DUDLEY HEALTH AND WELLBEING BOARD

WEDNESDAY 26TH MARCH 2014

AT 3.00 PM
COMMITTEE ROOM 2
COUNCIL HOUSE
DUDLEY

If you (or anyone you know) is attending the meeting and requires assistance to access the venue and/or its facilities, could you please contact Democratic Services in advance and we will do our best to help you

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You can view information about Dudley MBC on www.dudley.gov.uk

health &wellbeing
looking after our borough

Dudley
Metropolitan Borough Council

IMPORTANT NOTICE

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Please turn off your mobile phones and mobile communication devices during the meeting.

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Directorate of Corporate Resources

Law **and Governance,** Council House, Priory Road, Dudley, West Midlands DY1 1HF
Tel: (0300 555 2345)
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Your ref:	Our ref:	Please ask for:	Telephone No.
	JJ/jj	Mr J Jablonski	815243

12th March, 2014

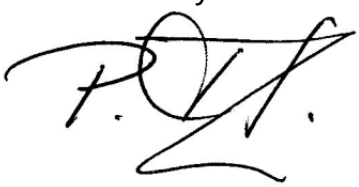
Dear Member

Dudley Health and Wellbeing Board

You are requested to attend a meeting of the Dudley Health and Wellbeing Board to be held on Wednesday, 26th March, 2014 at 3.00 pm in Committee Room 2, the Council House, Dudley to consider the business set out in the Agenda below.

The agenda is available on the Council's Website www.dudley.gov.uk and follow the links to Councillors in Dudley and Committee Management Information System.

Yours sincerely



Director of Corporate Resources

A G E N D A

1. APOLOGIES FOR ABSENCE

   To receive apologies for absence from the meeting

2. APPOINTMENT OF SUBSTITUTE MEMBERS (IF ANY)

   To report the names of any substitute members serving for this meeting.

3. DECLARATIONS OF INTEREST

   To receive Declarations of Interest in accordance with the Members' Code of Conduct

The attention of Members is drawn to the wording in the protocols regarding the general dispensation granted to Elected Members and the voting non-elected representative from requirements relating to other interests set out in the Members' Code of Conduct given the nature of the business to be transacted at meetings.

However, Members and the voting non-elected representative (and his potential substitutes) are required to disclose any disclosable pecuniary interests. In such circumstances, the voting Member would be required to withdraw from the meeting.

If Members have any queries regarding interests would they please contact the Director of Corporate Resources, Philip Tart, prior to the meeting.

4. MINUTES

To approved as a correct record and sign the minutes of the meeting of the Board held on 28th January, 2014 (copy herewith)

5. NEXT STEPS FOR THE HEALTH AND WELLBEING BOARD INCLUDING A WORK PROGRAMME FOR 2014/15 (PAGES 1 -11)

To consider a joint report of Officers

6. DUDLEY CCG OPERATIONAL PLAN 2014/2015 -2016/2017 AND STRATEGIC PLAN 2014/2015 – 2018/2019 (PAGES 12- 42)

To consider a report of the Chief Accountable Officer, Dudley Clinical Commissioning Group

7. URGENT CARE CENTRE (UCC) PROCUREMENT AND DRAFT UCC SERVICE SPECIFICATION (VERSION 0.6) (PAGES 43 - 77)

To consider a report of the Chief Accountable Officer, Dudley Clinical Commissioning Group

8. BETTER CARE FUND (PAGES 78 -80)

To consider a joint report of Officers

9. UPDATE ON DUDLEY HEALTHWATCH PROGRESS (PAGES 81 - 84)

To consider a report of the Chief Officer of Healthwatch Dudley

10 TO ANSWER QUESTIONS UNDER COUNCIL PROCEDURE RULE 11.8 (IF ANY)

MEMBERSHIP OF THE BOARD

Councillors Branwood, Crumpton, Miller and S.Turner

Director of Adult, Community and Housing Services, Interim Director of Children's Services and Assistant Director of Planning and Environmental Health

Director of Public Health

Roger Clayton – Chair of Safeguarding Boards

Dudley GP Clinical Commissioning Group

Dr. D Hegarty, Dr S.Cartwright and Mr P Maubach

Alison Taylor – Local Area Team - NHS Commissioning Board – Lead Director for Dudley

Andy Gray – Dudley CVS CEO

Pam Bradbury – Chair of Healthwatch Dudley

Chief Superintendent Johnson – West Midlands Police

OFFICER SUPPORT

Cc Brendan Clifford Assistant Director, Adult Social Care (DACHS)

Ian McGuff Assistant Director Quality and Partnership (Children's Services)

Mr N. Bucktin,Head of Partnership Commissioning.(CCG)

Ms K.Jackson, Consultant in Public Health (Office of Public Health)

DUDLEY HEALTH AND WELLBEING BOARD

Tuesday, 28th January, 2014 at 3.00 pm
in Committee Room 2, The Council House, Dudley

PRESENT:-

Councillor S Turner (Chair)
Councillors Branwood and Miller
Director of Adult, Community and Housing Services, Interim Director of Children's Services, Assistant Director of Planning and Environmental Health, Director of Public Health, Dr D Hegarty and Mr P Maubach - Dudley Clinical Commissioning Group; Alison Taylor, Local Area Team, NHS Commissioning Board, Pam Bradbury – Chair of Health Watch Dudley and Chief Superintendant Johnson – West Midlands Police.

In attendance

Assistant Director, Adult Social Care (Directorate of Adult, Community and Housing Services), Assistant Director (Quality and Partnership) (Directorate of Children's Services), Mr N Bucktin, Head of Partnership Commissioning – Clinical Commissioning Group, Ms K Jackson, Consultant in Public Health (Office of Public Health) and Mr J Jablonski (Directorate of Corporate Resources)

Also in attendance

Ms N Hussain, Stroke Programme Lead (for Agenda Item No. 8)
Ms L Prescott, Senior Development Officer, Dudley CVS (for Agenda Item No. 6)

Observer

Councillor Foster; together with Dr Rob Dalziel – Healthwatch Dudley and 7 members of the public.

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23. COMMENTS MADE BY THE CHAIR

The Chair welcomed everyone to the meeting in particular Pam Bradbury the newly elected Chair of Healthwatch Dudley and Lorna Prescott, Senior Development Officer of Dudley CVS.

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24. APOLOGIES FOR ABSENCE

Apologies for absence from the meeting were submitted on behalf of Councillor Crumpton, Dr Cartwright and Andy Gray.

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25. DECLARATIONS OF INTEREST

No member declared an interest in any matter to be considered at this meeting.

26. MINUTES

RESOLVED

That the minutes of the meeting of the Board held on 26th September, 2013, be approved as a correct record and signed.

27. PERFORMANCE MONITORING ARRANGEMENTS AND CURRENT PERFORMANCE STATUS

A joint report of Officers was submitted giving an overview of proposed arrangements by which the Health and Wellbeing Board could monitor performance outcomes against national and local priorities for health and wellbeing and an update on current progress in relation to national and local priorities and the implementation of Dudley Borough's Health and Wellbeing Strategy. Attached as Appendices 1 and 2 of the report submitted were Supporting Commentary for Indicators Significantly Below the England average (accompanies the outcomes frameworks report) and Local Indicators and Actions Health and Wellbeing Strategy Implementation Plan 2013/14 – 2014/15 together with Health and Wellbeing Priorities – Outcomes Frameworks.

Arising from the presentation given on the contents of the report, and its Appendices, a comment was made in relation to the indicator – Access to GP Services – in Appendix 1 to the report that the Lead should be amended to CCG/NHS England. It was indicated that this would be done.

RESOLVED

That the information contained in the report, and Appendices to the report, submitted on the current performance status for Dudley Borough be noted and that the proposed performance monitoring arrangements be agreed.

28. CHANGE IN ORDER OF BUSINESS

Pursuant to Council Procedure Rule 13(c), it was

RESOLVED

That Agenda Item Nos. 10 and 11 be considered as the next items of business

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29. PRESENTATION ON DEVELOPMENT OF CLINICAL COMMISSIONING GROUP'S STRATEGIC PLAN – EVERYONE COUNTS – PLANNING FOR PATIENTS 2014/15 – 2018/19

A presentation was given on the development of the Clinical Commissioning Group's Strategic Plan entitled Everyone Counts – Planning for Patients 2014/15 – 2018/19. The presentation had previously been circulated to Board Members and was available on the Council's Committee Management Information System (CMIS).

The content of the presentation was a response to outline planning guidance from NHS England to whom the planned framework needed to be submitted by 31st January, 2014. The initial planning assumptions and the basis of those assumptions were set out in the presentation.

Contracts with the main providers had to be agreed by 28th February, and the substantive Plan would be submitted to this Board at its meeting to be held on 26th March, 2014. The Plan to be considered at that meeting would include further detail on particular key performance indicators. The final Plan will then be submitted to NHS England by 4th April, 2014.

The Plan will comprise a 2 year detailed operational plan and a 5 year plan to deliver six service models, as set out in the presentation. However, in addition to the requirement for a 15% reduction in emergency activity there would also be a requirement for a 20% efficiency gain for elective activity.

Arising from the presentation given comments were made and responded to regarding the process indicated in particular the agreeing of contracts before the final plan had been agreed.

RESOLVED

That the information contained in the presentation submitted on the development of the Clinical Commissioning Group's Strategic Plan entitled Everyone Counts – Planning for Patients 2014/15 – 2018/19, be noted and that a further report on this matter be submitted to the meeting of this Board to be held on 26th March, 2014.

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30. URGENT CARE CONSULTATION OUTCOME AND THE RECONFIGURATION OF URGENT CARE

A report of the Chief Accountable Officer, Dudley Clinical Commissioning Group was submitted on the outcome of the Clinical Commissioning Group's (CCG's) consultation process in relation to the future clinical model for urgent care in Dudley and on the CCG's final proposals for urgent care in the light of the consultation exercise. Attached as Appendices to the report were two reports considered by the CCG at its Board meeting on 9th January, 2014. The first set out an overview of the consultation process and the feedback received and the second set out the CCG's proposed clinical mode for urgent care in the light of the outcome of the consultation process. The recommendations in both reports had now been approved by the CCG and had been the subject of a separate report to the Health Scrutiny Committee of the Council on 23rd January, 2013.

Mr Maubach, the Chief Accountable Officer, Dudley CCG, in presenting the report commented on the discussions held by his Board on this matter in particular the three main areas of concern regarding the transfer of the Walk In Centre to the Russells Hall Hospital site. These concerns had arisen from the Questionnaire Survey carried out by Health Watch Dudley during the period 29th November to 5th December, 2013. A copy of their report had previously been circulated to Members of the Board and an updated report had subsequently been e-mailed to them.

The three areas of concern were

- Whether co-locating the walk in service at Russells Hall Hospital would create additional pressure on the Accident and Emergency Service at Russells Hall
- That access to Russells Hall was better
- Parking at Russells Hall

There were considered to be no challenges or issues around clinical arrangements in relation to the proposal.

In relation to the three issues raised, Mr Maubach reported that it was considered that the pressure on A & E Services would in actual fact reduce as a result of the co-location of services as all patients would be triaged at the single point of entry; that access by public transport was better to Russells Hall and that the issue regarding parking was that whilst there were difficulties with parking at Russells Hall and it was free at the Walk In Centre there were other issues regards parking at the Centre and on balance it was considered that the advantages of the transfer outweighed any difficulties.

The recommendation that had been agreed therefore was for the creation of a new Urgent Care Centre on a 24/7 service basis maintaining the ability to walk in and integrating the out of hours service into the walk in service thus extending the activity beyond the current arrangements. There would also be an option within the Centre for appointments to be booked following triage over the telephone using the 111 service, particularly out of hours and at weekends.

However, also arising from the Survey undertaken, it was noted that the public preferred improved GP access and there was a recommendation contained in the covering report submitted as regards involving NHS England in this issue as a partner on the Board with the contractual responsibility for GP access.

Arising from the presentation given a number of questions were asked and issues raised to which responses were given, in particular

- That the scenario three model agreed upon would meet current levels of demand with the long term preference seeing a reduction in demand arising from improved GP access and efficiencies. There was, therefore, an important link between the two.

- As indicated above the new service would be provided on a 24/7 basis.

- The issue of quality of clinical care was a contractual challenge the key being to get the specification right. Mr Maubach undertook to report to a future meeting of the Board on the development of the specification.

- Arising from concerns raised about whether a person visiting the new centre would be guaranteed to see a GP it was considered that not everyone attending the new service would need to see a GP and their availability may depend on the time of day someone attended the centre. GP provision as part of the out of hours service would need to be included in the contract specification.

- The contact specification would need to be developed in relation to the high paediatric element attending the Walk In Centre and in relation to people with mental health issues. The Survey results arising from the work undertaken by Health Watch Dudley would assist with this.

- There did not appear to be any barriers to GP's fulfilling their contractual obligations so that GP access could be improved in Dudley.

- Various arrangements including developing joint Commissioning arrangements for GP services with NHS England and asking them to demonstrate how they intend to improve this in Dudley will be put in hand. NHS England for their part were aware of the issues and considering them.

- That there was the linked issue of variations in resources across practices in the Borough, which also required attention. The need for local determination of resources was suggested.

- The need for harmonisation of IT systems across practices was considered to be a big issue, however, changes would give rise to disruption in practices. The issue of whether the meeting of targets by practices during any period of change could be varied was raised. It was considered that practices in the Borough were moving towards linked IT systems as this was one of the key enablers to improving access.

- A report on the contractual element with joint Commissioning regarding future arrangements in terms of IT, the problems and what might be done to over come this was requested for a future meeting of this Board.

Arising from the comments made the Chair indicated that he was more confident now about the proposal for an urgent Care Centre especially with regards to the 24/7 service aspect with the booking of appointments, however, he would like to see more details on access to GP's at the new Centre and how it was proposed that this work in practice.

He also referred to the scenario detail and estimated activity levels referred to in the second report to the CCG Board attached as an Appendix to the current report and considered that Scenario 5 was were the CCG would wish to be eventually whereas the current decision related to Scenario 3.

He therefore requested assurances regarding GP provision within the urgent Care Centre and for the CCG Board not to move to Scenario 5 until that aspect had come back to this Board.

RESOLVED

That, subject to assurances around GP provision within the new Urgent Care Centre and to the CCG Board not moving to Scenario 5 until this proposal had come back to this Board for consideration:-

(1) The consultation process carried out by the CCG and its outcome be noted.

(2) That the recommendations on the future configuration of urgent care as approved by the CCG in the light of the public consultation process be noted.

(3) That NHS England, as a partner on this Board, with contractual responsibility for access to General Practice, be invited to demonstrate how they intend to improve this in Dudley.

(4) That joint commissioning as a means of addressing the issue of access to General Practice be supported; and

(5) That the CCG's proposals for the future configuration of urgent care be approved.

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31. HEALTH AND WELLBEING BOARD COMMUNITY ENGAGEMENT PRINCIPLES

A report of a Senior Development Officer of Dudley CVS, prepared on behalf of the Health and Wellbeing Board Development Group, was submitted on a summary of findings from interviews with Board Members in relation to engagement and proposed principles in relation to involvement and engagement.

The Board was also invited to consider the principles to guide processes and practice in relation to the engagement and involvement of local people in the commissioning and provision of services and in the realisation of vision, aspirations and priorities in Dudley's Health and Wellbeing Strategy.

Attached, as an Appendix to the report submitted was a copy of a report entitled Engaging Together? Towards a collective approach of involving individuals and communities led by Dudley Health and Wellbeing Board.

Arising from a presentation of the content of the report, and Appendix to the report, submitted Lorna Prescott, the Senior Development Officer of Dudley CVS who had prepared the report was thanked for the work undertaken and it was noted that a further report would be submitted to the Board in due course.

RESOLVED

That, arising from consideration of the content of the report, and Appendix to the report, submitted on community engagement principles the Dudley Health and Wellbeing Board Development Group be requested to develop plans, which support the Board to undertake responsibilities in relation to engagement and involvement and address the issues raised by Board Members highlighted in the Appendix to the report submitted.

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32. UPDATE ON HEALTHWATCH DUDLEY PROGRESS AND ACTIVITY IN RELATION TO INTELLIGENCE GATHERING AND PUBLIC ENGAGEMENT

A report of the Chief Officer of Healthwatch Dudley was submitted updating the Board on Healthwatch Dudley progress.

The Chair of Healthwatch Dudley, Pam Bradbury, was in attendance at the meeting and commented on the content of the report and on proposed topics for further consideration so that Health Watch Dudley became more proactive as opposed to the reactive work that had been undertaken.

The Healthwatch team were congratulated on the work done with particular reference to the report referred to in the previous Agenda item.

RESOLVED

That the information contained in the report, and reported at the meeting on the work being progressed by Healthwatch Dudley, be noted.

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33. UPDATE AND PRESENTATION ON STROKE RECONFIGURATION PROGRAMME

A report was submitted on an overview of the Birmingham, Solihull and Black Country Stroke Reconfiguration Programme whose aims were to draw together work undertaken to date by the Midlands and East Stroke Review and to understand if their was a need to reconfigure local Stroke Services to deliver improved patient outcomes. Attached as Appendices to the report submitted were details on Stroke Services specifications; Stroke Services Reconfiguration Programme Brief Birmingham, Solihull and Black Country, January, 2014 and the terms of reference for the Stroke Programme Board.

Nighat Hussain, Stroke Programme Lead, was in attendance at the meeting and circulated copies of a presentation entitled Reviewing Stroke Services for a Healthier Future. A copy of the presentation was available on the Council's Committee Management Information System.

In her commentary on the presentation she indicated that the review related to a possible reconfiguration of hyper-acute stroke units dealing with the first 72 hours after a stroke with other services still being provided in local Hospitals after that period. If current consultations were approved there would be six such units in the West Midlands. However, no decisions had been made and the review was looking at whether there was a need to change.

Arising from the presentation given Board Members queried the engagement of Adult Social Care and Healthwatch Dudley with the work to be carried on.

In response the involvement of Adult Social Care was acknowledged together with involvement in task and finish groups and a request was made for the Programme Board to consider how to involve Adult Social Care at a much earlier stage in the development.

Regarding the involvement of Healthwatch Dudley and other Health Watch's it was reported that further consultations with these Bodies would be welcomed either jointly through meetings with Healthwatch Chairs or on a one to one basis.

RESOLVED

(1) That the programme scope and approach including governance arrangements be noted and endorsed.

(2) That it be noted that the Board's primary point of contact were their local commissioners supported by Sandwell and West Birmingham Clinical Commissioning Group; and

(3) That if consultation was required this would be determined in September, 2014, the proposals being the subject of a period of formal consultation.

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34. BETTER CARE FUND DUDLEY

A copy of a presentation in respect of Better Care Fund Dudley was circulated at the meeting; a copy of the presentation was available on the Council's Committee Management Information System.

A commentary on the content of the presentation was given by the Director of Adult, Community and Housing Services and Paul Maubach, Chief Accountable Officer, Dudley Clinical Commissioning Group. It was noted that the information contained in the presentation would form the basis of the initial plan to be submitted to NHS England by 14th February, 2014 with the final plan to be submitted to the meeting of this Board to be held on 26th March, 2014. The final submission would then be made to NHS England by 4th April, 2014.

The model outlined in the presentation involving Prevention Hubs and GP's and multi-disciplinary teams was considered to be an exciting opportunity with the aim of bringing about a transformation in the ways in which services were provided and in methods of working the approach was therefore innovative. Whilst the approach was based on national criteria it was also focused on what was considered would work best in Dudley.

The focus of the fund would be in relation to older people with frailties and how to bring the services together with the aim of limiting hospital admissions where alternatives might have been possible. The model was therefore multi-layered and services available would be wide ranging. The prevention hubs would provide a single point of contact again with the overall aim of reducing pressure and lengthy stays in Hospital and ensuring the elderly were in sustainable environments. The aim was to reduce emergency admissions by 15% and all unplanned admissions would be seen as a failure.

GP's had a pivotal role to play in the development of the model.

As regards the funding aspects of the proposal the only new monies were £1.57 million additional Section 256 funding (NHS England). The transfer of funding from the CCG will need to support a 15% reduction in emergency admissions. It was noted, overall, that the funding arrangements were very challenging and would also involve the need to deliver efficiencies from within the fund of £4 million.The net total fund was indicated to be £23.84 million .

The aims and ambitions of the Better Care Fund were therefore a sizable challenge the overall object being to enable people to stay longer in their own homes. A further significant financial aspect of the fund was the need to demonstrate that proposals could be delivered next year in 2015/16 without additional resources.

As regards the next steps following the submission of the final plan to NHS England on 4th April, 2014 shadow arrangements would be established from April, 2014 and Clinical Commissioning Group investment in key initiatives to support the fund would also apply from that date.

Arising from consideration of the presentation Councillor Branwood wished to place on record thanks to the Director of Adult, Community and Housing Services and the Chief Accountable Officer – Dudley Clinical Commissioning Group and their colleagues for their work that had been done to date in preparing the approach in respect of the Better Care Fund Dudley.

Comments were also made in relation to whether the reduction in emergency admissions by 15% was achievable and the need for the model to include systemic long term condition management. In response it was recognised that admission rates were lower than elsewhere in Dudley so delivering the reduction was a significant challenge.

Arising from a query regarding the preparedness of staff to meet the new and challenging environment envisaged by the introduction of the Better Care Fund arrangements it was reported that resources were available for staff development and meeting the challenges ahead including the cultural changes. It was also noted that the Voluntary Sector were key partners in the arrangements and reference was also made to the importance of the Ambulance Service in the arrangements, that service being a key part of the team.

At the conclusion of this item the Chair congratulated all those involved in developing the approach and cited the work done as a good example of working together.

RESOLVED

That the approach outlined in the presentation given and circulated at the meeting in relation to Better Care Fund Dudley be agreed and that a further detailed report be submitted to the meeting of this Board to be held on 26th March, 2014.

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35. CHARTERS

It was reported that the Board had signed up to:

(i) The Disabled Children's Charter for Health and Wellbeing Boards; and

(ii) The Children and Young People's Better Health Pledge

and that the Council had signed up to

(iii) The Local Government Declaration on Tobacco Control.

Copies of the Charters concerned had been circulated to Members of the Board. As regards the Local Government Declaration on Tobacco Control it was noted that this Council had been the first Black Country Borough to sign up to the Declaration.

RESOLVED

That the information circulated and reported on in respect of the Charters referred to be noted.

The meeting ended at 5.35 pm

CHAIR

Agenda Item No. 5

DUDLEY HEALTH AND WELLBEING BOARD

26th MARCH 2014

Joint Report of the Director of Public Health, Director of Adult, Community and Housing Services, Director of Children's Services, Director of the Urban Environment and the Chief Officer of the Dudley Clinical Commissioning Group

NEXT STEPS FOR THE HEALTH AND WELL-BEING BOARD INCLUDING WORK PROGRAMME FOR 2014/15

PURPOSE OF REPORT

1. For the Dudley Health and Well-Being Board to confirm next steps and its work programme for 2014/15.

BACKGROUND

2. This Report covers a range of matters relating to the purpose and conduct of the Board going forward, given the development it has undergone so far. It addresses the following issues:
   - Joint Health and Well-Being Strategy and the Joint Strategic Needs Assessment;
   - Community Engagement and Communications
   - Quality Assurance
   - Governance
   - Draft Work Programme 2014/15

3. The proposals are based on discussion with the Chair, evaluation from spotlight sessions, and discussion with Board members and the Development group

JOINT HEALTH AND WELLBEING STRATEGY AND JOINT STRATEGIC NEEDS ASSESSMENT

4. During 2013/14 the JSNA group has focused on production of the JSNA 2012 synthesis report and also setting up the All About Dudley website which provides datasets and information tools on Dudley borough. During 2014/15 the work-plan will centre on production of a 2013 JSNA synthesis, maintenance of the All About Dudley website and further development of the assets based approach. This will include continued piloting of the open hub model at Wren's Nest community centre which is a membership model that encourages residents to initiate their own activities and reflection and evaluation of asset based approaches to inform the JSNA.

5. During 2013/14, the Board has progressed the 5 priority areas in the Health and Wellbeing strategy through a series of spotlight events with key stakeholders, one for each priority area. Following these events, the intention was that existing partnership or commissioning groups would take responsibility for finalising spotlight outcomes in terms of action plans and indicators. These collectively would form the implementation plan for the Joint Health and Wellbeing Strategy. The spotlight session approach was evaluated and the evaluation report drew a number of conclusions and recommendations that will be taken forward during 2014/15. This includes:

    a. The continuation of the spotlight approach but with less events – a maximum of 2 or 3 events. The delivery of 5 spotlight events and a conference, alongside quarterly Board meetings was very ambitious. A more focused, approach is suggested that concentrate further events on the two areas of work the Board is already committed to for 2014/15- integration and the Better Care Fund and the healthy neighbourhoods work on strong inclusive communities with Think Local Act Personal (TLAP). The latter will also include the physical and economic environment. This will allow the Board to develop as an instrument that builds bridges, champion and drives these work areas and make a real difference to the health and wellbeing of Dudley borough residents.

    b. The H&WB Board takes the approach of tasking existing groups/committees to take forward the development of action plans and indicators for the spotlight issues rather than developing new groups. This ensures work is embedded into existing plans and work patterns and can be sustained. However, there is a need to strengthen the governance arrangements and accountability of these designated groups. The spotlight evaluation illustrated that the roles of these groups is not clear either with the groups themselves or spotlight attendees. Direct accountability to the H&WB Board should be reinforced for the relevant theme, and incorporated as part of an emerging sub-structure of the H&WB Board, with a lead Health and Wellbeing Board member established for each issue. The updated governance arrangements are drafted in Appendix 1. Discussions will be taken forward with the Chairs of each group. The sub-structures will change as new themes arise.

    c. Future design of spotlight events will play to their strengths as an opportunity to gain greater awareness and understanding about issues and generate fresh ideas from different perspectives from a wide group of stakeholders. Board member attendance will be encouraged. Public and service user involvement will be enhanced either through attendance at the events themselves or via prior consultations/events which are then fed into the spotlight, whichever is most appropriate.

    d. There is a need to be clearer on how the topics of any future spotlight events are identified and to make this process more transparent and inclusive where possible. It is proposed to develop a 2 way process with the JSNA synthesis work so that learning from prior spotlights can be fed

into the JSNA but also that key issues and gaps being identified through the JSNA are flagged as potential spotlight themes, for wider discussion and prioritisation with key stakeholders and the public.

COMMUNITY ENGAGEMENT

5. As well as the spotlight events, it is proposed to develop a community engagement programme that allows the Board to make best use of existing partner engagement mechanisms for developing and reviewing the Health and Wellbeing Strategy and its priorities. Principles of community engagement have been agreed and insight from Board members detailed in the 'Engaging Together?' report tabled in January 2014, will be used to develop the programme. A task and finish group will be set up for this purpose.

6. Following the success of the conference in June 2013, it is proposed to hold an annual accountability conference in early July. This will give feedback on Board progress and spotlights. A task and finish group will be set up to plan and deliver the event. The group will take account of feedback from the previous event in their plans. It is proposed to target specifically the groups best suited to this type of event-Board members, health and care workers and organisational stakeholders i.e. voluntary organisations etc. The community engagement plan discussed in paragraph 5 will target the public, communities and service users.

7. Communications plans will be developed to dovetail into the community engagement programme and will actively explore new media as well as develop a Health and Wellbeing Board web site.

QUALITY ASSURANCE

8. In January 2014, a development session was held with Board members to agree the Board's role and mechanisms for quality assurance. A number of recommendations were made that will be taken forward during 2014/15 to finalise the Board's QA approach and system. These include:

    a. The draft protocol to support working relationships between the H&WBB and health Scrutiny Committee be updated to reflect the agreed role distinctions in relation to QA. These are that the H&WB Board functions to give overarching strategic direction and a framework for commissioning across health and care sector, through the Joint Strategic Needs Assessment and Health and Wellbeing Strategy. Health Scrutiny functions to scrutinise and challenge people delivering front line services and drill down on specific areas of concern.

    b. Adoption of the high level risk assessment model by the Board as its QA process, and adoption of the escalation route to the Quality Surveillence Group to trigger a risk summit and to health scrutiny for drill down.

c. Sessions to identify and review QA issues and risks to be timetabled into the H&WBB work-plan to populate the risk assurance model and monitoring.

d. Identify current QA systems of commissioners/partners to raise general awareness of these for all Board members.

e. Working relationships with Healthwatch Dudley to be agreed that maximise their role on the Board in terms of patient/public voice.

GOVERNANCE

9. Following debate and feedback from Board members, it is proposed to change the Board format to a less formal, relaxed, accessible style, to encourage greater public attendance and greater discussion and debate among Board members. Emphasis will also be to actively encourage public attendance around specific interest areas e.g. dementia, neighbourhoods, when on the agenda. During 2014/15 incremental changes will be made, the first of which are:

    a. to host the Board meetings in a range of community venues around the Borough
    b. to adopt a user friendly Board reporting style – draft guidelines in appendix 2. The draft guidelines are an attempt to help the Board approach its business effectively and to open up discussion, not limit or hinder the Board in anyway. Board members will be responsible for ensuring reports from their organisation are congruent.
    c. It is suggested the health and wellbeing brand is added to the agenda and board report templates.
    d. Provide a welcome and support to members of the public who attend. Lorna Prescott has offered to take on this role at future Board meetings
    e. To structure the Board meeting agenda to include 3 sections: Information – to take reports and business; Discussion Items- to take substantive issues that need to be talked about in more detail; and Strategic Issue- to take 1 strategic issue each meeting that needs to be developed or a Board view determined.

10. The Board agenda will also continue to be organised to ensure the main business items are covered - quality, engagement, integration, and health inequalities.

11. It is suggested that the Board meeting continues to be a meeting held in public, and further incremental change will address the level of public attendance or engagement at the meetings. Options for actively encouraging public attendance will be developed for discussion at the June Board.

12. Health and Wellbeing is a massive agenda and the Board needs to be assured that all issues are being progressed. It is suggested that the Board review its governance arrangements across the health and care sector to reflect this.

13. It is proposed that the H&WB development group membership be widened to include healthwatch Dudley and NHS England representation, and build opportunities for links with other health and wellbeing agencies, providers and local leaders.

14. A conflict resolution protocol for the Board will also be finalised and voting rights considered within this context, and within the requirements of the Local Authority regulations (2013).

WORK PROGRAMME 2014/15

15. Meetings in public – taking into account the responsibilities of the Board, it is suggested that there continue to be four Board meetings in public, held quarterly- the draft workplan is scheduled below with provisional dates and times where known.

16. One of the key issues being raised nationally as a driver for effective Board functioning, is the need for the Board to have 'thinking and talking' time. This was reflected in local feedback and discussions. Board members need to be allowed to develop as equally engaged, capable and accountable members of the board as opposed to organisation representatives. As a result it is proposed to reinstate some Board development time by incorporating a few short session slots throughout the year. This will give space for the Board to discuss issues informally, or address development or governance needs.

17. Consultation and engagement – as described in previous sections, 2 spotlight events and an annual accountability conference are timetabled in the workplan. Further engagement events with the public and users will be built into existing partner mechanisms.

18. The Board has submitted an expression of interest to be peer reviewed in September. This may require additional Board member time to complete.

19. It should be noted that should the Chair wish to do so, dates and times of meetings may alter from those below and extra meetings can be called through the year if the need arises. The Board may also wish to consider any issue connected to decision-making for the Board outside of its formal meeting structure, should the need arise.

Date	**Activity**
TBC May/June 4pm-5.30pm	Development session
Tuesday 17th June 5pm-7pm Venue TBC	Board meeting in public
Early July TBC 10am-3.30pm	Annual accountability Conference
Tuesday 30th Sept 5pm-7pm Venue TBC	Board meeting in public
September	Peer review
October	Spotlight

TBC November 4pm-6pm	Development session
Tuesday 16th Dec 5pm-7pm Venue TBC	Board meeting in public
February	Spotlight
TBC March 2015 4pm-5.30pm	Development session
Wednesday 25th March 2015 5pm-7pm Venue TBC	Board meeting in public

FINANCE

20. Any financial implications resulting from these proposals will be met within existing budget arrangements.

LAW

21. The statutory duties of the Health and Wellbeing Board are detailed in the Health and Social Care Act 2012 and related guidance.

EQUALITY IMPACT

22. Improving equality and tackling health inequalities are key priorities of the Health and Wellbeing Board and will be discharged through implementation of the Board's Joint Health and Wellbeing Strategy. The establishment of the Dudley Health and Well-Being Board provides an opportunity to extend the influence of the Council in working more closely with partners, particularly GP and Clinical Commissioners, to consider equality issues through the work of the Board.

RECOMMENDATIONS

23. That the Board agrees the work plan and proposals in this report.

Valerie A Little
Director of Public Health

Andrea Pope- Smith
Director – DACHS

Pauline Sharrat
Interim Director – DCS

John Millar
Director – DUE

Paul Maubach

Chief Officer
Dudley CCG

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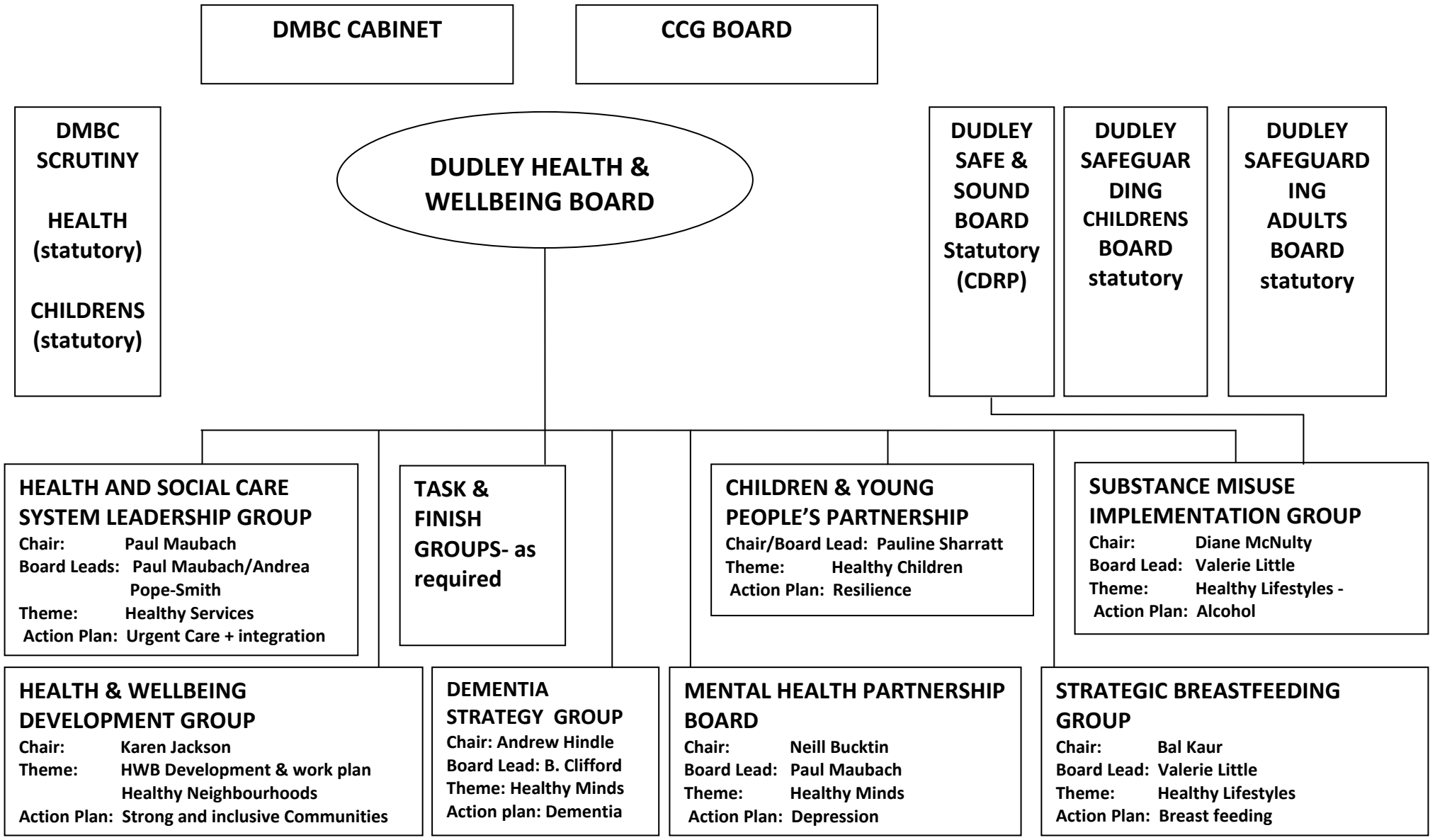
Sue Holmyard
Assistant Director –DUE
DMBC

Neill Bucktin
Head of Partnership Commissioning
Dudley CCG

Josef Jablonski
Principal Officer –CRD
DMBC

DUDLEY HEALTH AND WELLBEING BOARD – DRAFT (26/03/2014) APPENDIX 1

SUGGESTED STRUCTURE / GOVERNANCE ARRANGEMENTS (DRAFT)



Appendix 2: HEALTH AND WELLBEING BOARD REPORTS

USER -FRIENDLY BOARD REPORTS

The Health and Wellbeing Board holds 4 quarterly Board meetings each year in public. The board members are committed to improving the access of the Board and its Board meetings to the public. These guidelines provide a template and guidance for producing user-friendly, easy to read Board reports. This will be an advantage to Board members themselves as well as the public.

User Friendly Checklist:

As report writer, your job is to make your reader's job as easy as possible. Use the techniques below to make it easy for them to find and understand the information they want.

Checklist for your report	√
• Is the report length within 6 A4 sides plus appendices?	
• Does it set out the main points in a series of short, crisp paragraphs.	
• Have you written with your reader in mind- in this case Board members from a range of different agencies, councillors and the public.	
• Are detailed analysis of complicated factors or statistics, left to the appendix/ supplementary sheets	
• In each section, and in each paragraph, have you given the most important information first, and then explained or given the detail?	
• Is it organised into sections, with headings and sub-headings where relevant to split up information?	
• Do use pictures, graphs etc to split up information and illustrate a point	
• Do use lists/bullet points to split up information where possible	
• Have you avoided jargon and legalistic words where possible, written acronyms in full and explained technical terms.	
• Is your average sentence length around 15 to 20 words?	
• Have you stuck to one main idea in a sentence.	
• Have you used everyday English whenever possible.	
• Have you used active verbs as much as possible. Say 'we will do it' rather than 'it will be done by us'.	
• Have you checked that your report is accurate, clear, concise and readable- have you gone through and removed useless words?	
• Is it in Arial font size 12 and the paragraphs numbered	

In terms of presenting reports at Board meetings it will be assumed that the report has been read, the role of presenter being to introduce the report, key points and recommendations and take questions.

A template summary sheet and Board report are below:

DUDLEY HEALTH AND WELLBEING BOARD

REPORT SUMMARY SHEET

DATE	
TITLE OF REPORT	
Organisation and Author	
Purpose of the report	
Key points to note	
Recommendations for the Board	
Item type	*Information, discussion , strategy*
H&WB strategy priority area	*Services, children, mental wellbeing, lifestyles, neighbourhoods, integration, health inequalities, quality assurance, community engagement,*

DUDLEY HEALTH AND WELLBEING BOARD

DATE

REPORT OF: *Who the report is from- Organisation/s and/or Director/s*

TITLE OF REPORT

HEALTH AND WELLBEING STRATEGY PRIORITY

1. *A statement detailing how the item links into the H&WB strategic priorities*

PURPOSE OF REPORT

2. *The main purpose of your report, if you can do this in a single sentence, so much the better.*

BACKGROUND

3. *Relevant details to give a brief context to the report, what has led up to the report for example*

THE MAIN ITEM/S OF THE REPORT

4. *The main information or discussion items and options*

FINANCE

5. *A statement of financial implications and budget that will meet them, or a statement confirming no financial implications*

LAW

6. *A statement of any legal requirements or implications*

EQUALITY IMPACT

7. *The impact on different demographic groups- e.g. black and minority ethnic, disabled, people living in deprivation, genders and other relevant groups.*

RECOMMENDATIONS

8. *Key considerations, actions, decisions that you want the Board to make.*

Signature of author/s
Contact officer details

Agenda Item No.6

Health and Wellbeing Board 26th March 2014

Report of the Chief Accountable Officer, Dudley Clinical Commissioning Group

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

Purpose of Report

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

Background

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

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

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

Existing Strategy and Plans

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

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

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

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

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

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

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

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

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

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

National Planning Guidance

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

    a. Domains

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

    b. Ambitions

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

    c. Measures

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

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

    - Quality
    - Innovation
    - Access
    - Value for Money

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

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

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

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

CCG Operational Plan

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

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

16. The plan:-

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

Issues for the Board to Consider

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

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

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

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

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

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

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

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

Next Steps and Timetable

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

Finance

26. See pp 7 – 8 of the draft plan.

Equality Impact

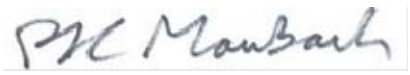
27. Equality impact assessments will be carried out on all planned initiatives.

Recommendation

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

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

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



……..

Paul Maubach
Chief Accountable Officer

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NHS
Dudley
Clinical Commissioning Group

From: Dependency, Hierarchy and Modernism

To: Autonomy, Networks and Mutualism

Operational Plan 2014/2016

Dudley Clinical Commissioning Group

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

Operational Plan 2014/2016

Background

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

This plan is designed to:-

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

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

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

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

In the sections below we have:-

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

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

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

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

Objective: System Effectiveness Reduce Emergency admissions by 15% Achieve Better Care Fund Measures Improve system productivity Improve elective efficiency by 20%	Initiative: Citizen Empowerment and Engagement. Creating opportunities for active citizenship in vibrant communities	Enabler: A mutualist based relationship with member practices and responsible local citizens – developing PPGs and an autonomous registered membership
Objective: Reduced Health Inequalities: •Reducing premature mortality •Reducing emergency hospital admissions due to alcohol •Reducing Childhood Obesity •Reducing CVD mortality	Initiative: Systematic Management of Long Term Conditions. Through primary care and community services delivered in response to health inequalities in our localities	Enabler: Network leadership, training and OD programmes.
	Initiative: Primary Care Strategy Delivering modern primary care at scale within a federated locality model.	Enabler: Joint Commissioning of Primary Care with NHS England.
	Initiative: Integrated Care Aligned health & social care teams providing proactive care operating in practices, localities and borough-wide.	Enabler: Integrated GP and mobile community IT systems.
Objective: Best Possible Outcomes •Improved patient experience and value-added outcomes of healthcare •Increased early detection of dementia •Improved individual autonomy •Improve access and choice of services	Initiative: Community Rapid Response Providing a real alternative to ambulance intervention and hospital admission, where unnecessary admission to hospital or care homes is seen as a system failure.	Enabler: Developing community service and provision choice through AQP.
	Initiative: Market Shaping and Development. To create responsive Integrated community services.	Enabler: Risk stratification to target resources based upon patient risk profiling and service utilisation across health and social care.
Objective: Improved Quality and Safety •Reduce incidence of pressure ulcers •Reduce unwarranted variations •Reduce incidence of Clostridium difficile •Zero tolerance of MRSA bacteraemia •Safeguarding children and adults	Initiative: Integrated Urgent Care A new integrated urgent care centre, providing a single point of access 24/7 and commissioning.	monitoring of systems to evaluate efficiency and outcomes. Enabler: PSIAMS – personalised patient-driven reporting on the value of care and implementation of personal health budgets.
	Initiative: Quality Programme CQUINs and quality initiatives to reduce patient harm and improve outcomes. 7 day working across acute and community services.	Enabler: Joint governance and performance and commissioning frameworks with all partners. Memorandum of Understanding with the Office of Public Health
	Initiative: Elective Pathway modernisation Streamlined elective pathways.	

Vision and Objectives

Our Vision

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

Our objectives which underpin this are to:-

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

Strategic Intent

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

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

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

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

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

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

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

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

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

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

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</td></tr>
</table>

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

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

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

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

active citizenship and autonomy from healthcare is encouraged and facilitated;

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

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

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

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

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

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

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

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

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

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

The Challenge

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

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

Financial

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

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

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

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

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

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

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

Health Status and Health Inequalities

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

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

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

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

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

- cancer
- heart disease
- stroke
- liver disease

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

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

This means:-

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

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

This is reflected in our plans.

Clinician and Community Engagement

Community Views:-

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

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

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

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

are all reflected in our key service and outcome priorities.

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

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

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

Clinician views:-

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

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

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

Our Outcome Ambitions

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

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

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

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

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

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

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

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

Increasing people's positive experience of hospital care:-

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

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

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

Progress towards eliminating avoidable deaths in hospital:-

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

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

Commissioning for Quality and Safety

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

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

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

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

Francis, Berwick and Winterbourne View

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

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

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

Staff Satisfaction

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

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

Patient Safety

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

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

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

Seven Day Services

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

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

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

Compassion in Practice

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

Parity of Esteem for People with Mental Health Problems

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

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

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

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

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

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

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

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

Our Key Priorities – 2014/15 and 2015/16

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

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

These are dealt with in detail below.

Impact on Providers

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

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

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

System Characteristics for Transformation

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

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

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

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

These include:-

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

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

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

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

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

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

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

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

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

2. Wider primary care, provided at scale

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

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

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

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

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

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

3. A Modern Model of Integrated Care

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

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

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

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

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

These services will provide:-

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

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

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

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

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

Success will be measured by:-

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

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

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

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

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

Our Better Care Fund Plan

The BCF reflects our approach to:-

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

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

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

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

In terms of the key performance metrics:-

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

4. Access to highest quality urgent and emergency care

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

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

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

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

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

Therefore, the system we have consulted upon envisages:-

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

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

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

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

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

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

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

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

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

5. A step change in productivity of elective care

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

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

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

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

In particular, we will:-

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

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

6. Specialised Services concentrated in centres of excellence

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

Governance and Performance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Deliverability

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

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

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

Thinking Differently

NHS
Dudley
Clinical Commissioning Group

Dudley
Metropolitan Borough Council

Agenda Item No. 7

Dudley Health and Wellbeing Board 26th March 2014

Report of Paul Maubach, Chief Officer, Dudley CCG

Urgent Care Centre (UCC) Procurement and Draft UCC service specification (Version 0.6)

Purpose of Report

1. This report provides an update on the design and procurement of the new Urgent Care Centre (UCC) proposed and agreed at the CCG Board on the 9th January 2014. Dudley Health and Wellbeing Board is a key strategic partner in the endorsement and design of the UCC. Consultation on the draft Urgent Care Centre (UCC) Service Specification is essential to move this process forward. It is acknowledged that review and comment from Health and Wellbeing Board members will be invaluable to developing an UCC that reflects the needs of local people, is safe, affordable and fit for purpose.

Background

2. The current contracts for the Walk-in-Centre and Out-of-Hours between Primecare Ltd and Dudley CCG come to an end in September 2014. The commissioning of new contracts provides an opportunity for Dudley CCG to adopt national guidance, deliver the CCG's Primary Care Strategy and respond to the needs of local patients, by re-designing these services into a simpler and more cost effective urgent care pathway. The redesign of urgent care is a core component of the CCG's Primary Care Strategy 2014/15 and also a focus of Dudley Health and Wellbeing Board. In June 2013 the first 'Spotlight Event' was held with the Health and Wellbeing Board on 'urgent and emergency care'. Outcomes from the event included agreement on a set of key principles relating to what a future urgent care system might include. The principles were as follows:

- A joined up, coordinated and seamless system, fluid- no 'bottle necks'
- A simple system-no confusion for the public (or professionals) of what to do, who to call or where to go
- Safe, responsive and high quality

One of the solutions the event delegates identified was to work to simplify the urgent care system, reduce duplication and develop a system which responded to patients' 'default behaviour.'

Specific proposals from the event included "co-locating the walk in centre, with the emergency department."

On the 9th January 2014 the CCG Board agreed to proceed with the design and procurement of the UCC. As a result the draft UCC Service Specification is being developed which is now in its six version (see Appendix 1, Version Control table Page 2 for details of these changes to date). A final version of the UCC Service Specification is required for the CCG Board meeting on the 4th April 2014. This process was also approved by the H&WBB on the 28th January 2014.

2.1 Procurement and commissioning

In March 2014 the CCG will issue a Procurement Information Notice (PIN) to Supply to Health. The PIN will advertise the intentions of Dudley CCG to tender the UCC contract nationally and provide potential bidders with an early notice of the process. Midlands Central Commissioning Support Unit are now developing the other documentation required to offer the service for tender once the UCC service specification has been finalised.

2.2 Finance and Premises Solution

Detailed planning on activity and finance is now in development via the weekly CCG UCC Activity and Finance Group. This group will develop modelling around patient flow and treatment at the UCC and provide detailed analysis of costs and savings as a result of reducing A&E activity. Dudley Hospitals Foundation Trust is currently in discussion with the CCG on the short and medium term premises solution for the UCC. Activity assumptions will be built into the CCG's contract with DGFT for 2014/15 and 2015/16.

2.3 Stakeholder engagement and impact

The likely impact and planned response of this proposal on different racial groups, disabled people, men and women and other relevant groups will be undertaken as part of the planning and procurement process.

Extensive public and user engagement has been undertaken on the UCC proposal and the analysis and recommendations of this were received at Dudley CCG Board meeting of the 9th January 2014. The following link will direct to the consultation report and papers: http://www.dudleyccg.nhs.uk/wp-content/uploads/2013/03/PUBLIC-Dudley-CCG-Board-Papers-View-Papers1.pdf

Recommendations

3. Recommendations

It is recommended that:-

- The Health and Wellbeing Board receive the information contained in this report for assurance on the planning and commissioning process of the new UCC.
- The Health and Wellbeing Board review and comment on the draft UCC service specification and feedback responses to the CCG for consideration and inclusion in the final draft version.

……..
Paul Maubach
Chief Officer of Dudley

List of Background Papers

Appendix 1 Draft Urgent Care Centre Service Specification (Version 0.6)

Thinking Differently

NHS
Dudley
Clinical Commissioning Group

Appendix 1

SERVICE SPECIFICATION

Dudley Urgent Care Centre

11 March 2014

Version Number: 0.6

Draft Version

Version Control

VERSION	AUTHOR	DATE	COMMENTS
0.1	Jason Evans	13 February 2014	Initial draft completed
0.2	Jason Evans	14 February 2014	Revised draft following 13.02.14 Health and Wellbeing Forum
0.3	Rachel Denning	14 February 2014	Comments marked in red throughout
0.4	Jason Evans	28 February 2014	Comments included from 28.02.14 Urgent Care Centre Reference Group meeting
0.5	Jason Evans	06 March 2014	Comments included from 05.03.14 UCC GP Working Group meeting
0.6	Jason Evans	11 March 2014	Comment worked in from Dr Steve Mann Clinical Lead for Urgent Care.

Document Approval

Dudley Clinical Commissioning Group

Paul Maubach (CRO) Chief Responsible Officer	Signed:	Date
Dr David Hegarty (Chairman)	Signed:	Date

Dudley Group of Hospitals NHS Foundation Trust

Paula Clarke	Signed:	Signed:

West Midlands Ambulance Service

	Signed:	Signed:

Dudley Metropolitan Borough Council

	Signed:	Signed:

Dudley Health and Wellbeing Board

	Signed:	Signed:

Dudley Healthwatch

Dudley and Walsall Mental Health Trust

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1 Document Terminology

The following terminology will be used throughout this document:

Emergency Department (ED) means the Dudley Group Foundation Trust (DGFT) Russells Hall Hospital site (RHH) Accident and Emergency (A&E) department as currently configured (i.e. consisting of majors, resuscitation, minors, paediatrics etc).

Triage is the process by which patients are assessed by a qualified clinician (at formal registration) when they arrive at the UCC to facilitate the immediate prioritisation of these patients according to their clinical condition.

Assessment means the performing of additional tests, investigations or treatment on appropriate patients after Triage to inform the prioritisation of these patients according to their clinical condition.

Treatment means the treatment a patient receives in any of the appropriate streams found within the UCC after Triage and an Assessment (if appropriate).

2 Executive Summary

- On the 9th January 2014 the Board of Dudley Clinical Commissioning Group (the "Commissioner")[1] agreed to commission a procurement exercise to identify a suitable provider for the new Urgent Care Centre (UCC) on the site RHH, adjacent to the existing ED;
- The commissioning by Dudley CCG of the UCC will also reconfigure and move the existing Dudley Walk-in Centre and Out of Hours service (OHH);
- The Dudley Walk-in Centre (WiC) and OHH service will cease to operate in its current location in Holly Hall Clinic but will instead be integrated with the new UCC;
- The new UCC will be clinically integrated with the RHH ED from 1st March 2015;
- A key feature of the new UCC service model will be the seamless integration with the 111 service and the triaging of all ambulatory and ambulance bound patients on arrival[2]. All GP practices will also offer directions to the UCC via their OOH answer phone message.
- Independent primary care General Practitioners (GP's) and Advanced Nurse Practitioners (ANP's) will be employed to help assess and treat patients, along with a dedicated non-clinical Navigator who will assist patients with none clinical needs i.e. in booking follow-up appointments (GP Practice or other community service etc);
- The Navigator will also help register unregistered patients and generally educate patients about appropriate services available in the community;

[1] See Board Paper 'Dudley CCG Urgent Care Reconfiguration V.8 09.01.14'.
[2] The exception to this being medical emergency conveyances requiring immediate ED care i.e. Resuscitation, Adult and Child majors.

- 95% of all presenting patients at the UCC will be seen and discharged within four hours
- There will be some building reconfiguration work at RHH to integrate the UCC and accommodate a primary care component.
- It is anticipated that the redirection of patients through the UCC will result in reduced attendances at ED and that the independent primary care GPs in the UCC will also help cut admissions, both eventually reducing long term costs to Commissioners.

3 Background

Primecare Ltd currently operates the Dudley Walk-in Centre (WiC) which is geographically located 700 meters from the existing RHH ED Department. Local consultation and national best practice identifies that this configuration for patients can be confusing when they make choices on accessing urgent care and it also promotes inefficiencies in the use of resources to have two services which can treat similar patients operating independently but so geographically close together. Attendances at the existing RHH ED Department continue to rise (combined ED, WiC and OHH attendances are approximately 460 patients per day).

It is estimated that approximately 25-30% of patients currently presenting at the existing RHH ED could be treated in community primary care facilities[2]. It is further estimated that 80-90% of patients presenting at the WiC could be treated in community primary care facilities[3]. This means that when the WiC and OHH is integrated into the UCC, there will be approximately 169,021 patients (c42% of total patient presentations) per year presenting to the UCC, of these approximately (specific figures currently being identified and tested) with primary care treatable conditions.

4 About This Document

This document should be read in conjunction with the following other UCC project documentation:

Document Title	Status	Owner
UCC Business Case	Version 0.8 submitted to the CCG Board meeting on the 09.01.14. Approval given to proceed to procurement.	Dr Steve Mann – CCG Clinical Lead for Urgent Care
UCC Procurement timeline (Delivery Stage)	Produced by the Commissioning Support Unit (CSU) on the 05.02.14	Jason Evans - Commissioning Manager of Urgent Care

[2] Reference evidence.
[3] Reference evidence.

UCC Project Plan	To be developed	
UCC Operational Policy	To be developed	
Triage Guidelines	To be developed	
Estates Design Specification[4]	To be developed	
IT Requirements	To be developed	

The final version of this document will be inserted into Schedule 2 of the main contract between the Commissioner and the Provider.

5 Service Objectives

There has been a historical trend of growth of patient numbers at RHH ED throughout the last few years. There has also been an increase in the number of ambulance conveyances and the complexity of medical admissions via the department. Furthermore the WiC has seen significant levels of growth since it was commissioned. By commissioning the UCC, the Commissioner requires the RHH ED (including the integrated UCC) to operate with a fundamental change in philosophy, culture and mindset about how patients are dealt with when they seek urgent care to avoid this trend continuing. With this in mind, the Commissioner's expected measurable quantitative outcomes from commissioning the UCC service and which will constitute "success" are to:

- Reduce the number of patients attending RHH ED. This will be achieved by treating and / or redirecting non-urgent patients presenting at the new UCC back to primary care and other community services (see Section 7.6 and Appendix ? *Dudley CCG Reconfiguration of Urgent Care v.8*);
- Reduce the number of RRH admissions from the ED. This will be achieved by the different approach to the clinical treatment of patients seen in the UCC by experienced GPs and ANPs (see Section 7.11); and thereby
- Reduce the total cost to the Commissioner of by reducing ED interactions (see Appendix ? *Dudley CCG Reconfiguration of Urgent Care v.8*).

Other expected qualitative benefits from commissioning the UCC are to:

- Refine the patient flow through the RHH ED which will in turn:
  - Ensure the patient is efficiently prioritised and directed to the right area of RHH and to see the right clinician and receive the right treatment;
  - Improve the patient experience and quality of service provided to patients (see Appendix 6); and

[4] The service specification will be maintained in accordance with current NHS Estates guidance and requirements).

- Reduce the proportion of patient handover delays from West Midlands Ambulance Service (WMAS).

- Ensure a patient's ongoing healthcare needs are met in the most appropriate setting within the community or primary care (see Appendix 6);
- Improve the integration of primary, community, Out-of-Hours (OOH), secondary and mental health services in the local area and help provide seamless care pathways between different service providers;
- Develop the distinctive culture and approach of a primary care service within the RHH site;
- Use EMIS Web patient record system throughout the UCC which allows staff to read patient GP records (where permitted) (see Section 7.17);
- Maximise the use of existing human resources in terms of skills, knowledge and competencies;
- Facilitate the registration of unregistered patients with a GP Practice;
- Provide health promotion, self-management, education and sign posting of patients to other primary healthcare services in the community;
- Operate as a fully integrated element of urgent care provision on the RHH site with a seamless patient transition from UCC to ED and other parts of the Trust (and vice- versa) where required; and
- Provide a seamless pathway to any further assessment required within RHH, including referral (if necessary) to a hospital specialist.

The UCC will not:

- Be a further access point for routine primary NHS care in the local health economy (these patients will be appropriately and actively navigated back into core primary healthcare services in the community); or
- Duplicate existing service provision by primary care services.

6 Commissioner Service Requirements

The Commissioner requires the Provider to implement and operate a robust patient triage, assessment and treatment streaming model, facilitating and delivering a primary care led UCC which shall:

- Have a service model as described in Section 7;
- Integrate with other healthcare services as described in Section 8;
- Meet the quality and clinical governance standards as described in Section 9;
- Meet the service commencement date as described in Section 10;
- Meet the activity and performance measures as described in Section 11; and
- Utilise the payment model as described in Section 12.

7 Provider Service Model

7.1 Overview

The UCC will provide 24 hours a day 365 days a year:

- A safe and consistent primary care Triage, Assessment and Treatment service to <u>all</u> patients presenting at the UCC; The Provider will adhere to DGH clinical governance and related service policies in delivery of this service.

- A "navigation service" will be available. Once identified as appropriate by a clinician the navigator safely redirects patients away from the UCC to other community based services more appropriate to meet their needs, as well as assisting unregistered patients to register with a GP Practice;
- A central reception that will be the single point of patient registration for all ambulatory, out of hours and ambulance bound patients (With the exception of Major trauma and Resuscitation cases which will go directly to ED); and

7.2 Name

(The New UCC will need careful development in regards to marketing and how it is identified to ensure patients do not use it inappropriately and particularly within GP core opening hours).

7.3 Access

7.3.1 General Principles

Upon presentation at the UCC a Triage clinical receptionist will determine if a patient is seen in the UCC or directed to ED (see Section 7.5). The Provider must contract to supply to all patients with communication difficulties a professional translation service.

Educating patients about the appropriate use of healthcare services will be an important part of the UCC Provider service model and will be a pervasive theme as patients move through the UCC pathway. This will include, for example, the Navigator helping unregistered patients register with a GP Practice or providing leaflets to patients on local pharmacy or dentistry services.

7.3.2 Opening Hours

The UCC will be physically co-located with, and have an integrated pathway to RHH ED. It will therefore be open 24 hours a day 365 days per year.

7.3.3 Telephone Access

The UCC will not provide clinical advice over the telephone to patients. Patients will call NHS 111 and first be call screened by a call handler through the Pathways call triage system. The patient will as a result be either dispatched an emergency ambulance via 999; encouraged to make an appointment with their own GP Practice, directed to the OOH service or to attend the UCC in person. If the patient is to attend the UCC or requires an OHH visit NHS 111 will pass their details to the UCC call handler who will arrange an appointment. (This model is currently subject to review).

7.3.4 Appointments

The UCC will provide pre-booked first appointments to patients outside of GP practice core hours (08:00 – 18:30 weekdays). The use of the UCC by patients as an alternative to primary care should be actively discouraged by the Provider as part of the education of patients. Patients will not be offered or be able to book appointments at the UCC for the follow up of certain conditions. Follow-up treatment must take place via their own GP or identified alternative provider (see Section 7.15).

7.3.5 Registered Patients

The UCC will not be a "traditional GP Practice" in the sense that it will not have a list of registered patients.

7.4 Patient Flow

The high level summary patient flow throughout the new UCC (Including ED) is set out in Appendix 1.

The patient flow described in Appendix 1 (in particular Triage (see Section 7.5) and Redirections (see Section 7.6) will be the subject of ongoing scrutiny and continual refinement to ensure the best possible service model is achieved for patients, the Provider and the Commissioner.

7.5 Triage

All patients arriving at the UCC (either by ambulance or self-presenting walk-in patients) will present for registration and initial Triage[5]. The rationale behind having rapid Triage integrated into the formal registration of a patient is to get a clinical "eye-ball" of the presenting patient as soon as possible. This allows for immediate prioritisation of patients based on clinical need[6]. The Triage will be clinically safe for patients and consistent both in terms of the clinical staff doing it and the time of day when it is done.

7.5.1 Staffing

The staff doing the Triage/Patient Registration will be qualified Clinicians (Health care Assistants) (see Section 7.18.1) who will have sufficient clinical skills and experience, including the confidence to safely redirect patients (see Section 7.6).

To avoid queues of patients waiting for their Triage/Registration the volume of staff doing the Triage/Registration will be sufficient, appropriately scheduled and rapidly scalable up and down to meet patient throughput (see example table below borrowed from a similar UCC service specification JE).

Estimation of number of Triage staff required to meet varying patient volumes:

25	50	75	100	125	Total patient presentations per hour
2.5	2.5	2.5	2.5	2.5	Average Triage time in minutes
63	125	188	250	313	Triage minutes required per hour
1.0	2.1	3.1	4.2	5.2	Number of Triage staff (& Triage spaces) required per hour*

* this is an approximation as obviously patients do not arrive evenly throughout a 1 hour period.

7.5.2 See and Treat

There will never be "see and treat" (i.e. seeing patients when they arrive, assessing their needs, and providing treatment) during the Triage although "see and advise" (e.g. "you need to see a dentist") is within the scope of the Triage. The rationale for this is the sheer volume of patient attendances at the UCC and the queues that would form if the Triage/registration clinicians were also "seeing and treating".

7.5.3 Length of Time

The average target time for Triage/registration will be 2 minutes 30 seconds. This is to manage the high volume of patient presentations (see Section 13) and avoid queues of patients waiting. The 2 minutes 30 seconds is an average target time which will allow for some Triages/Registration to be shorter (less than 1 minute) and some to be longer (e.g. to make a clinically safe redirection decision). The average target time for Triage/Registration will be monitored and adhered to. Integration of the UCC into EMIS Web will make this target achievable for Dudley registered patients.

[5] Ambulance "blue light" and other seriously ill patients requiring immediate emergency treatment will be met at the ambulance entrance to the UCC and escorted straight through to Resuscitation, Adult or Child Majors.

[6] If the process was for patients to first formally register on arrival with a non-clinician before being seen by a clinician, there is the potential for a seriously ill patient to be queuing behind a minor illness patient for some time as they wait to be registered. With the volume of attendances at UCC this process is clinically unacceptable.

7.5.4 Physical Layout

There will be (Number to be confirmed based on patient flow modeling) dedicated stations for Triage/registration for patients arriving by ambulance (Staffed by Advanced Nurse Practitioners) and (Tbc. See comment above) dedicated stations for walk-in patients (Staffed by Health Care Assistants). In addition there will be clinical assessment rooms (number tbc) adjoining the dedicated stations that can be used flexibly (either for further assessment or treatment).

7.5.5 Outcomes

Using the Triage/Registration process will result in a patient being directed one of the following:

1. The Navigator (see Section 7.18.5) for redirecting to other healthcare or social services in the community (see Section 7.6).
2. or a GP or ANP in the UCC;
3. or another service within RHH.
4. or ED;
5. Resuscitation;

Alternatively the patient may be advised no further assistance with treatment can be provided at the UCC; “Immediate Redirection”.

7.5.6 4 Hour Clock

A patient will go through the Triage/Registration process. On completion of this registration the “4 hour clock” will begin for the purposes of recording total patient time spent in the RHH Urgent Care treatment (ED) pathway (see Appendix 6).

7.6 Redirections

There are four “redirection” patient pathway options when a patient is deemed appropriate for redirection outside the UCC:

1. GP Practice redirection (in hours) or when the practice is next open;
2. Social Services / Community Services redirection (hours dependent on individual providers); and
3. Immediate Redirection (Advised no further interaction with the UCC is required).
4. Voluntary sector provider

The redirection model described here will be used at UCC service commencement. However it is anticipated that the redirection model will be the subject of ongoing scrutiny and continual refinement to ensure the best possible service model is achieved for patients, the Provider and the Commissioner.

7.6.1 GP Practice Redirection (in hours)

Appendix 2 describes the detailed patient pathway for redirection to GP Practices from Monday to Friday 08.00 to 18.30.

7.6.2 Community Services (hours dependent on individual community providers)

Appendix 2 describes the detailed patient pathway for redirection to Community Services. Community Services include dentists, optician, pharmacy, social services, expert patient programmes, drug and alcohol services etc.

7.6.3 Immediate Redirection

The patient is advised at Triage that no further assistance can be provided at the UCC.

7.6.3 Voluntary Sector Provider

The patient is advised at of an alternative and appropriate voluntary sector provider and details / information are offered for the patient to pursue this.

7.7 UCC Reception

There will two Reception areas for the UCC within RHH. One reception area will be exclusively for ambulatory / booked in patients and staffed by Health Care Assistants. The second reception waiting area will receive patients conveyed by West Midlands Ambulance Service and staffed by Advanced Nurse Practitioners. An ED waiting area will still be maintained for patients that are triaged and directed through to this service. The UCC Reception will have (Number to be confirmed?) reception desks. The UCC Reception will be the only place where patients are triaged/registered. Separate reception areas will still be maintained for existing admission avoidance services within RHH i.e. Medical Assessment Unit, Paediatric Assessment Unit etc.

7.8 Unregistered Patients

All patients will be asked at their Triage/Registration if they are registered with a GP Practice. Any unregistered patients will be encouraged to register with the assistance of the Navigator if required. The Navigator will contact a GP Practice on behalf of the unregistered patient and arrange a convenient appointment for completion of their preliminary health checks necessary for GP Practice registration. If the patient does not wish to choose a GP Practice while at the UCC, or if the GP Practice of their choice is not accessible, the Navigator will supply the patient with hard-copy information about relevant GP Practices and of the treatment they have received.

Unregistered patients from outside the Dudley Metropolitan Borough will be asked to contact the registration department of NHS England via NHS Choices to obtain a GMS1. The Navigator will then provide them with contact details for NHS Choices registration department.

7.8 Out of Borough Patients

The Commissioner will not provide a payment or tariff to the Provider for patients that are treated at the UCC and not registered with a Dudley CCG GP. Rather, it will be the responsibility of the Provider to identify the patient's registered GP practice and invoice their 'home' CCG for reimbursement of costs. As part of the UCC communication strategy local CCG's will be formally noted of this payment process.

7.9 Flagged Patients

The Commissioners and other organisations will provide the Provider with a list of "flagged patients" (for example, patients within "virtual wards", "frequent flyers", registered mental health patients etc) along with guidance as to what action should be taken for each flagged patient that presents at the UCC. At patient registration the IT system will have the ability to flag up these patients and the appropriate action to be taken. (Are all these IT functionalities factored in to the CCG finance/investment planning?)

7.10 Waiting Areas

The UCC will have a single waiting room area. This waiting area will comply with accepted standards, national and local policies and statutory responsibilities[7].

7.11 Assessment and Treatment

The main assessment / treatment element of the UCC service model will be based in one area and delivered by a GP and / or ANP.

- Patients with minor injury or minor illness;
- Patients that have a problem that may need further investigation, diagnostics or observation, but who are not regarded as requiring their main treatment in ED.
- All patients presenting with trauma will be directed straight to ED.

The UCC principal assessment / treatment area will be similar in style to those provided in primary care, in particular utilising individual consulting rooms to facilitate privacy and confidentiality. The detailed design of the UCC is contained in the *Estates Design Specification* document (to be developed).

[7] For example, the Royal College of Paediatrics and Child Health (2012) Standards for Children and Young People in Emergency Care Settings: Developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings.

7.12 Children

The Provider will need to respect the different needs and approaches to delivering a primary care service to children and respond appropriately. This consideration will be separate to and not replace the existing RHH ED Paediatric Assessment Unit.

7.13 Diagnostics

The UCC will have access to suitably identified diagnostics commensurate with primary care treatment. Any further investigations will be available via established and existing pathways within RHH.

7.14 Discharge

Where the UCC treats a patient, the UCC will pass the patient's details, information of the care provided by the UCC and any further information (for example, the need for the GP to follow up with the patient) by 8am the next day to the patient's own GP Practice (see Appendix 6).

Patients who are directed to another clinical pathway within RHH (for example Medical Assessment Unit) will be provided with a printed summary of their episode of care at the UCC that summarises their presenting condition, diagnosis (if undertaken) and the treatment that was provided (if given). Patients should also be given appropriate printed materials relating to their specific condition.

If a patient has any questions once they have been discharged from the UCC they will be asked to call their own GP Practice.

7.15 Follow Ups

The Provider will not provide a bookable appointment service for following up certain conditions. If further follow-up care is required, the UCC should transfer the patient appropriately (for example: to their own GP, the IMPACT team, a community bed, care at home or other intermediate care services), and will need to agree processes for this to happen.

7.16 Supply of Medicines

7.16.1 Overview

In the UCC, medication will be available to patients via two methods:

a) Patient Group Directions (PGDs). Nurses can supply a range of medicines (pre-labelled pre-packs or single doses) without a prescription under an agreed PGD; or
b) RHH ED prescriptions. Any doctor or independent nurse prescriber working within the UCC can use the RRH ED prescriptions.
c) FP10 prescriptions will also be available to be used in the including UCC.

7.16.2 During RRH Pharmacy Opening Hours

The RRH pharmacy opening hours are as follows:

Pharmacy	Monday – Friday	Saturday	Sunday
Russells Hall Hospital	9am – 7pm	10am – 3pm	10am – 3pm

The patient (or representative) will take the UCC prescription to the RHH outpatient pharmacy to be dispensed. Normal NHS prescription charges will apply. A maximum of one week supply of medication will be provided to patients.

(Front door RHH pharmacy planned but hours and opening date tbc.).

7.16.3 Outside RRH Pharmacy Opening Hours

Pre-labelled pre-packs can be issued by clinicians under a PGD. If clinically necessary a single dose of the medicine can be administered in the UCC and a RRH ED prescription written which will be taken to the RRH outpatient pharmacy the following day. In addition there is an on-call pharmacy service for emergency supply from 8am to midnight 7 days per week.

7.16.4 Formulary

All medicines must be prescribed according to the DGH Formulary and some combination products may be issued as separate constituents as per DGH Formulary.

7.16.5 Private Patients

The RHH ED prescription can be used as a private prescription to enable supply for non-NHS patients. The patient will be charged for these drugs where the normal prescription levy is not applicable. High street pharmacies (chemists) will treat hospital prescriptions as private prescriptions and private prescription charges may vary.

7.16.7 Advice

Advice on medicines is available from the RRH Medicines Information department.

7.17 Patient Records

7.17.1 GP Patient Records

GP patient records will be able to be accessed on a “read only” basis and read by clinical staff (who have been granted access rights) at the UCC through EMIS web.

Where the UCC treats the patient, the relevant GP Practice will need to be informed electronically and by fax about the episode of care (with appropriate details) by 8am the next day.

7.17.2 Community Patient Records

(An ideal would be for UCC staff to be able to electronically identify patients currently receiving care from Social Services and Community Services.)

7.18 Workforce

The Provider’s final staff model for the UCC will reflect the need for a strong primary care presence, from the clinicians doing the Triage/Registration, to the clinicians in the UCC doing the main assessment / treatment, to the Navigator providing advice about alternative primary care services in the community.

7.18.1 Clinical Staff

The table 2. below sets out the proposed full clinical staffing establishment in the UCC at service commencement of the UCC. The skill mix for clinical staff will be regularly reviewed in light of the UCC mobilisation, development and Winter flexibility (see Section 7.18.2). The UCC will be operated 24 hours a day 365 days a year. As set out in the table 2 the UCC will be staffed by appropriately skilled clinical staff/ nurses / ANP's and GP's.

Table 2. Clinical Staff Establishment in the UCC (to be developed)

	Triage / Registration	UCC	Total
Health Care Assistants			
Advanced Nurse Practitioners			
Nurses			
GP's			

It is also anticipated that the staff skill mix may change and include a wider range of practitioners with varying competencies as the UCC becomes established and protocols are implemented and reviewed. As part of the development of an integrated service the Provider will work closely with partner organisations to develop an appropriate skill mix of staff to ensure patients are seen, treated and redirected back to primary care core services for ongoing care.

7.18.2 General Practitioners

The GP hours will be deployed as set out in Section 7.18.1, however it is recognised that the GPs will need to move fluidly between UCC appointments to meet patient demand and utilise their skills in the best possible way.

7.18.3 Non-Clinical Staff

The table below sets out the proposed non-clinical staffing establishment for the UCC at service commencement. This list does not include the UCC Navigator (see Section 7.18.5).

Non-Clinical Staff Establishment in the UCC

Navigators	
Band 5	?
Band 4	?
Band 3	?
Total	?

As can be seen in the table above there will be no dedicated security staff operating in the New UCC. If security staff are needed they will be provided by the general RHH security services.

7.18.5 Navigator

The Navigator will be employed from Monday to Friday 09.00 to 18.30. The Navigator is a non-clinical role but nevertheless a crucial role in helping patients who are identified for redirection by the Triage/reception clinicians (see Section 7.6). This includes advising and helping:

- Unregistered patients to register at a GP Practice of their choice; Registered

patients book a GP Practice appointment;
- Patients understand how and when to contact their OOH provider;
- All patients to access other community services or resources e.g. dentists, optometrists;
- Signpost other key services such as welfare rights advice, social services, expert patient programmes, drug and alcohol advice services, virtual wards, health telephone numbers (e.g. 111), local authority homeless service and other voluntary agencies etc.

The Navigator will have the required training and information tools to provide the above help and advice and will be responsible for keeping up-to-date details (e.g. opening hours, telephone numbers etc) of all these community based services.

Clinicians doing the Triage/registration and other clinical staff in the UCC will direct patients to the Navigator, if the patient needs help or advice or assistance for any of the above.

The Navigator will be responsible for recording details of all help and advice they provide. In particular they will be responsible for recording details (e.g. time, date, name, age, presenting complaint, GP Practice, the reason why a GP Practice appointment could not be made etc) of all successful and unsuccessful attempts to book a GP Practice appointment. These details will be collated on a monthly basis and fed back to the GP Practices in question (see Appendix 5).

7.18.6 Overall Management of UCC

The overall management of the UCC (including the OHH provision) will be undertaken by the Provider.

7.18.7 Clinical leadership

The Provider will be expected to develop a model for clinical leadership and clinical governance, consistent with the existing DGFT internal clinical governance arrangements. As part of this, a designated Primary Care Clinical Lead (either one of the senior nurses or one of the GPs working in the UCC) will be assigned by the Provider for the UCC. The Primary Care Clinical Lead will take responsibility for all GPs and nurse practitioners working in the UCC that treat patients autonomously. The Primary Care Clinical Lead will also take responsibility for the development, approval and implementation of care pathways and protocols within the UCC. The Primary Care Clinical Lead will hold membership on any clinical governance arrangements identified by DGFT.

7.18.8 Integration, Training and Development

The Provider will need to successfully integrate the UCC staff into the existing DGFT practices and protocols. The Provider will be expected to develop the capacity for staff training for all staff or contractors operating in the UCC.

7.19 Estates and Facilities

This section should be read in conjunction with the Estates Design Specification which is to be developed document.

7.19.1 Wider DGFT capital estates plans

DGFT has identified a major re-design of the ED department as a priority estate projects for the short to medium term. A two year estates plan will be published by DGFT in 2014/15 with a further strategic plan to follow. The site this major capital scheme is expected to be based in or around the footprint of the existing ED Department. The UCC building work, for its proposed location (see Appendix 3 and 4), will need to be scheduled and integrated within the broader aim of this capital scheme.

7.19.2 WiC

The existing WiC (currently based at Holly Hall Clinic) will be physically relocated and seamlessly incorporated into the UCC on the RHH site.

7.19.3 Physical Layout

The proposed layout of the UCC is attached in Appendix 3 (To be developed).

The UCC will have a waiting area for approximately ? people and approximately ? consultation spaces (which will be a mixture of rooms with doors and spaces with curtains).

The detailed design of the UCC is contained in the *Estates Design Specification* Document (To be developed).

7.20 Information Technology

This Section should be read in conjunction with the IT Requirements document (To be developed).
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7.20.1 IT System

The same Integrated Clinical Information Programme software as in place in RHH ED will be used throughout the UCC. This will allow the clinician in charge of the floor to properly monitor patient activity across the whole of the UCC as a fully integrated service area and move doctors around and within as required. It will also mean that patient data is seamless between the UCC and ED (for example, if a patient is transferred between the UCC and ED). This may also be needed for payment purposes (see Section 12).

7.20.2 Training

All staff will need to undergo appropriate IT system training.

8 Integration with Other Services

The UCC, as part of the wider unscheduled care system, will be expected to develop strong links with other stakeholders in the local healthcare economy.

8.1 RRH

The Provider will be expected to agree direct referral pathways from the UCC to additional specialist services and clinics within RHH. Where an admission is required this will be made directly from the UCC to the specialty concerned. Patients will not be referred back to, for example, ED for diagnostics or admission.

8.2 GP Practices

GP Practices in Dudley Metropolitan Borough are critical to the success of the UCC service and in particular its ability to redirect patients (see Section 7.6). GP Practices will need to make sufficient appointments available to patients being redirected from the UCC. A GP Practice engagement plan will be a key part of the external stakeholder engagement plan referred to in Section 16. In addition Dudley CCG is implementing a GP Practice "Access LES" in 2015/16 to facilitate availability of additional appointments.

8.3 OOH

OOH provision will be a seamless component of the UCC. Access to the service out of GP core hours will be via NHS 111, following which an appointment at the UCC or home visit will be offered.

8.4 WMAS

8.4.1 Placements

The Provider will provide a space for the WMAS HALO officer to be based at the UCC if and when required to facilitate delays in ambulance turnaround.

8.4.2 WMAS Handovers

The WMAS "patient handover" process in the new UCC is set out in Appendix 7. There should be a significant reduction in the number of Patient Handover delays as a result of this new process.

8.5 Mental Health

8.5.1 Adults (needs further development and inclusion of Drug and Alcohol services)

Patients with suspected mental health problems who present at the UCC are initially assessed by a nurse using the "Mental Health Risk Assessment Matrix". In most cases the patient is then referred directly to the Liaison Psychiatry team (provided by Dudley and Walsall Mental Health Partnership NHS Trust) based at RHH. Those patients who require a physical assessment in addition to a psychiatric assessment (e.g. where the patient has attended following an overdose) will be assessed by a clinician prior to, or concurrently with referral to the Liaison Psychiatry team. The psychiatric liaison service will operate within the UCC 24 hours a day 365 days per year (is this a correct description of the current service?).

In the UCC, the Triage will inform the sorting and prioritisation of mental health patients. Appropriately qualified staff in the UCC will then use the Mental Health Risk Assessment Matrix to assess the patient in more detail before deciding whether referral to the Liaison Psychiatry team is required.

8.5.2 Children (Needs further development)

The process as described above for adults will also apply to children.

8.6 Community Services

There will be an intranet based service directory for all Local Authority / other services for UCC staff to use to confirm services available and referral systems.

There will be a one step, 24 hour referral process for all Social Work services that will support discharge from the UCC (e.g. community nursing, intermediate care, specialist nurses, community matrons and virtual wards etc). The one step referral process will also support referrals to routine and preventative community health services e.g. falls service, primary care therapy teams etc.

Community staff and matrons from the virtual wards may attend the UCC on a planned basis to facilitate identification of patients suitable for discharge to community services.

Community health staff will provide training on a planned basis for UCC staff to develop improved understanding of community services

9 Quality Standards and Clinical Governance

The Commissioner requires that the quality of the service to be provided is of a consistently high standard and all professionals abide by the guidance of their professional self-regulatory body. The Provider will be expected to outline clinical governance mechanisms to be applied when concerns about the quality of the service is raised. The UCC will be an integrated part of DGFT and operate within a common framework of standards and governance. The Provider will deliver the services in accordance with Good Clinical Practice, Good Healthcare Practice, and will comply with all clinical standards, recommendations, policies, procedures and legislation as set out in the DGFT Acute Contract.

The Provider will implement mechanisms for managing risk, including disaster recovery, contingency and business continuity plans as set out in the DGFT Acute Contract.

All incidents (both clinical and non-clinical) will be reported by staff (using the DGFT Datix system) and managed appropriately as set out in the DGFT Acute Contract.

10 Service Commencement

The target full service commencement date for a fully operational and integrated UCC within the RHH site adjacent to ED is 31st March 2015.

Some indicative high level programme plan options for the UCC are set out in Appendix 4. These are draft and subject to change.

11 Performance Management

11.1 Management Board

It is very important to Commissioners that the service model in the UCC is effectively evaluated and refined over time where necessary.

There will be an operational management team consisting of the responsible managers from the UCC, ED and DGFT. This team will report to an overall Performance Management Board (PMB) chaired by the Commissioner which will meet once a month. The PMB will be responsible for monitoring and managing overall performance and deciding how the UCC service model will develop over time.

11.2 Activity Reporting

The Commissioner requires that there is the ability to separate overall data reporting between the UCC and ED. The activity reporting requirements for the UCC are set out in Appendix 5.

11.3 Performance Measurement

The Commissioner requires that the performance and success of the UCC service will be measured against a series of operational and quality indicators to be reported by the Provider. These are set out in Appendix 6.

12 Payment Model

A summary of the key elements is provided below.

12.1 Trial Period

The payment model described in this section is for a Trial Period from six months of service commencement. After the Trial Period the payment model will be reviewed based on actual activity and performance metrics.

12.2 In Year Operational Payment Model

There shall be one operational payment model for the whole of the UCC which will be used to calculate payments from the Commissioner to the Provider during the Trial Period.

12.3 Payment Ceiling and Floor

There shall be a maximum total payment amount that the Commissioner will pay during the Trial Period (the Payment Ceiling). This is required in order to mitigate the risk to the Commissioner over the volume of redirections and the percentage of activity within each payment band.

The Payment Ceiling shall only be used if the operational payment model results in a payment during the Trial Period by the Commissioner of an amount greater than the Payment Ceiling.

There shall be a minimum total payment amount that the Commissioner shall pay during the Trial Period (the Payment Floor). This is required in order to mitigate the risk to the Provider of the redirections policy being extremely successful.

The Payment Floor shall only be used if the operational payment model results in a payment during the Trial Period by the Commissioner of an amount less than the Payment Floor.

The Commissioner will also run a shadow tariff within the first full year of running the UCC to ensure pricing is correct for year two of the contract.

13 Activity

13.1 Payment model and activity

The following table sets out the anticipated patient activity volumes in the UCC by payment band:

Table to be developed. The table should show forecast patient presentations pre and post redirection against the tariff price for each over the next five years of activity.

13.2 By Geography

The following table sets out an example of the potential distribution of patients between the UCC and ED (it should assume that the UCC (excluding redirections) = ED minors + current WiC and OOH activity):

Table to be developed

14 Procurement and Contracting

14.1 Main Contract

There will be a main contract between Dudley CCG (as Lead Commissioner) and a Provider to provide the UCC. As this is considered a significant variation of health care services a formal public procurement process has been undertaken. The contract will be for five years with a negotiable two year extension if required.

14.2 Sub Contract

As part of the main contract there will be a condition that specifies that the Provider has the ability to commission an independent third party to provide any element of the UCC in agreement with the Commissioner. The Department of Health Procurement Guide for Commissioners of NHS-Funded Services (July 2010) will need to be followed in respect of the procurement of this contract.

15 Public Consultation

From 1st October 2013 to 24th December 2013 a formal public consultation took place. The outcome of the public consultation is detailed in the post consultation report received at the Dudley CCG Board meeting on the 9th January 2014.

16 Communication and Stakeholder Engagement

16.1 Provider Internal Stakeholders

As part of the reconfiguration to the UCC there will be a capital development scheme being undertaken within the term of the contract (see Section 7.19). The Provider will therefore need to ensure that internal communications with DGFT are formally kept to ensure they are informed of plans and developments.

16.2 External Stakeholders

The Commissioner and Provider will need to work together to produce an external stakeholder engagement and communication plan.

16.2.1 Media

Communication messages will need to be developed to deal with media interest in the UCC and its ongoing performance and development. It is a requirement of the contract that all media communication regarding the UCC is issued via Dudley CCG Communication Team.

16.2.2 Healthcare Stakeholders

A communication plan for healthcare stakeholders will need to be developed.

Stakeholders that will need to be considered are:

- GP Practices
- Healthwatch
- Other CCGs who have patients that use RRH;
- Dudley Council and Community Services
- Neighbouring Acute Trusts and Local Authorities.

16.2.3 Patients

Throughout the patient experience at the UCC, patients will be educated on other healthcare services in the community and actively encouraged to use their own GP Practice (or register with a GP Practice if they are unregistered).

Once patients do present at the UCC there will be a series of marketing materials (for example on waiting room TV screens) to explain how the UCC operates.

APPENDIX 1: SUMMARY PATIENT FLOWS THROUGH THE UCC

To be developed

APPENDIX 2: REDIRECTION PATIENT PATHWAY OPTIONS

To be developed. The following process diagram would describe the possible outcome options for patients presenting to the UCC with presenting conditions that are suitable and appropriate for direction to the Navigator.

APPENDIX 3: UCC LAYOUT

(to be developed)

APPENDIX 4: PROGRAMME PLAN

To be confirmed.

APPENDIX 5: ACTIVITY REPORTING

National Activity Reporting Requirements

The Provider is required to report UCC activity in line with national DH reporting requirements.

Local Activity Reporting Requirements

The Provider and Commissioner will work together to agree any additional local activity reporting requirements. As a minimum the following local activity reporting will include:

a) Redirections

The Provider shall produce a monthly report which details successful and unsuccessful patient redirection attempts by the Navigator. This shall be in a format suitable to be emailed to local GP Practices. For example, this may include for every GP Practice:

Patient details (name, DOB, presenting condition, GP Practice);
Time and date of redirection attempt by the Navigator during the month;
Outcome of redirection attempt by the Navigator;
If redirection was unsuccessful, the reason for this;
Attempts to register unregistered patients and outcome.

b) GPs and Nursing staff in the UCC

Measuring the value of the GPs and Nursing staff commissioned by the Commissioner to work in the UCC is very important to demonstrate value of money when evaluating the success of the UCC.

The Provider shall produce a monthly report which details activity and performance of the GPs and Nurses in the UCC during the one year trial period.

c) Frequent Flyers

The Provider shall send to Commissioners a list of those patients who attend the UCC more than 3 times in a calendar month, including, as a minimum, the details of their attendances, their name, their address and their GP Practice.

APPENDIX 6: PERFORMANCE MEASUREMENT

The performance and success of the UCC service will be measured against a set of national and local performance indicators set out in the tables below.

National Performance Indicators

Short Title	Full Title

Local Performance Indicators

Origin	Quality Requirement	Threshold	Method of Measurement	Consequence of breach

GP Practice Notification

Origin	Quality Requirement	Threshold	Method of Measurement	Consequence of breach

Other

Origin	Quality Requirement	Threshold	Method of Measurement	Consequence of breach

APPENDIX 7: WMAS HANDOVER

25% to 35% of total patient attendances at the UCC will arrive by ambulance. It is therefore critical to the success of the UCC that these patients are dealt with as efficiently as possible.

Detail definition of 'handover / turnaround'.

Patient Group 1 – " Blue Light" Patients

Patient Group 2 – Patients not able to get off WMAS Trolleys

Patient Group 3 – Other Patients (who are ambulatory)

Any others?

Dudley Metropolitan Borough Council

Agenda Item No. 8

DUDLEY HEALTH AND WELL-BEING BOARD

26th March 2014

Joint Report of the Director of Adult, Community and Housing Services, the Chief Accountable Officer of the Dudley Clinical Commissioning Group and the Director of Finance, NHS Local Area Team for Birmingham, Solihull and the Black Country

BETTER CARE FUND

Purpose of Report

1. For the Dudley Health and Well-Being Board to receive a further up-date on Dudley's Better Care Fund proposals and to confirm direction and next-steps

Background

2. On 28th January 2014, the Board received a presentation by Andrea Pope-Smith, the Director of Adult, Community and Housing Services and Paul Maubach, Chief Accountable Officer of Dudley Clinical Commissioning Group, on Dudley's work to develop its approach to the Better Care Fund

3. The main areas of the presentation covered:

    - the proposed model building on CCG work to develop locality working as it links to council work in developing preventative services for adults as well as building on the children services township model;
    - performance measures – aimed at the current purpose of the fund to improve performance in relation to avoidable hospital admissions
    - the overall funding levels where it was noted that the only new monies were £1.57 million additional funding from NHS England referred to as "Section 256" which is the relevant legal mechanism for this funding.
    - It was also noted that the transfer of funding from the CCG will need to support a 15% reduction in emergency admissions and would involve the need to deliver efficiencies from within the fund of £4 million. The net total fund was indicated to be £23.84 million.
    - Dudley's overall approach including a shared understanding and practical arrangements for risk-sharing

4. In Dudley, partners have continued to work closely since the last meeting of the Board to sharpen the focus of the bid and extend preparation for what is acknowledged to be a very challenging aim of reducing emergency admissions by 15%.

5. This work has been done alongside an assurance-process across the NHS England Local Area Team , as part of their planning process..

6. Feedback from this process has given the initial submission an "amber" rating. Further work is taking place to strengthen the submission in time for the next submission on 4th April 2014.

7. Through this Report the Board are requested to confirm the direction and next steps.

8. Through strategic plans and activities of partners, the Board is aware that its overall purpose is to lead the integration of health and care services which help improve the quality of life and wellbeing for Dudley people across the course of their lives. On-going activity including the review of urgent care arrangements in Dudley; the review of stroke services in Birmingham, Solihull and the Black Country; the promotion of personalisation in adult social care; work to improve the life-chances of children and young people as well as wider public health measures will all contribute to achieving the policy aims of the Better Care Fund.

Finance

9. Any financial implications arising from the content of this Report will be met from within existing budgets between the agencies.

10. Those resources are as stated in para. 3 above.

Law

9. The background to the development of Health and Well Being Boards and the production of Joint Health and Well-Being Strategies lies in the guidance issued to date leading up to the enactment of the Health and Social Care Act 2012 and associated regulations.

10. The legal basis upon which resources will be pooled between the NHS and local government is contained in the provisions of Section 75 of the NHS Act 2006.

Equality Impact

11. The aims of the Better Care Fund are consistent with principles of health and social care to improve the health of people living in Dudley and the quality of health services which they experience.

12. The Board has recognised the need for a more coherent approach to engagement to support this and approved the development of a new direction at its meeting of January 2014.

Recommendation

11. That the Dudley Health and Well-Being Board: -

- receive further up-date Dudley's Better Care Fund proposals to confirm direction and next-steps

Andrea Pope- Smith
Director – DACHS

Paul Maubach
Chief Officer
Dudley CCG

Alison Taylor
Director of Finance
NHS England

Contact Officers:

Brendan Clifford
Assistant Director – DMBC DACHS

Neill Bucktin
Associate Director –Dudley CCG

Agenda Item No. 9

DUDLEY HEALTH AND WELL-BEING BOARD 26TH MARCH 2014

Report of the Chief Officer of Healthwatch Dudley

Update on Healthwatch Dudley progress

Purpose of Report

1. To update the Board on Healthwatch Dudley (HWD) progress.

Background

2. All Councils were required to establish a Local Healthwatch organisation (LHW) by April 1st 2013. Local Healthwatch is the consumer champion for health and social care. The establishment of LHW is of particular relevance to the Health and Wellbeing Board, how the Board and Local Healthwatch interact with each other will have a direct influence on improving outcomes for local communities and people who use services.

Healthwatch Dudley

3. Dudley Council for Voluntary Service (DCVS) commenced delivery of Healthwatch Dudley (HWD) on 1st April 2013. The following outlines key areas of progress made by HWD up to the end of February 2014:

Organisational Development

4. HWD Board have spent the last two months identifying priorities and producing strategies on a page and action plans.

5. Meetings have been arranged with key stakeholders over the coming month to further develop opportunities to collaborate on programmes of research or work, in order to highlight the voice of the patient and public on health and social care issues. The aim is to influence stakeholder thinking on how they are going to meet patient and public health and social care needs and ensure quality services are delivered.

Urgent Care

6. Following HWD input to the consultation, we now have a seat on the Urgent Care Project Steering Group tasked with developing the service specification for the new Centre.

Information Points

7. 60 settings have now registered as Community Information Points from public facing settings in Dudley borough. Points registered include local authority reception points, community churches, voluntary networks and local pharmacies. Training jointly developed by HWD and Dudley Citizens Advice Bureau is being rolled out to the 57 Information Champions that have signed up so far, in venues provided by DMBC. The focus is to prevent people from falling into crisis situations by providing them with information about where to go for preventative health, wellbeing and benefits advice.

Dudley Group NHS Foundation Trust

8. Following the meeting in December with Paula Clark, Chief Executive, Liz Abbiss, Head of Communications and Patient Experience and Paul Maubach, Chief Accountable Officer, Dudley CCG, feedback has been given on the Trust's patient experience strategy.

9. HWD has offered to run a focus group session to review the new complaints procedures established by the PALS/Complaints Department.

10. CQC is due to inspect the hospital week commencing 24th March 2014. HWD will be sharing information on patient experiences prior to the inspection and participating at the two public listening events on 25th March 2014.

CQC Inspection of Dudley and Walsall Mental Health Partnership NHS Trust

11. HWD held a Mental Health Discussion Group event on 8th January 2014 and 27 individuals who were users of services, carers, and support workers, provided details on their experiences of accessing mental health services. The aim was to focus on the five areas of interest to the CQC – 'are local mental health services safe, effective, caring, well led, and responsive to your needs.' Feedback from the event which was relevant to the quality of care provided by the Trust was shared with the CQC to inform the design of the inspection process.

12. A further meeting will be held with the participants to feedback findings following the release of the inspection final report.

13. HWD attended Dudley Mind's event 'listening to experiences of users of services' within Bushey Fields.

Enter and View

14. On the 19th February 2014, the first training session for 8 volunteers interested in becoming Enter and View authorised representatives was delivered by HWD staff and a colleague from Dudley MBC Learning and Development Team. A further session is planned for 27th March.

15. The session outlined HWD's statutory powers to Enter and View public and communal areas in publicly funded health and social care settings, the role of the authorised representative, what excellence in health and social care should look like and an overview of safeguarding and abuse.

Safeguarding

16. Two HWD staff members have undertaken Safeguarding Adults Training delivered by Dudley MBC Learning and Development Team.

17. HWD participated in the Stoke Peer Review of Adult Safeguarding in Dudley.

18. HWD is a member of the Dudley Safeguarding Adults and Children Boards Pan Review Group seeking reassurance of safeguarding standards at Dudley Group NHS Foundation Trust.

Engagement Statistics

19. During the last two months, in addition to the many engagement activities undertaken by HWD, over 20 enquiries have been received from the public with the majority being directly from someone who accesses services and of a negative sentiment. The greatest number of enquiries related to primary care/GPs closely followed by inpatient care and mental health services. Where appropriate enquirers were signposted to organisations complaints processes.

Social networking and connecting

20.

- **158** signed up to the Healthwatch Dudley mailing list
- **695** total followers on Twitter

Website hits

January	1059
February	1036

Finance

21. Local Healthwatch is funded by the Government and primarily through Department of Health.

    The contract runs for a 3 year period subject to the Governments on-going funding of the Healthwatch programme.

Law

22. As outlined within the Health & Social Care Act 2012, Local Authorities have a statutory duty to support and establish local Healthwatch in their area.

Recommendation

23. It is recommended that the Dudley Health and Well-being Board note the work being progressed by Healthwatch Dudley.

Jayne Emery
Chief Officer of Healthwatch Dudley

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