parity of esteem we will increase our investment in mental health services by £1,118,000 for 2015/16.

a) Mental health at the heart of our integration model

Our integrated locality service model (see below) is focused on both physical and mental health. Mental health practitioners are key members of our locality teams, recognizing 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. Access to locality link workers and a social pre scribing scheme enhances this provision and the case study in our film on MDT working illustrates this.

https://www.youtube.com/watch?v=4vKTOIMwoxw

We will work with our practices 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.

Evidence has demonstrated that historically medications prescribed for mental illness and lifestyle have had extensive side effects on physical health and life expectancy. The lifestyle of an average person with a severe and enduring mental illness is one of poor self-care, poor diet, heavy smoking, sedentary behaviour all exacerbated by poor motivation, lack of insight and lack of capability to bring about the necessary changes. This creates a gap in life expectancy when compared to others without mental illness. There is also evidence that many people with mental illness develop diabetes, heart disease, respiratory disease and high blood pressure.

For people with a mental illness, their physical illness is just as important and must not be ignored. GPs and our service providers are required to undertake regular physical health checks on all patients and make every contact count.

We will continue to work with our partners to develop the "healthy neighbourhoods" envisaged in our Joint Health and Wellbeing Strategy, providing opportunities for guided walks, cookery and weight management classes. Our physical activity and sport action plan (see above) will contribute to this.

b) Access

We will work with the Office of Public Health to tackle the issue of poor access by people with mental illness to public health interventions which can increase life expectancy e.g. smoking cessation, screening programmes and immunisation**.**

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 review the provision of primary mental health services and look to use the AQP procurement mechanism to extend choice where

we consider this appropriate.

c) A new mental health service model

We will commission services which are “age appropriate”. The current age criteria do not reflect the differing ability of the brain to process cognitive information which is evidenced to be effective from 14 years of age, or to develop psychosocial maturity which enables processing of emotion and thinking evidenced to be effective from 21 to 25 years. These factors are vitally important in how people accessing services can effectively utilise and achieve optimal outcomes from the interventions provided.

We intend to commission services for people aged 0 to 25 years and 25 years upwards, together with a specialist dementia service. We will eradicate the gap in provision for young people aged between 16 and 18 years created by the current criteria. This will also include appropriate out of hours provision for young people.

As part of this model, we will commission a multi-agency hub as a single point of contact for children; young people; and their families experiencing social; emotional; developmental and/or safeguarding problems. This will include access to community based eating disorder services.

We will ensure that there is a primary care mental health service for people aged 0 to 25 years and 25 years upwards. Research demonstrates that 50% of first time experience of mental health problems will occur by age 14 years and 75% by age 25 years.

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

d) Pathway efficiency

We will look specifically at the pathway for early intervention in psychosis with a view to eliminating any unnecessary variation, enhancing pathway efficiency and meeting the new waiting time standards. We will apply the same approach to the IAPT pathway as we seek to meet the new waiting time standards for this service.

e) Crisis care

As part of our commitment to the Crisis Care Concordat, we will review the operation of our mental health urgent care centre that has been in place over winter, incorporating our existing psychiatric liaison service with a view to making this a permanent, “all age” service.

The street triage service, providing a combined ambulance service, mental health and police response to people experiencing mental health crises, has been a successful scheme this winter. It has:-

- prevented the unnecessary use of ED;
- prevented unnecessary use of our local place of safety;
- made better use of police and ambulance service resources;
- avoided the criminalisation of people with mental health problems.

We will now look to commission this service on a permanent basis. We will ensure that our new model of urgent care provides an appropriate and timely response to those presenting in crisis.

f) Substance misuse

We recognise the significance for the local system of alcohol related admissions and the associated dual diagnosis. We will work with the Office of Public Health on prevention initiatives associated with alcohol. Again, our integrated service delivery model and our approach to risk stratification will address the issues associated with substance misuse.

8. Children's Services

We will apply the principles of parity of esteem to children as well as adults. This will apply to all children who are or might become vulnerable. Although there is no one way of measuring vulnerability, in general it can be said that a vulnerable child is one who is unable to keep themselves safe from harm, or who is at risk of not reaching their potential and achieving appropriate outcomes.

We will work with partners to commission services which ensure that this group of children have the necessary additional support to allow them to achieve and engage to the same level as other children and young people. Initiatives to support this include: -

- ensuring that the looked after children health assessment pathway meets demand and delivers outcomes;
- promoting breast feeding;
- preventing smoking by pregnant women;
- work in partnership with the Office of Public Health on initiatives to reduce childhood obesity;
- providing support to carers;
- fulfilling our statutory duty to contribute to education, health and social care plans for children with special educational needs;
- reviewing existing services designed to meet our statutory duties for safeguarding;
- reviewing the end of life pathway and improving Advanced Care Planning;
- implementing an integrated children's community health service;
- expanding our paediatric triage service;
- introducing "Health Champions" for young people.

9. Our Key Priorities – 2015/16

In responding to the challenges we face there are 4 key priorities which need to be delivered in 2015/16:-

- **urgent care** – our new Urgent Care Centre becomes operational from 1st April 2015. We will ensure that this functions effectively to eliminate inappropriate demand;
- **planned care** – the delivery of service efficiencies through the elimination of unwarranted variation in our pathways for ENT, diabetes, cardiology, ophthalmology, urology and orthopaedics;
- integrated care – completing the implementation of our model of practice based multi-disciplinary teams, transforming the nature of joint working across health and social care and providing a real alternative to hospital admission;
- **primary care development** – co-commissioning a modern system of primary care capable of managing patients systematically supported by skilled staff, appropriate IT and modern premises.

These are dealt with in detail below.

a) 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.

b) System Characteristics for Transformation

In December 3013, NHS England identified six key characteristics which sustainable health and care systems will need to demonstrate by 2017/18. Our key initiatives in relation to these are set out below.

In terms of delivering system transformation, the CCG has put forward a proposal to develop a new model of care as envisaged in the NHS Forward View. This is a variant of the multi-specialty provider (MCP) model and is described below.

c) A new model of care

We are implementing a sustainable and replicable whole-system change, designed around the person, communities and clinically-led delivery, which enables both mutual-networked care and best practice pathways of care.

We have already made significant progress to implement the main components and key enablers of this care model in 2014/15.

Our core objective is to support population-based health and well-being: for the person, registered with their GP, with the GP as the main co-ordinator of care, organised around the concept of mutual-networked care. This, in effect, creates a Multispecialty Community Provider (MCP).

This means providing a network of care that is organised around, and adaptive to, patients' changing needs. Care will be delivered with a focus on mutuality between patients and professionals, to change the medical dependency model of expert-patient and maximise the potential for people's wellbeing. Care will be commissioned to encourage services to take a shared responsibility for shared outcomes for the same population of patients; and to establish co-produced outcome objectives with each individual person.

Our second objective is to implement best practice pathways of care for value-added treatments provided to individuals – either planned or in an emergency. This means re-orientating the way we both commission and organise care on the basis of patient centred pathways, removing unwarranted variation to achieve best possible clinical outcomes, as well as efficient delivery of care.

i) **Clinical development**

The core concepts of the clinical model are that care should first be person-centred, integrating population-based health and wellbeing services around the person:-

- to maximise people's independence from care;
- based upon the registered patient with the practice.
- delivering best practice pathways of care:
- to achieve best possible outcomes from treatment;
- to provide efficient care offering the best possible experience.

Secondly, that care should be designed around our clinical delivery, with GPs as the lead coordinators of population health and wellbeing:-

- providing care-coordination of mutual-networked care;
- taking shared responsibility for achieving shared outcomes for patients.

With consultants as the lead co-ordinators of pathways of care-providing value-added treatments in line with best practice.

ii) **Stage one – teams without walls**

The first stage, already substantially in place, of delivering this mutual-networked

care is to establish across our borough (population c318,000) a joined up network of GP-led, community-based multi-disciplinary teams which enable health, social care and the voluntary sector to work together in “teams without walls” for shared benefits and outcomes, coordinating the care planning for individual patients.

These teams transcend organisational boundaries and interests, and focus collectively on delivering integrated patient centred care aimed particularly at that cohort of patients identified as being most at risk of emergency hospital admission. This concept begins at practice level with Multi-Disciplinary Teams (MDTs) including the GP, District Nurse, Assertive Case Manager, Mental Health Worker, Social Worker and Voluntary Sector Link Worker.

A detailed explanation of this model is set out in our film on integration
https://www.youtube.com/watch?v=4vKTOIMwoxw
which we have used this to inform our existing system change.

iii) Stage two – aligning specialist services

This involves expanding the mutual network of care to fully incorporate all specialist community services and some aspects of urgent care, better aligning health and social care services into a single approach – such as single access to CAMHs services and the integration of telecare and telehealth.

This includes the establishment of a community rapid response service, designed to intervene in a crisis in the patient’s home – both avoiding the need to go to A&E and connecting the person back into their local network of care.

This also includes redesigning the model of urgent care to establish a primary-care led urgent care centre as a point of triage for all patients attending hospital. This will open in April 2015, will reduce the need for ED services, and will connect people back to their local primary care service.

iv) Stage three – community care led retrieval

This extends the model to include current consultant-led services which operate to support population health and wellbeing.

This next stage has already been agreed by our clinical strategy board, which includes consultants and GP leadership from across the CCG and our main provider. This will include specialties which support the management of long-term conditions such as diabetes medicine and respiratory medicine. Consultants will work in partnership with GPs to the same outcome objectives for improving population health and wellbeing. This will include collaborating to deliver improved services to the frail elderly.

Our ambition is to remove all delayed transfers of care from the system. We will achieve this by shifting the locus of control from hospital to community. The integrated MDT, with support from consultant physicians, will become responsible for the whole pathway of care for the frail elderly: from community, into hospital and back into the community – so that there are no longer any transfers of care. Patients will be retrieved back into the community rather than transferred from one team, or

one organisation, to another.

v) In parallel – whole pathway care

We will be piloting a new approach to planned care to develop best practice pathways of care – based upon the whole pathway of care followed by the patient.

Our aim will be to streamline and standardise the actual pathways that patients follow, so that they are fully patient-centred, efficient and deliver best practice outcomes. We are looking at the whole pathway, not just the stages from referral to treatment.

d) **Citizen Participation and Empowerment**

- Each of our practices will have an active Patient Participation Group (PPG), moving from 44/47 in 2014/15 to 47/47 in 2015/16.
- We will capture the experiences of patients in practices and develop improvement measures with our PPGs.
- We have delivered a structured programme of training and development for PPG members, we will now develop a guide to support their future development.
- We will build on the success of our #mefestival for young people, with a further event for young people in 2015/16.
- We will work with the Primary Care Foundation, our PPGs, our practices and NHS England to develop innovative approaches to enhancing access to primary care. This will include feedback given by the Youth Council to our Board on how young people prefer to access health services. Areas to be examined include arrangements for access to repeat prescriptions; telephone access and consultation; online access and arrangements for follow up appointments.
- We will ensure that we respond to the health needs of new migrants by developing a better understanding of our local communities.
- We have commissioned 5 voluntary sector community link workers in our localities to support our service integration model. We will ensure the benefits of this are embedded as our service delivery model is extended across all practices.
- We will continue to ensure our contracted levels of activity meet NHS Constitution requirements.
- Our Building Healthy Partnerships Initiative has supported the development of a refreshed community information directory for Dudley citizens. We will make sure this is promoted through all our communication channels.
- We will develop the PSIAMs tool to empower individuals to assess the impact of commissioning interventions on them. This will be used in particular for our social prescribing and primary mental health care services.
- We will work with Dudley Healthwatch and Dudley MBC to develop a local indicator of patient experience as part of our Better Care Fund performance measures.
- We will double the size of our citizen contact database to 1000 people who are interested in being actively involved in decisions about their health and

care.

- We will work with our partners to use all available communication channels to extend our reach to local citizens.
- We will work with more families to exercise their right to have personal health budgets for NHS Continuing Healthcare and examine how this can be extended to patients with long term conditions.

i) Engagement channels

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 of 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 2015/16 is to further develop a locality and borough wide structure, mirroring our GP practices, 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 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.

ii) Feedback

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 PPGs, POP and Health Care Forum;
- announced and unannounced visits to providers by the quality team;
- feedback from GP forums including locality and borough wide members' meetings.

iii) Developing our Engagement Network

- Each of our practices will have an active Patient Participation Group (PPG), moving from 44/47 in 2014/15 to 47/47 in 2015/16.
- We will continue to deliver a structured programme of training and development for our PPG members along with supporting innovations through our 'PPG Purse' bid programme.

- We will support our PPGs to have a stronger voice at locality and CCG Board level and continue to develop our POP, as a representative group for our PPGs.

iv) Supporting Young People

- We will build on the success of this year's #mefestival, to make this an annual youth summit.
- We will act on the feedback from our young people to develop a network of young health champions and strive to make our information more accessible to young people through the internet and social media.

v) Supporting Carers

- We have in place existing joint strategies with Dudley MBC to support carers and these will be refreshed for 2015/16.

vi) Improving Access to Primary Care

- We will build on the work from the Primary Care Foundation to engage our PPGs and our practices in developing innovative approaches to enhancing access to primary care.

vii) Supporting New Migrant Communities

We will ensure that we respond to the health needs of new migrants by:-

- developing a better understanding of our local communities, working with our partners and building on the JSNA; improving data recording in primary care so that we can more effectively target health interventions;
- working with Healthwatch to identify and respond to issues associated with access, quality and patient experience;
- identifying how we can ensure our engagement approaches are sensitive to the needs of new migrants.

viii) EDS 2 and the NHS Workforce Equality Standard

We will review the membership of the CCG Board in the light of the composition of the Dudley community and using the NHS workforce race equality standard. This will inform our succession planning process.

ix) Improving Information

- We will promote the new Dudley Community Information Directory for Dudley citizens.
- We will support practice staff to become Accredited Dudley Information Champions.

x) Measuring, Learning from and Improving the Patient Experience

We are working with our main provider, Dudley Group NHS Foundation Trust, to achieve openness and transparency of all patient experience data.

Through strong relationships and sustainable infrastructure we will initially work with Dudley Group Foundation Trust to establish a strong mechanism for recording and presenting patient experience from a variety of feedback sources into one central system. This system and methodology will be extended to all providers in Dudley.

- We will work with Dudley Group NHS FT to establish a system where an individual's journey can be measured and individual feedback can be used to establish the overarching issues but also provide the actions by having the ability to go right back to the individual story. We will develop the infrastructure in general practice so that friends and family test and other information provides real insight to our members, of the experiences of patients in their practice. With this information we will support our members along with our network of PPGs to reflect on these experiences and look at how both on a practice level but also locality and borough wide improvements can be made to patient experience.
- We will encourage partnership working across multiple organisations to make patient experience learning transferable between organisations and encourage other providers to be more open through the sharing of infrastructure and experience reporting templates.
- We will support this development through mutually aligned targets and measures for the services we commission.
- We will develop a smart phone app to capture more real time patient experiences, initially in the hospital but then in all healthcare settings in Dudley
- We will work with our PPGs to develop effective indicators of patient experience in primary care, measure these and develop action plans to enhance performance.
- We will work with Dudley Healthwatch and Dudley MBC to develop a local indicator of patient experience as part of our Better Care Fund performance framework.
- We will measure the success of this through patient experience insight of the Friends & Family test in primary care, comments posted on NHS choices and Patient Opinion and patient surveys.

xi) Invest in Social Value

- We will use the PSIAMS system of personal and social impact action measurement to understand the impact of our commissioning interventions as part of our approach to commission for value.
- We will develop the PSIAMs tool to empower individuals to assess the impact of commissioning interventions on them.
- By the end of 2015/16, 1000 assessments will be carried out by our Age UK partners leading to the issue of social prescriptions as necessary.
- We have a solid relationship with our local voluntary and community sector. The 5 locality link workers that support our practice based MDTs are an example of this. We will ensure that these workers act as a catalyst for mobilising volunteering in response to identified need.

xii) Let's get Personal

- 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.
- In terms of children's services, the CCG will explore how personal budgets can be used as part of the strategy for early intervention, recovery, family crisis and long term health conditions, including other circumstances identified through joint assessment.
- We will work with up to 15 families in exercising their right to have personal health budgets for NHS Continuing Healthcare and explore how this can be extended to patients with long term conditions.
- We will improve parental and young people's choice, access and control over services by working with Dudley MBC to explore how personal budgets can be used as part of the strategy around early intervention, recovery, family crisis, exclusion from school, and long term health conditions or other circumstances identified through joint assessment.

e) Wider Primary Care, Provided at Scale

i) In 2014/15

- All practices have worked in partnership with their PPGs to implement plans to improve access within their practices; opening hours within member practices have increased and seven practices have been commissioned to provide extended access on a Saturday morning, providing approximately 2000 more GP and nurse appointments over the winter.
- We have developed and implemented a support package to practices piloting the 'productive general practice' quality improvement programme that has improved practice efficiency; improved knowledge and skills for clinical and non-clinical staff; improved the leadership and change management skills; improved communication, relationships and staff morale; created and embedded the skills within primary care to lead and manage change
- We have supported all practices moving to EMIS web in 2014/15 and have put in place a support team whose sole function is to maximise the efficiency within our member practices: this has included developing standard protocols and searches across member practices and 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.
- We have increased the use of technologies within out member practices, such as telecare, online prescriptions and appointment booking.
- We have developed and commissioned a number of schemes and enhanced services that have resulted in service improvement and improved outcomes for patients, examples include healthy living programmes, customer service training for reception staff, telemedicine for COPD management and pilots that have prevented alcohol admissions using risk stratification tools.
- We have invested in the staff development and training for member practice staff, delivering care planning training to support the delivery of the unplanned admissions enhanced service; commissioning eLearning/online training packages to ensure CQC compliance

- We have worked with our practice managers group to develop and implement an annual training programme that has provided annual updates for practice managers, nurses and HCAs. Topics have included CPR, safeguarding, infection control, information governance and employment law.

We will be commissioning and rolling out the support package to a further cohort of member practices: expanding upon our existing and effective support structure for primary care by bringing together teams of specialist staff whose sole function is to maximise the efficiency within our member practices.

ii) Delegated Commissioning

Our primary care development strategy sets out six priorities which devolved commissioning will help us deliver:-

- managing workload and improving access - we have already conducted a comprehensive audit for improvement with the Primary Care Foundation.

- developing integrated locally-based services - primary care is at the heart of our integrated model which we have developed in partnership with Dudley MBC.

- managing the shift from secondary to primary care service provision - we have achieved our local quality premium targets and are developing a new long term conditions framework to develop provision in primary care.

- developing primary care's role in urgent care – we are implementing a new primary care led Urgent Care Centre.

- building resilient primary care and supporting practices to thrive - we have invested in a single IT system for all practices and established a premises development strategy to underpin delivering primary care at scale.

- reducing unwarranted variation and rewarding excellence - we have established a comprehensive practice support programme and a new quality performance tool.

Our proposal for full delegated authority is predicated on three areas:-

- to effectively review and pilot new ways of commissioning outside of the core requirements of GMS – setting one set of outcome measures that will apply to all those services commissioned and working as part of an integrated population based health and wellbeing service with primary care at the heart of the model;

- to commission for shared outcomes across the whole system of integrated care to ensure that all the organisations working in Dudley are working to the same outcome objectives for our population;

- to lead and manage the process for review and revising all GP contracted activity outside of GMS (so including QOF, enhanced services and PMS resource allocations), and retain any surplus within Dudley to reinvest within

Dudley to improve the quality of primary care services and support the delivery of our service integration model.

We have well developed plans to redefine and improve the quality standards for primary care, including an option for re-investing the “PMS premium” into a local quality improvement scheme.

We have the infrastructure to engage with our GP membership to support performance improvement - capacity that is not available to NHS England.

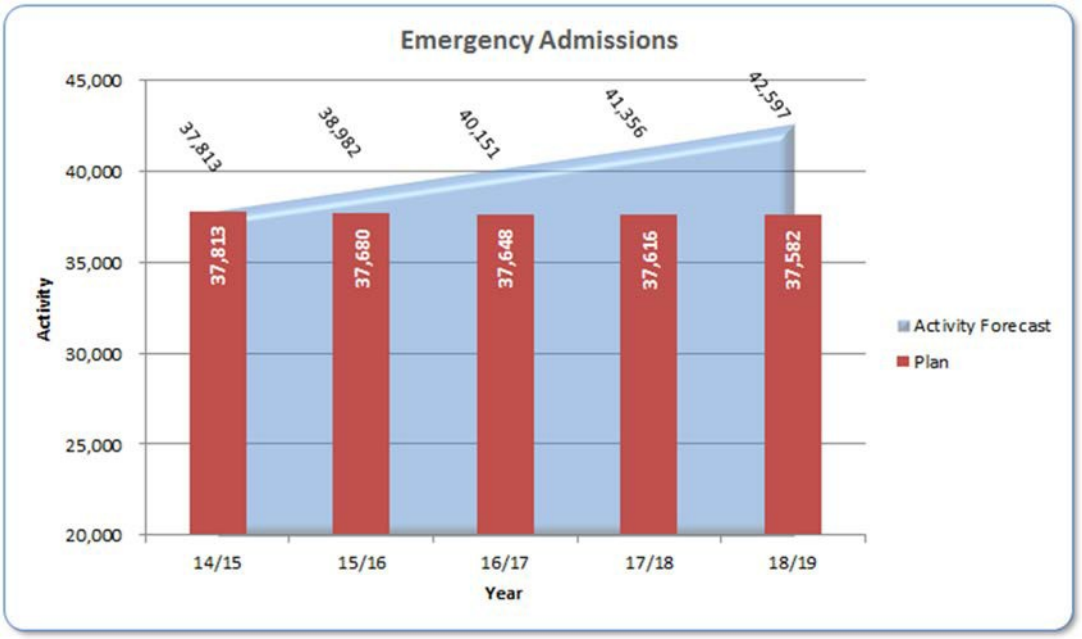
We have well established patient and public involvement in the commissioning of our services as described above.

We have developed robust governance arrangements that have been independently assessed by the Good Governance Institute. These include a revised conflict of interest policy; standards of business conduct policy; and amended constitution that have been agreed by the CCG Board.

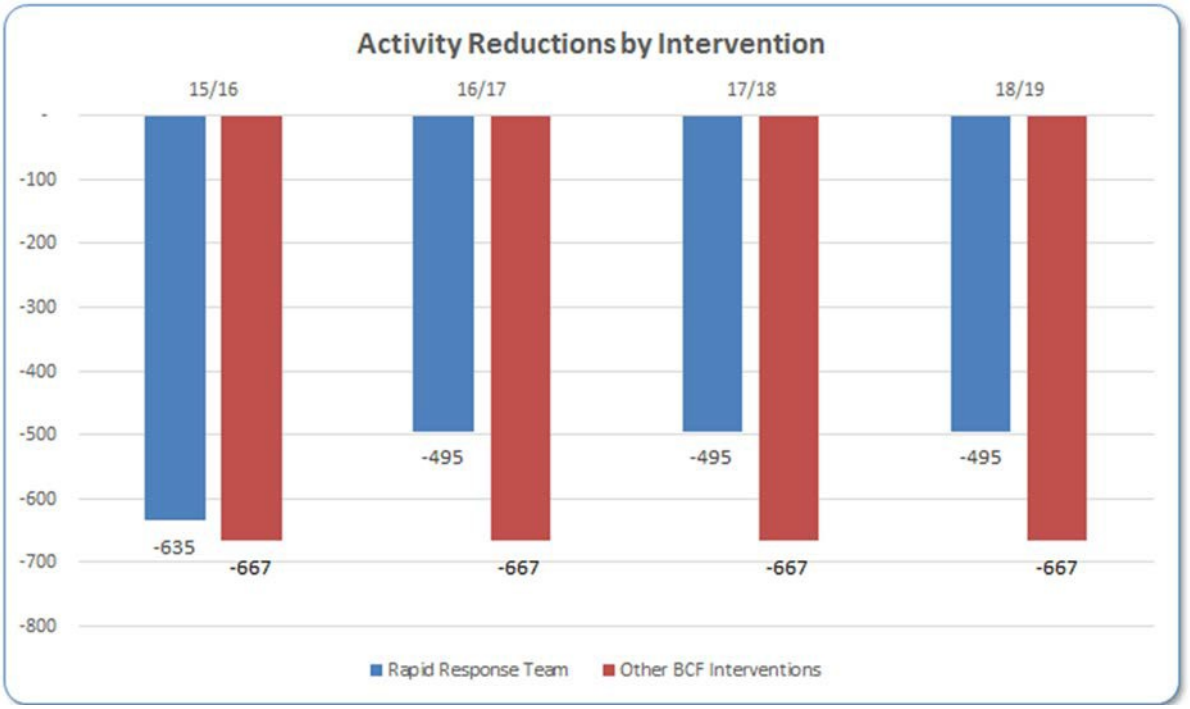
The ability of the CCG to lead this process of change will be supported through our education; training; mentorship; and engagement activities. We have an Organisational Development Plan that describes the support we will provide to ensure that our ambitions for devolved commissioning can be achieved.

f) A Modern Model of Integrated Care

- Emergency admissions will be reduced by from 37,813 to 37,680.
- Avoidable admissions will reduce from 2448 per 100,000 in 2012/13 to 2384 per 100,000 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.
- We expect the specialties of general medicine, geriatric medicine, respiratory medicine and endocrinology to be most affected by the reduction in emergency admissions.



The graph above shows the planned reductions in Emergency Admissions against the backdrop of predicted activity growth due to changes in demography.



The graph above demonstrates the interventions and the respective impact required to achieve the planned reductions in Emergency Admissions.

We have described above our vision for a new model of care.

i) Our model of integrated care

This 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. 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.

Specific initiatives which underpin this model are set out below.

ii) Practice based multi-disciplinary teams (MDTs) - building on the work of our early implementer sites, we are now rolling out our MDT model across all practices, will MDTs in place fully by June 2015. This has been supported by a comprehensive organizational development programme. Our film to support the development process can be viewed here https://www.youtube.com/watch?v=4vKTOIMwoxw

General practitioners will act as the lead clinicians for these community teams. A significant development 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.

iii) Community nursing service – this is intrinsic to the functioning of the MDTs and will incorporate both district nursing and the virtual ward case managers. This will provide a generic community nursing skill base, support timely and safe discharge from acute care settings; through a co-ordinated 'pull function' as part of the MDT.

iv) Intelligent service response – MDTs are using our risk stratification tool to support their work and reviewing all admissions for over 65s in their practices. We will review the use of the existing tool in the light of others available.

v) GP locality leadership – 5 GPs have been appointed. They will lead the implementation of our integrated model in each locality in 2015/16.

vi) Locality link workers – 5 workers have been commissioned from the Council for Voluntary Service, working with the MDTs and ensuring patients are connected to voluntary services in their communities. This will be extended across all MDTs

vii) Social prescribing scheme – commissioned from Age UK as an alternative means of supporting people in their communities. This and the locality link workers will use the PSIAMSs tool (see above).

viii) Community Rapid Response Team (CRRT) - phase 1 of this service with Advanced Nurse Practitioners co-responding to calls with the ambulance service, commenced in January 2015. Phase 2 – independent response to calls – will be fully operational in 2015/16.

ix) Dementia support - the diagnosis rate has increased to 53.7% as at December 2014**.** A comprehensive programme is in place to achieve the national target. The majority of practices are participating in the National Enhanced Dementia Identification service and are undertaking dementia harmonisation coding.

In addition:-

- the Dudley Dementia Strategy will be refreshed;
- a specialist dementia community team will be commissioned;
- a home treatment service as an alternative to hospital admission will be commissioned;
- patients with dementia will be offered the opportunity to have an advanced care plan.

- the ‘Namaste Care’ model for people with advanced dementia in a nursing or a residential home will be commissioned;
- MDTs to be trained on caring and managing people affected by dementia;
- minimum time from referral to psychiatric assessment to be in place for people on acute hospital wards;
- contribute to the creation of a Dementia Friendly Dudley.

x) Elderly care

A new elderly care pathway will be commissioned based upon the notion of “retrieval” of patients from hospital into the community. This will include the development of the role of the geriatrician in the community and contribute to MDT meetings on management issues in relation to complex frail elderly patients

A new falls strategy will be developed with adult social care and public health. A particular focus will be given to primary revention to reduce the numbers of older people falling and particularly those requiring assessment in ED or admission to hospital.

xi) Dudley Care Home Programme

The Care Home Nurse Practitioners and CPN will provide 7 day support to care homes.

Services that support care homes will be co-ordinated in an integrated approach including the care home nurse practitioners; older people’s pharmacist; specialist diabetes nurse for care homes; and Macmillan nurses for care homes. Objectives will include reducing admissions to hospital and attendances at ED; increasing utilisation of advance palliative care plans; improved discharges from hospital; consultant out-reach form hospitals; improved knowledge and management of non-life threatening conditions such as urinary tract infections.

xii) Seven day services - the provision of services on a 7 day basis has commenced for the virtual ward and community rapid response team. The community heart failure team palliative care team and care home nurse practitioners will form part of the next phase. Seven day service standards have been developed for community services as part of our work with NHS IQ and shared with NHS England. These will now feature in our service specifications

xiii) Palliative and end of life care

Recent initiatives include:-

- Completion of Midhurst Project - the Dudley Macmillan Specialist Care at Home Team. The service has now amalgamated the hospital team, the community Macmillan team and Mary Stevens Hospice and is accessed via one single point of access with a central specialist triage team.
- Enhanced service launched on the Gold Standards Framework. The objectives/outcomes are to enhance the quality of care provided to people requiring palliative care and end of life care with a particular focus on increasing support to the non-cancer conditions; reducing admissions to hospital by

increased support in the community; and ensuring advance care plans are in place that include the patients preferred place of care at end of life, with the desired outcome of reducing deaths in hospital.
- Launched a new standardised advanced care plan across secondary, community and primary care.

Further initiatives to include:-

- To launch a DNACPR (Do not attempt co-pulmonary resuscitation) form that is compatible, agreed and signed off across WMAS, primary, community and secondary care.
- To commission electronic patient care records system for end of life/palliative care that includes the utilisation by WMAS.
- To extend the palliative care service to a 7 day service
- 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.

xiv) Extra care housing – we have commenced a pilot project with a community nurse to support practices with patients in extra care housing schemes. This was in response to residents requiring health services and increased admissions from extra care housing to hospital.

xv) Community respiratory service – a community based service will be commissioned in 2015/16. Each locality will be provided with a named community respiratory nurse or nurses linked to the MDTs and palliative care nurses. Palliative care MDTs for patients with advanced respiratory disease and on the Gold Standards Framework register will form part of this model.

xvi) Community back pain service - a community back pain clinic will be commissioned. This will comprise of triage and access to a multi-disciplinary team (GP, consultant, physiotherapist and psychologist)

xvii) Neurology e-mail triage – initial evidence suggests that this has reduced out-patient attendances and further work will take place with practices to increase use. Further work will take place in relation to Acquired Brain Injury; muscular dystrophy, palliative care needs and advanced dementia.

xviii) Community IV antibiotics – this service has commenced for primary care initiation. GPs can diagnose and refer patients to avoid a hospital admission.

xix) Our Better Care Fund Plan

Our BCF Plan was fully approved in January 2015:-

This centres upon the development of our integrated health and social care service model, designed to reduce emergency admissions 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. The plan is based upon 4 schemes:-

- crisis and emergency intervention;
- promoting independence;
- stabilization and maintenance;
- support for people with dementia.

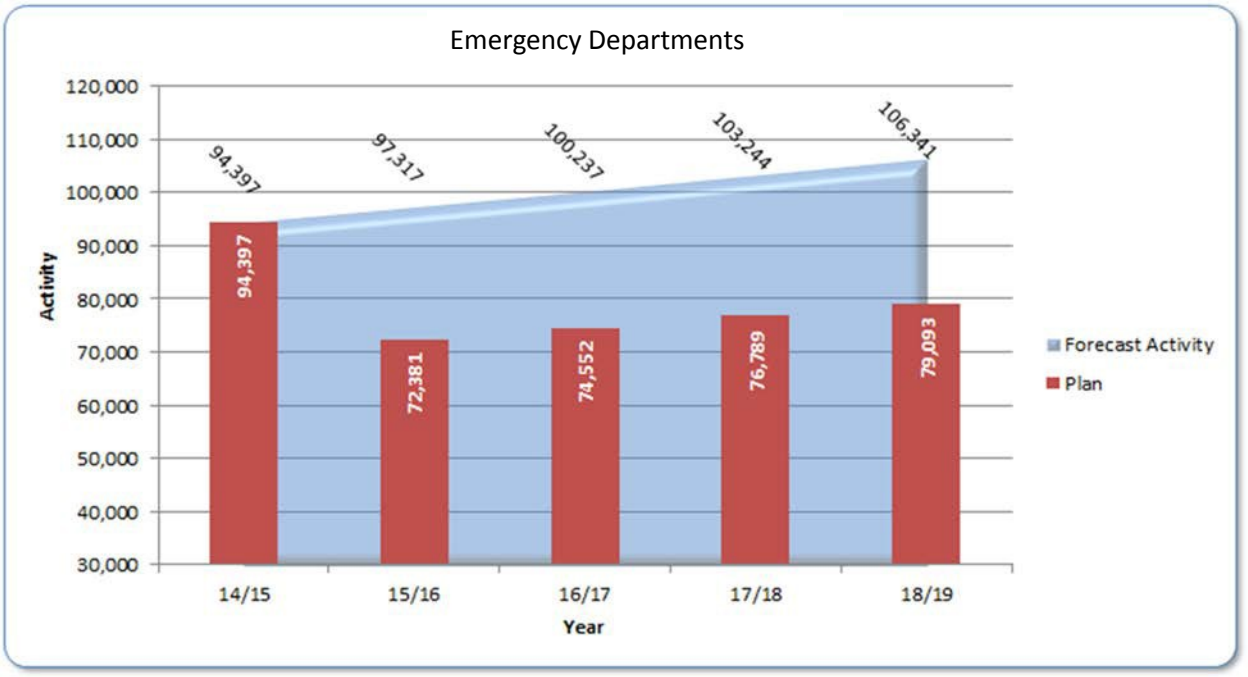
In terms of the key performance metrics:-

- service efficiencies will provide the recurrent investment for the rapid response service and the GP leadership role for the over 75s;
- emergency admissions to reduce by 15% in financial terms by 2018/19;
- Avoidable admissions will reduce by 129 from 8,142 (2,596/100,000 population) in 2012/13 to 8,278 (2,530/100,000 population) in 2014/15;
- delayed days in hospital will reduce by 600 days in 2014/15 and by a further 636 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.

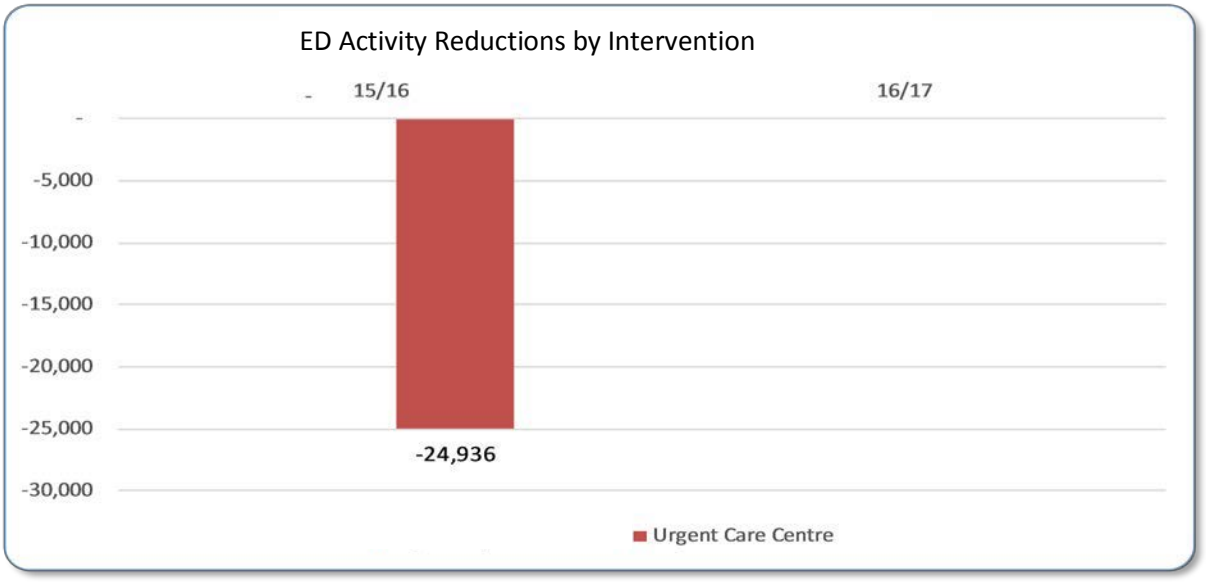
Our agreed contract with Dudley Group NHS Foundation Trust for 2014/15 and 2015/16 is constructed on the basis of the required reduction in emergency activity from the BCF.

g) Access to Highest Quality Urgent and Emergency Care

- A 22.016 reduction in ED attendances by 2015/16 resulting from a redesigned urgent care system and the rapid response team.
- A reduction in emergency admissions of 100 cases from a review of the GP respite pathway.



The graph above shows the planned reduction of A&E attendances against the back drop of predicted activity growth due to changes in demography.



The graph above demonstrates the interventions and the respective impact required to achieve the planned reductions in ED Activity.

i) A new urgent care model

Our new urgent care system for Dudley, has been developed, following extensive patient and public engagement, in line with national recommendations on urgent and emergency care.

The 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 of "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 were 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 commissioned is based on:-

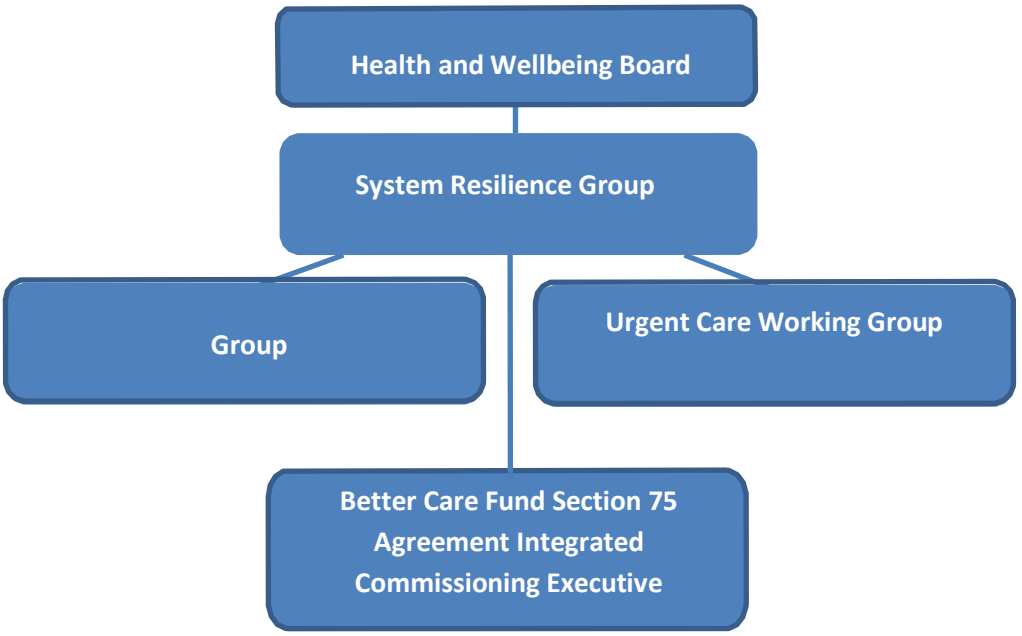
    - general practice being the first place that patients go for urgent care during normal surgery hours;
    - patients ringing 111 for out of hours advice, potentially resulting in an
    - urgent GP appointment the next day, a visit to a new urgent care centre (see below) or potentially a home visit;
    - 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.
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. Until such time as this work is concluded, our planning assumption is that there will be no change to local service provision.

ii) System resilience

Our Urgent Care Working Group, reporting to the System Resilience Group and in turn the Health and Wellbeing Board, has oversight of the urgent care system.



The Urgent Care Working Group will co-ordinate the system at times of pressure. For the winter period in 2015/16 we will have changed the existing system by:-

- implementing our community rapid response service as part of our integrated services model to reduce the number of patients going to ED;
- redesigning our existing virtual ward service so more patients are cared for at home;
- redesigning the local urgent care system to establish better path ways of care for the elderly;
- enhancing the level of support available to patients with mental health problems at times of crisis;
- using an agreed model to manage the number of supported and unsupported discharges destined for health or social care, together with an integrated community bed management system.

Alongside these major system changes, schemes that have been developed to manage demand and facilitate discharge during the 2014/15 winter period are being reviewed in February 2015 and we will invest recurrently in those initiatives which are demonstrably effective.

Schemes subject to this review are:-

Winter Schemes 2014/15

	Better Management of current Pathways/services	Value £	Provider
1	Frail Elderly Assessment Unit	259,600	DGH
2	Extension of HALO cover	21,000	WMAS
	Divert Pathway	Value £	Provider
3	Social Care Urgent Response Service	140,000	DMBC
4	Falls First Response Service	131,000	DMBC
5	Urgent Care Streaming	51,000	DGH
6	Dudley Paramedic pathfinder	20,000	WMAS
7	Black country mental health car response service	85,000	WMAS
8	NHS 111 GP on calls pilot.	14,000	NHS 111
9	Walk in centre Extended hours	145,700	Primecare
	Better Discharges	Value £	Provider
10	Care Home Select	84,000	ind Sector
11	Discharge to Assess	172,000	DGH
12	Bed Management System	28,600	DMBC
13	Red Cross Patient Transport and Home Ready Initiative	224,000	ind Sector
14	Trusted Assessor pilot	29,300	DGH
15	Increase in intermediate care capacity	319,000	ind Sector
	Consistency of services across 7 days	Value £	Provider
16	Extension of DISCO OOH	13,000	DGH
17	Weekend Discharge (3 day team)	78,000	DGH
18	Increase in therapy support to intermediate care beds	84,700	DGH
19	7 Day streaming for surgical assessment unit	15,600	DGH
20	Increase in intermediate care team capacity	100,000	CCG
	Local Plans for Innovation	Value £	Provider
21	Rapid Response Team	1,000,000	CCG
22	GP Locality Leads	135,000	CCG
23	Voluntary Sector Locality Link Workers	388,000	CCG
24	Social Prescribing Scheme	126,000	CCG
25	Mental Health Crisis Service	654,000	CCG/DWMH
	Preventative	Value £	Provider
26	Flu vaccination Campaign	N/A	CCG
	Additional A&E Monies schemes	Value £	Provider
27	Reconfiguration of acute medical unit	£821,594	DGH
28	Wrap around services to support patient discharge from hospital	£151,000	DGH

29	Spot Purchase	£200,000	DGH
30	Increased Impact therapy support	£20,000	DGH
31	Patient Trackers in ED	£151, 575	DGH
32	Increased therapy into minors flow	£25,000	DGH
33	Additional Dr Support to 7 day working	£58,293	DGH
34	HIP attack	£35,000	DGH
35	PAU extension to hours	£23,000	DGH
36	Increased Portering Staff	£50,000	DGH
37	Tri Agency Funding	£60,000	DGH

It is anticipated that the following will be made recurrent: -

- mental health strategic triage
- discharge to assess
- weekend discharge team
- mental health urgent care centre
- increased capacity and 7 day working for intermediate care team

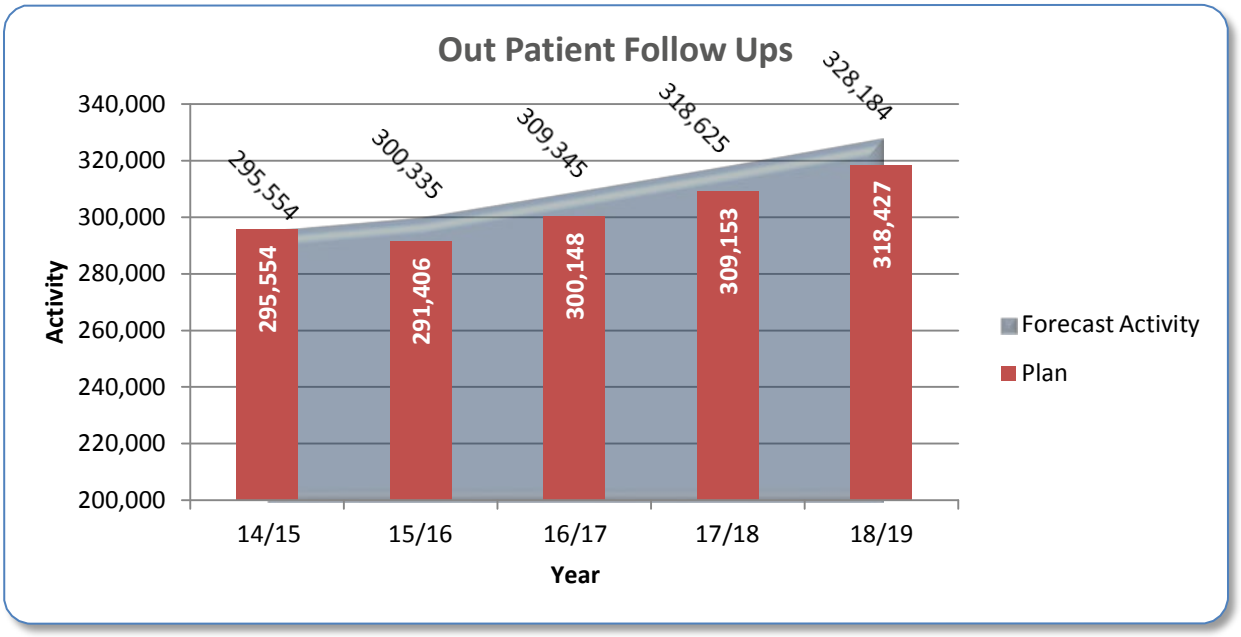
Our expectation is that by implementing these initiatives and by making recurrent those winter plan initiatives deemed to be effective, the ED performance target will exceed 95% in line with the recent performance. Sustained performance will then be achieved through the implementation of a redesigned urgent care centre and the community rapid response service.

In addition in 2015/16 we will:-

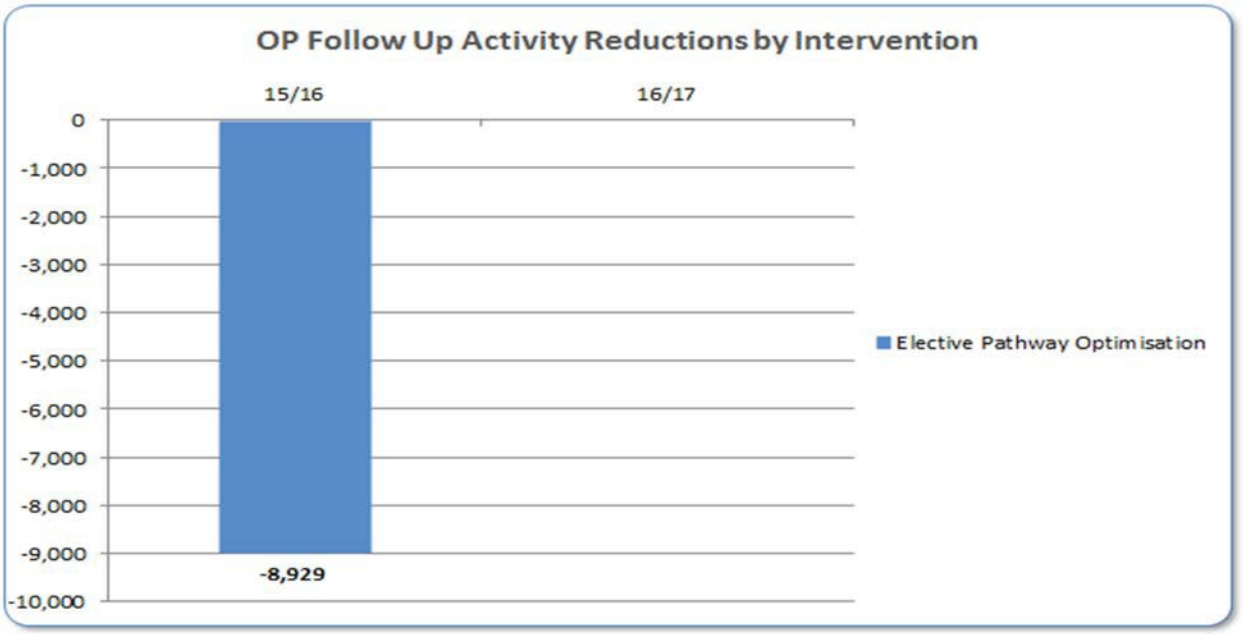
- redesign and re-specify admission and assessment units linked to the new urgent care centre;
- re-commission the NHS 111 service by October 2015;
- implement new ED / assessment unit payment mechanism.

h) 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 follow up attendances to reduce by 8929 by 2015/16.
- Individual consultant performance to be assessed for every pathway.

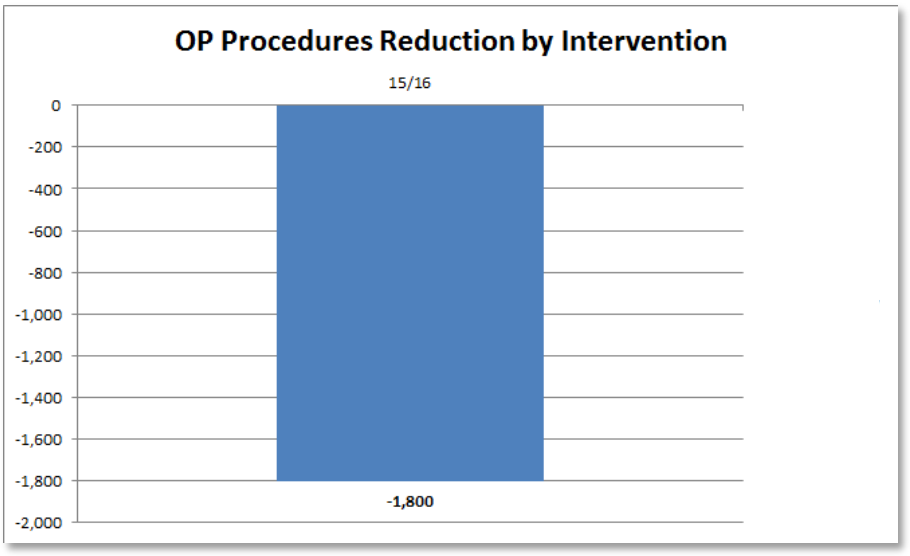


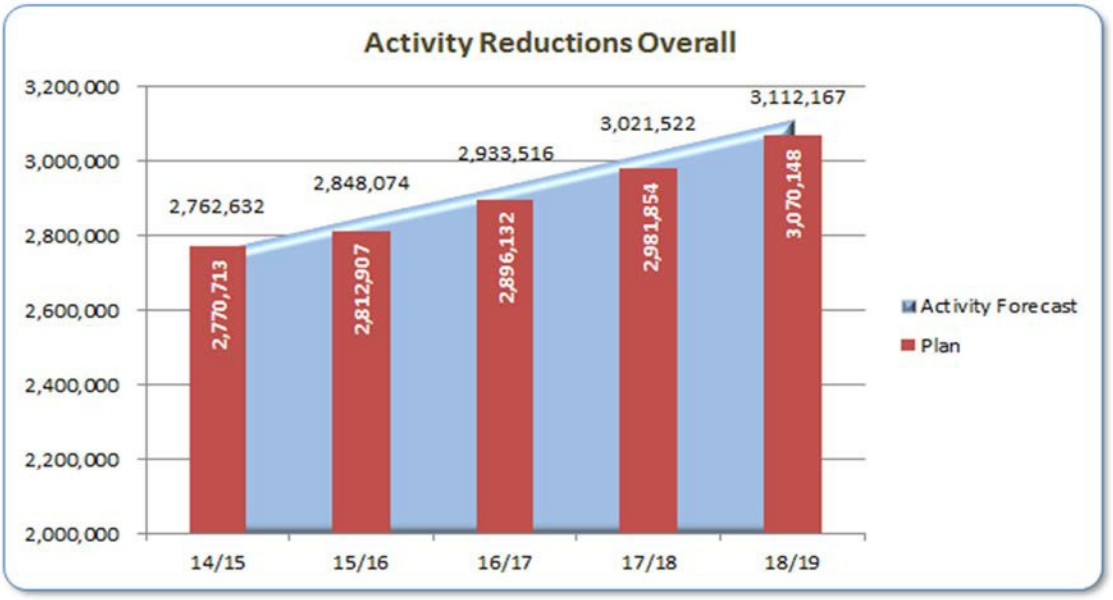
The graph above shows the planned reduction of Elective Activity against the backdrop of predicted activity growth due to changes in demography.

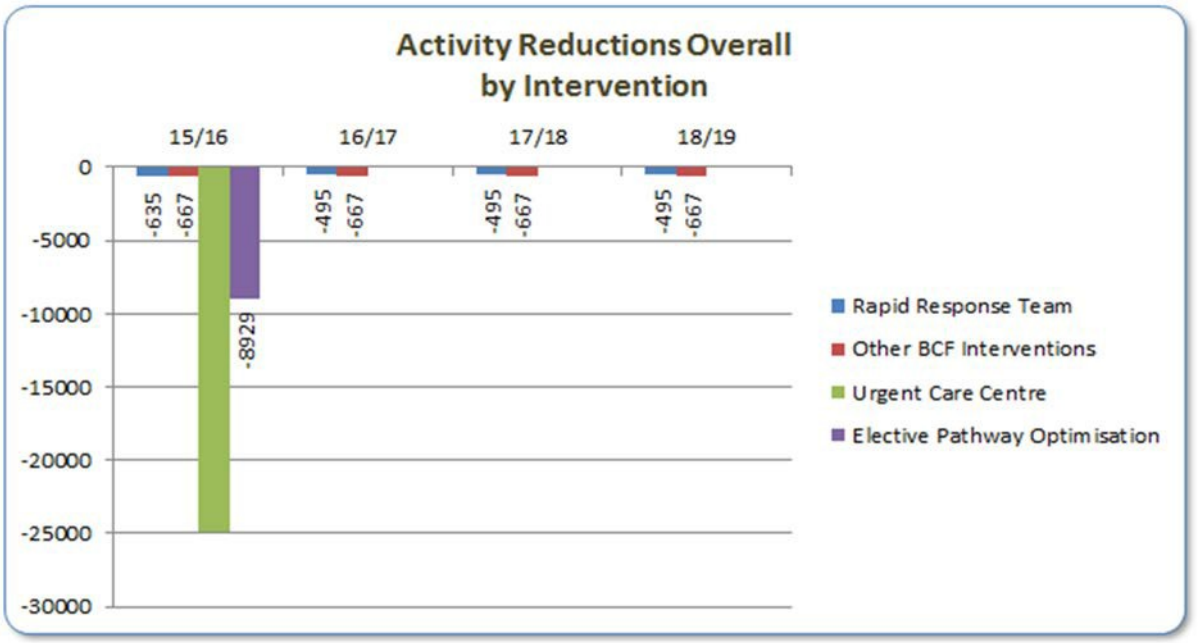


The graph above demonstrates the interventions and the respective impact required to achieve the planned reductions. Reductions in Musculo-Skeletal activity are predicated on the 'Commissioning for Value insight pack' which demonstrates that Dudley CCG could realise significant activity and cost reductions by moving from 2nd highest CCG in England for activity and expenditure on Musculo-skeletal Elective and day cases to the average of Dudley's ONS Cluster Group (most similar CCGs).

The graph below shows the planned reduction of Out Patient Procedures against the backdrop of predicted activity growth due to changes in demography.







i) Pathway efficiency

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.

During 2014/15, referral to treatment (RTT) times have improved at Dudley Group NHS FT. In December 2014, 93.5% of patients received treatment within 18 weeks.

The number of patients waiting over 18 weeks has significantly reduced. Challenges remain for the specialties of trauma and orthopaedics; ophthalmology; urology and oral surgery.

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 specialties.

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;

- ensure that 100% of referrals take place using the choose and book mechanism;
- redesign those pathways where inefficiencies have been identified. This will begin with musculoskeletal services, including the contribution of physiotherapy;
- reduce the number of inappropriate referrals to secondary care through use of the Orthopaedic Assessment Service and permit direct referral by the service to other specialties;
- transfer dermatology and pain services to the community;
- neurology – embed the email triage service to reduce inappropriate referrals;
- heart failure pathway – integrate acute and community teams and move to 7 day working;
- Improving cardiac rehabilitation pathways and reducing readmission rates;
- enuresis and encopresis services – move to nurse led community clinics;
- expand paediatric triage through a pilot service at Dudley Group NHS FT to reduce out-patient attendances;
- realign pathways to facilitate early discharge from hospital into the community or primary care including the pathways for children with neurodevelopment delays and faltering growth;
- implement alternative pathways and develop a revised service model for Community Paediatric Officers;
- develop a single point of access for all children with complex and additional needs.

i) Specialised Services Concentrated in Centres of Excellence

Specialised services are those services that are provided in relatively few hospitals to a catchment population of more than one million people. The number of patients accessing these rarer services is small and a critical mass of patients is needed in each centre in order to deliver the best outcomes. In addition a concentration of skills and expertise by the clinical team undertaking the treatment also benefits the standard of care delivered. These services are commissioned directly by NHS England.

It is important for the CCG to align its local strategy to the direction of travel nationally for specialised services over the next five years as:-

- the focus on planning across the entire patient pathway is vital i.e. any changes to a patient's pathway considered by the CCG/Local Authority for a service such as Child and Adolescent Mental Health Services (CAMHS) will impact on the specialised element of the inpatient care given to children as part of the directly commissioned tier 4 service (or vice versa);

- historically specialised services account for £12.2 billion per annum of the NHS allocation. Historically, the growth in cost exceeds other parts of healthcare by as much as 4% per annum. Planning to look at how we work together with NHS England to review and achieve better value for money and improved quality is a key priority. Specialised services will be

developing a robust QIPP challenge of its own and the CCG will need to work with NHS England to understand the QIPP agenda on the local health economy;

- the national strategy for specialised services is in the early stages of its development but it is clear the direction of travel is towards fewer centres concentrated in centres of excellence (around 15 to 30 centres). The CCG will need to work closely with NHS England to understand the implications of the strategy and work together on how to implement the transformational change required;

- there will be joint opportunities for maximising research and teaching opportunities to encourage innovation and change;

The CCG will therefore be ensuring that local operational plans involve:-

- strong engagement in the development of the national strategy for specialised services through the call to action programme completing in July 2014;
- active participation in the proposed West Midlands governance arrangements for the strategy development;
- identification of opportunities for joint planning and development of care across the whole patient pathway within local plans. Supporting the need for change within an agreed case for change.
- close contract management arrangements with specialised commissioners for providers;
- supporting the development of the local service priorities and/or reconfigurations currently being considered by the Area Team which include camhs tier 4, cancer services, cardiology, paediatric intensive care and high dependency services and neuro-rehabilitation services.

10. Innovation

The CCG is strongly committed to supporting and championing innovation at all levels within the organisation. The Chair and Chief Accountable Officer take personal responsibility for ensuring that this process is reflected in our commissioning plans. A GP Board Member has specific responsibility for innovation and research and in addition the CCG has a designated management lead for research and innovation along with an appointed Clinical Lead for Research. Therefore a strong disseminated leadership promotes innovation throughout the membership of the CCG. These governance and facilitation arrangements are backed up with £200,000 of direct CCG investment available to the 5 localities on a non-recurrent basis to fund innovative practice specifically.

This disseminated innovation has supported:-

- the development of our community rapid response service;
- measuring individual consultant performance and pathway variance;
- having one IT system for all 49 GP practices;
- using the PSIAMS system to understand the holistic commissioning impact from the patient perspective;
- the development of a new integrated performance and analytics platform
- the development of new and user friendly methods for patient feedback on services and interventions.

However, the CCG also recognises the importance of innovation horizon scanning and connectivity with the broader network of research and innovation. Dudley CCG is linked to areas of best practice and research based interventions through membership of the NHS Benchmarking network, health literature research via academic portals and working in conjunction with Birmingham University's Health Service Management Centre on continuing development and evaluation. The CCG embraces the acceleration of innovation described in 'The Forward view into action: Planning for 2015/16' and mirrors the principles of this acceleration in the development of robust and integrated outcomes measures for all services commissioned, facilitating more responsive and impactful decision-making within the commissioning cycle.

11. Effective Information Management

We will continue to make the best use of information Technology to support the delivery of better care and to influence clinician and patient behavior. This will include:-

- moving all referrals and discharges to an electronic basis;
- mobile technology, particularly for our integrated MDTs and GPs to enable remote access to clinical records;
- document management systems to improve efficiency in primary care;
- remote monitoring systems – for heart failure and COPD;
- risk stratification – evaluating the use of the EMIS tool;
- text messaging – to reduce missed appointments.

12. Governance and Performance

Our outline planning issues were shared with the CCG Board and the Health and Wellbeing Board in January 2015.

Key issues already identified in our commissioning intentions are contained in our contracts with our main providers.

Our final plans, including our outcome ambitions, key metrics and quality premium targets will be submitted to the CCG Board and the Health and Wellbeing Board on 12 and 25 March 2015. Our final plan will be considered by the CCG Board on 30 March 2015.

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 Integrated Commissioning Executive, as the governing body of the Section 75 Agreement for the Better Care Fund, reporting to the Health and Wellbeing Board (see above).

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.

We recognise our statutory duty to reduce health inequalities and the Director of Public Health is a member of the CCG Board. Our relationship with the Office of Public Health is reflected in an annually agreed memorandum of understanding.

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, which approved this plan at its meeting on 26th March 2014, 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.

13. Deliverability

The proposed changes to service models included in this strategy cannot be delivered by the current infrastructure.

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 the delegation of commissioning from 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 develop our 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.

We will develop a Project Management function to deliver this plan, and our 5 year Strategy, to plan and on-budget.

In addition, we will ensure we get the highest quality and best value from our corporate support structures. We will review the range of services we commission from our CSU and ensure we have a management infrastructure that is fit for purpose. This may bring new corporate support providers into Dudley in addition to the external support we currently commission, including

support on organisational development, governance, patient experience and primary care. We believe this is the most appropriate model to deliver our aim to continue to innovate and support the delivery of the best services possible to the population of Dudley.

We will continue to invest in and develop our workforce. We undertake regular staff surveys and have reviewed all our employment policies. This has resulted in: -

- more flexible working opportunities;
- more support for staff with carer responsibilities;
- implementation of a staff health and wellbeing programme

We have an extensive organizational development programme from Board level downwards, together with a focus on individual development opportunities for all staff.

We are committed to being a “healthy board” and will shortly conclude a comprehensive review of our governance processes and behaviours by the Good Governance Institute.

We are in the process of reassessing the organisation against the goals and outcomes of EDS2. We believe we are on track to being compliant in terms of having a “representative and supported workforce” and “inclusive leadership”. The review of our employment policies described above has contributed to this.

We will review the composition of the CCG Board in the context of the community we serve and the NHS workforce race equality standard when published. This will inform the succession planning process.

JSNA	Outcome Ambition	Initiative
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.	Securing additional years of life 3.5% reduction in potential years of life lost per annum from 2087/100,000 in 2012/13 to 1875.4/100,000 in 2015/16	• Systematic management of long term conditions • Prescribing for heart disease • Prescribing for cholesterol • Smoking cessation • Weight management • Sport and physical activity action plan • Diabetes LES and diabetes control
Nearly one fifth of 40-59 year olds are living with a long term limiting illness	Improving the quality of life for people with long term conditions. Average EQ-5D score for people with one or more long term condition to increase by 1.6% from 70/100 people in 2012/13 to 71.6/100 in 2015/16.	• Responsive IAPT services • Diagnosing and responding to dementia • Diagnosing hypertension • Vascular checks • Improved recording in disease registers for heart failure, hypertension and kidney disease • Community based respiratory service • Community based pain service • COPD LES review • Revised diabetes LES • Community diabetes team
The rate of delayed discharges attributable to social care is higher than the national rate	Reducing time spent in hospital through more integrated care Avoidable emergency admissions to reduce from 8,142 (2,596/100,000 population) in 2012/13 to 8,013 (2,530/100,000) in 2015/16	• Rapid Response Team • Redesigned virtual ward • Care home CPN • 7 day services • Community respiratory, diabetes and anti-coagulation services • Enhanced telehealth and telecare • Community pain, dermatology and ophthalmology services
20% of single person	Increasing the proportion	• Integrated locality

households are in the 60+ age range	of people living independently at home People still at home 91 days after discharge to increase by 4% from 86% at March 2013 to 90% at March 2016	services • Rapid Response Team • Social prescribing scheme • Locality link workers
Musculoskeletal services present an opportunity to improve the patient pathway, secure value for money and deliver better outcomes	Increasing people's positive experience of hospital care Reducing the average number of negative responses from 159.2 per 100 patients in 2012/13 to 153.5 per 100 patients in 2015/16. A reduction of 3.58%	• Clear clinical standards • Efficient planned care pathways • Patient safety CQUIN • Organisational learning CQUIN • Medication error reporting
Systematic management of long term conditions is required in primary care	Increasing the proportion of people with a positive experience of GP care and in the community Reducing the average number of negative response from 6.1 per 100 patients in 2012/13 to 5.66 in 2015/16. A reduction of 7.2%.	• Better access • 7 day services • Active patient participation groups • Reducing variation • Transfer of services to primary care • Managing long term conditions • Single IT system for all practices
Emergency admissions for gastroenteritis and lower respiratory disease are increasing for the 60 – 74 age group	Eliminating avoidable deaths in hospital	• MRSA zero tolerance • Grade four pressure ulcer zero tolerance • Reducing infection rates including Cdiff • Reducing medication errors

GLOSSARY

ADVANCED CARE PLANNING	A process of discussion between an individual and a care practitioner to make clear a person's wishes in the event of their health deteriorating.
ANP	Advanced Nurse Practitioner – a nurse working at an advanced level of practice, encompassing aspects of education, research and management but grounded in direct care provision.
AHRQ	Agency for Healthcare Research and Quality – an agency of the US Government responsible for improving quality, safety, efficiency and effectiveness.
AQP	Any Qualified Provider – a mechanism for procuring services where there are multiple providers working to a common quality standard and price.
ANP	Advanced Nurse Practitioner.
BERWICK REPORT	A report into patient safety.
BCF	Better Care Fund – a pooled budget with the Local Authority designed to support service integration and reduce admissions to hospital, nursing and residential care.
6 CS	Care, Compassion, Competence, Communication, Courage and Commitment – the Chief Nursing Officer's 'culture of compassionate care'
CAB	Citizen's Advice Bureau – a charity providing advice on legal, financial and other matters.
CDIFF	Clostridium Difficile – a bacteria best known for causing diarrhoea.
CEN	Community Engagement Network – Dudley Council's network for public consultation.
CHD	Coronary Heart Disease.
CPN	Community Psychiatric Nurse.
COPD	Chronic, Obstructive, Pulmonary Disease – a type of lung disease characterised by poor airflow.
CIP	Compassion in Practice – see 6Cs.
CQUIN	Commissioning for Quality and Innovation – a system of payment designed for commissioners to reward excellence.
CSU	Commissioning Support Unit – an organisation providing services to support the CCG's functions.
CALL TO ACTION	A programme of engagement with the public about the future of the NHS.

CONTINUING HEALTHCARE	A situation where responsibility for meeting the costs of a patient's health need continues to rest with the NHS.
ECIST	Emergency Care intensive Support Team – A Department of Health sponsored team which assists health and social care systems to improve emergency care.`
ED	Emergency Department.
EDS	Equality and Diversity Scheme – a mechanism used to deliver the CCG's duties under the Equality Act.
EMIS	A computer system for general practice.
ENT	Ear, Nose and Throat
FRANCIS REPORT	A report of an enquiry conducted by Robert Francis, QC into events at Stafford Hospital.
FRIENDS AND FAMILY TEST	A test of patient satisfaction based on asking 'how likely are you to recommend our services to your friends or family if they needed treatment.'
GSF	Gold Standards Framework – A means of managing end of life patients to agreed standards in primary care.
HED	Health Education Data – a system drawing upon multiple data sources to benchmark performance.
HSMR	Hospital Standardised Mortality Ratio – a method of comparing mortality levels in different years.
HSW	Health and Wellbeing Board – a statutory committee of the council responsible for producing the JSNA (see below) and the JHWS (see below). The Board consists of representatives from a number of bodies with a responsibility for health and wellbeing.
HEALTHCARE FORUM	Dudley CCG's forum for consultation with patients and the public.
HEALTHWATCH	The voice of the consumer in healthcare.
IAPT	Improving Access to Psychological Therapies – an initiative to enable patients to access psychological 'talking' therapies.
JSNA	Joint Strategic Needs Assessment – a joint assessment carried out by the CCG and the Council on the main needs affecting the residents of Dudley.
JHWS	Joint Health and Wellbeing Strategy – a Strategy developed by the Health and Wellbeing Board in response to the JSNA.
LA	Local Authority – an elected local government body, eg Dudley Metropolitan Borough Council.

LES	Local Enhanced Service – a service commissioned from primary care beyond the scope of their usual contract.
MIND	A national charity supporting people with mental health needs.
MRSA	Methicillin Resistant Staphylococcus Aureusis – a bacterial infection resistant to a number of antibiotics.
POP	Patient Opportunities Panel – a group consisting of representatives from PPGs (see below) with whom the CCG consults.
PPG	Patient Participation Group – a group established to enable engagement with practices at GP practice level.
PRIMARY CARE FOUNDATION	An organisation set up to support the development of best practice within primary care and urgent care.
PSIAMS	Personal and Social Action Measurement System – a mechanism for measuring the impact of an intervention on an individual.
QIPP	Quality Innovation, Productivity and Prevention – a programme designed to deliver improvements in quality and productivity.
QOF	Quality and Outcomes Framework – Part of the GP contract which links remuneration to the improvement of quality and outcomes.
QP	Quality Premium – a series of nationally and locally agreed indicators against which the CCG's performance is assessed and for which a performance payment is received.
RMN	Registered Mental Nurse.
RTT	Referral to Treatment – The target waiting time for elective care.
SAU	Surgical Assessment Unit
SHIMI	Summary Hospital Level Mortality Indicator – an indicator of mortality at Trust level.
SHO	Senior House Officer.
SRG	System Resilience Group – Multi-agency body, reporting to the Health and Wellbeing Board, responsible for system wide management and resilience.
WINTERBOURNE VIEW	A former facility for patients with learning disabilities where patients were mistreated.