# Health Scrutiny Committee

**Thursday 24th March, 2016, at 6.00pm**
**In Committee Room 2 at the Council House, Priory Road, Dudley**

## Agenda - Public Session

**(Meeting open to the public and press)**

1. Apologies for absence.

2. To report the appointment of any substitute Members for this meeting of the Committee.

3. To receive any declarations of interest under the Members' Code of Conduct.

4. To confirm and sign the minutes of the meeting held on 15th February, 2016 as a correct record.

5. Public Forum – To receive questions from members of the public:-

   The Public are reminded that it is inappropriate to raise personal cases, individual details or circumstances at this meeting, and that an alternative mechanism for dealing with such issues is available.

   Please note that a time limit of 30 minutes will apply to the asking of questions by members of the public. Each speaker will be limited to a maximum of 5 minutes within the 30 minutes.

6. People Directorate: Quality Transfers of Care Pages (1 – 15)

7. Clinical Commissioning Group: Draft Operational Plan 2016/17 Pages (16 – 100)

8. Black Country Partnership Trust: Health Visits 0-5 Years Pages (101 – 107)

9. Clinical Commissioning Group: Dudley New Model of Care (Vanguard) Programme Update Pages (108 – 116)

10. West Midlands Ambulance Service: Quality Priorities Pages (117 – 169)

11. To consider any questions from Members to the Chair where two clear days notice has been given to the Strategic Director Resources and Transformation (Council Procedure Rule 11.8).

**Strategic Director Resources and Transformation**
**Dated: 16th March, 2016**
**Distribution:**

**Members of the Health Scrutiny Committee:**
Councillor Hale (Chair)
Councillor A Goddard (Vice-Chair)
Councillors M Attwood, K Casey, K Finch, S Henley, Z Islam, S Phipps, N Richards, D Russell and E Taylor.

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# Minutes of the Health Scrutiny Committee

## Monday 15th February, 2016 at 6.00 p.m.
## in Committee Room 2 at the Council House, Dudley

**Present**:-

Councillor C Hale (Chair)
Councillors N Barlow, K Casey, K Finch, S Henley, Z Islam, M Miller, S Phipps, N Richards, D Russell, E Taylor.

**Officers**

A Sangian (Senior Policy Analyst – People Directorate) and K Buckle (Democratic Services Officer – Resources and Transformation Directorate).

**Also in Attendance**

Ms Marsha Ingram – Dudley and Walsall Mental Health Partnership Trust
Ms Rosie Musson – Dudley and Walsall Mental Health Partnership Trust
Mr Derek Eaves – Dudley Group NHS Foundation Trust (DGNHSFT)
Ms D Wardell – Dudley Group NHS Foundation Trust (DGNHSFT)
Mr N Bucktin – Dudley Clinical Commissioning Group.
Mr C Barron – Healthwatch Dudley.

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42. **Apologies for Absence**

Apologies for absence from the meeting were submitted on behalf of Councillors M Attwood and A Goddard and P Bradbury.

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43. **Appointment of Substitute Members**

It was reported that Councillors N Barlow and P Miller had been appointed to serve in place of Councillors M Attwood and A Goddard respectively and C Barron had been appointed to serve in place of P Bradbury for this meeting of the Committee only.

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44. **Declarations of Interest**

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

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45. **Minutes**

**Resolved**

That the minutes of the meeting of the Health Scrutiny Committee held on 21st January, 2016 be approved as a correct record and signed.

46. **Public Forum**

No issues were raised under this agenda item.

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47. **National Health Service (NHS) Quality Account**

Quality account summary reports were submitted from the Dudley Group NHS Foundation Trust and the West Midlands Ambulance Service NHS Foundation Trust.

The Dudley Group NHS Foundation Trust

Arising from the presentation of the report submitted Members asked questions, raised concerns and made suggestions and representatives from the Dudley Group NHS Foundation Trust responded as follows:-

- The issues raised following the Friends and Family Test in relation to the outpatient service referred to waiting times and in particular patients wanting information in relation to the length of time they would have to wait. It was noted that in order to resolve issues, boards were now in situ advising of waiting times and it was proposed to also introduce a LED screen system which would display waiting times.
- Further concerns had been raised regarding inadequate gowns and as a result these had been improved to produce more coverage.
- Issues in relation to the information contained in outpatient appointment letters had now been addressed with letters being re-worded and the signage around the hospital following the introduction of the new Urgent Care Centre had been updated.

Measures taken to improve services including consultations were outlined as follows:-

- Launching a project investigating the possibility of the introduction of telephone clinics and clinics outside the hospital environment, together with a consultation with parents and Governors of the Trust with regard to the possibility of introducing such clinics.

- Introduction of a “One Stop Clinic” which had resulted in patient times being reduced as patients received their results on the same day as their initial consultation.

- That consultations had taken place at the Annual General Meeting which was attended by approximately 40 to 50 members of the public, flyers were handed out and there had been a presentation on the Quality Account when ideas and suggestions were invited from members of the public and the Trust Governors met regularly to investigate any themes and trends in relation to patients complaints.

- That the inclusion of suggestions to improve services were included on the Questionnaire which could be completed on the Trust's website.

Regarding infection control, work had been conducted with multidisciplinary teams which had resulted in changes to normal practices, including assessing patients who were at greater risk, focusing on those who had a cannula fitted, with those patients being monitored with a view to removing the cannula as soon as practicably possible, in order to avoid exposure to the risk of infection and the new systems of monitoring as referred to above were being shared at learning events.

Details in relation to work to improve awareness regarding infections such as MRSA and Clostridium difficile including work through General Practices and community services were referred to.

In relation to in-hospital deaths and the specialist multidisciplinary review which would take place within a twelve week period following the death, details in relation to the review process were referred to including ascertaining whether any treatment was missed with all care providers being investigated in order to ascertain whether the care was adequate, better than adequate or optimal and if the death could have been preventable the review would be escalated to the Medical Director with a further review focusing on the changes that were required to address the issues raised.

Following a query raised regarding detailed figures in relation to responses received from the Friends and Family tests, D Eaves undertook to provide Members with response rates including percentages across all Departments.

In relation to pressure ulcers, it was noted that all patients were assessed once they were admitted and detailed figures would be available in the final Quality Account both in relation to the number of patients that developed pressure ulcers and the number of those that were avoidable and every pressure ulcer case underwent a root cause analysis process, which examined all care in order to establish whether care had been provided to the requisite standard and the Clinical Commissioning Group also conducted an independent review.

It was further noted that details of pressure ulcers would only be conveyed to a patient's next of kin should a patient not have mental capacity or specifically request that the information be shared.

The Chair requested that further information be included in the final Quality Account in relation to how may in-hospital deaths had been determined to be avoidable together with detailed reasons including a breakdown of the Root Cause Analysis.

In relation to nutrition and hydration auditing, the national tool used throughout the National Health Service was referred to, which was evidence based with many Trusts using the same tool which involved obtaining data in respect of ten patients from each Ward, as an indicator which provided a snapshot on a number of patients.

In relation to mortality issues and age groups it was noted that as part of the review following an in-house hospital death any patient trends would be reviewed and ultimately those trends would be reported in the final Quality Account.

Regarding the pressure ulcers review targets those had been set as no greater than the preceding year, given the increasing admission of frail elderly people and it was a great achievement to meet the target given the increase in admissions.

In relation to the two cases of MRSA, following the review both cases had occurred as a result of the removal of the patient's cannula sooner rather than later.

That looking ahead in relation to the targets for nutrition and hydration resulting in some areas that were not consistent with the future target of 93% in all Wards, this was in relation to replacement boards that had now been installed behind beds in order that nursing staff with could update dietary requirements for certain patients with special dietary requirements.

Following Members being invited to provide the Trust with suggestions in relation to prioritisation of quality priorities for 2016/17, the Chair suggested that pressure ulcers and infection control should be prioritised.

West Midlands Ambulance Service NHS Foundation Trust

Following further discussion A Sangian, Senior Policy Analyst was requested to collate Members comments and suggestions in relation to the Quality Accounts 2015-16 update and forward those to the West Midlands Ambulance Services NHS Foundation Trust.

It was noted that the final Quality Accounts would be considered at a future meeting of the Committee.

A Sangian, Senior Policy Analyst was requested to advise report authors of the requirement to provide a glossary of acronyms for each report submitted to future meetings.

**Resolved**

That the information contained in the reports, submitted on the Quality Account relating to the Dudley Group NHS Foundation Trust and the West Midlands Ambulance Service NHS Foundation Trust, be noted.

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The meeting ended at 7.25 p.m.

Chair

Agenda Item No. 6

# DTOC
# Delayed Transfers Of Care

## "we are in the business to avoid delayed discharges"

NHS Dudley Clinical Commissioning Group

The Dudley Group NHS NHS Foundation Trust

Dudley Metropolitan Borough Council

## Delayed Transfers of Care

- DMBC Hospital Discharge teams support timely and effective discharges from an acute setting, for all adults who are deemed medically fit and safe to discharge.
- Discharges are supported in the vast majority, from Russell's Hall Hospital (70% of the clients within RHH are DMBC citizens) but DMBC do facilitate discharges from out of borough hospitals as well.

**2014/15 supported discharges were on average 37 p/w**
**2015/16 supported discharges are on average 43 p/w**

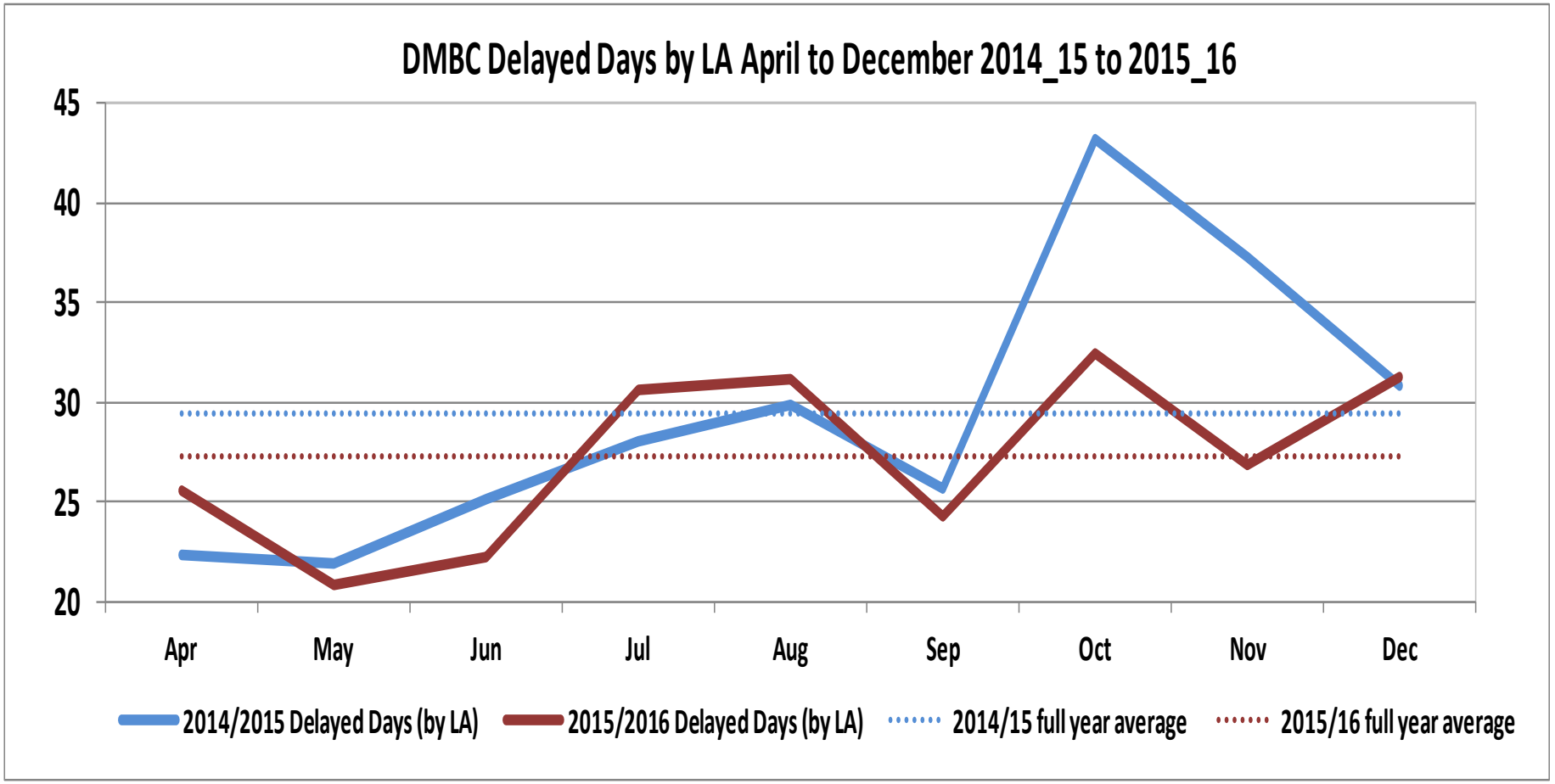
- ***An increase of 16%,***
- ***Around 50% of all new people receiving Adult Social Care, receive it as a result of a Hospital discharge.***

**However we do have discharge plans in progress for people that are delayed -** This can lead to;

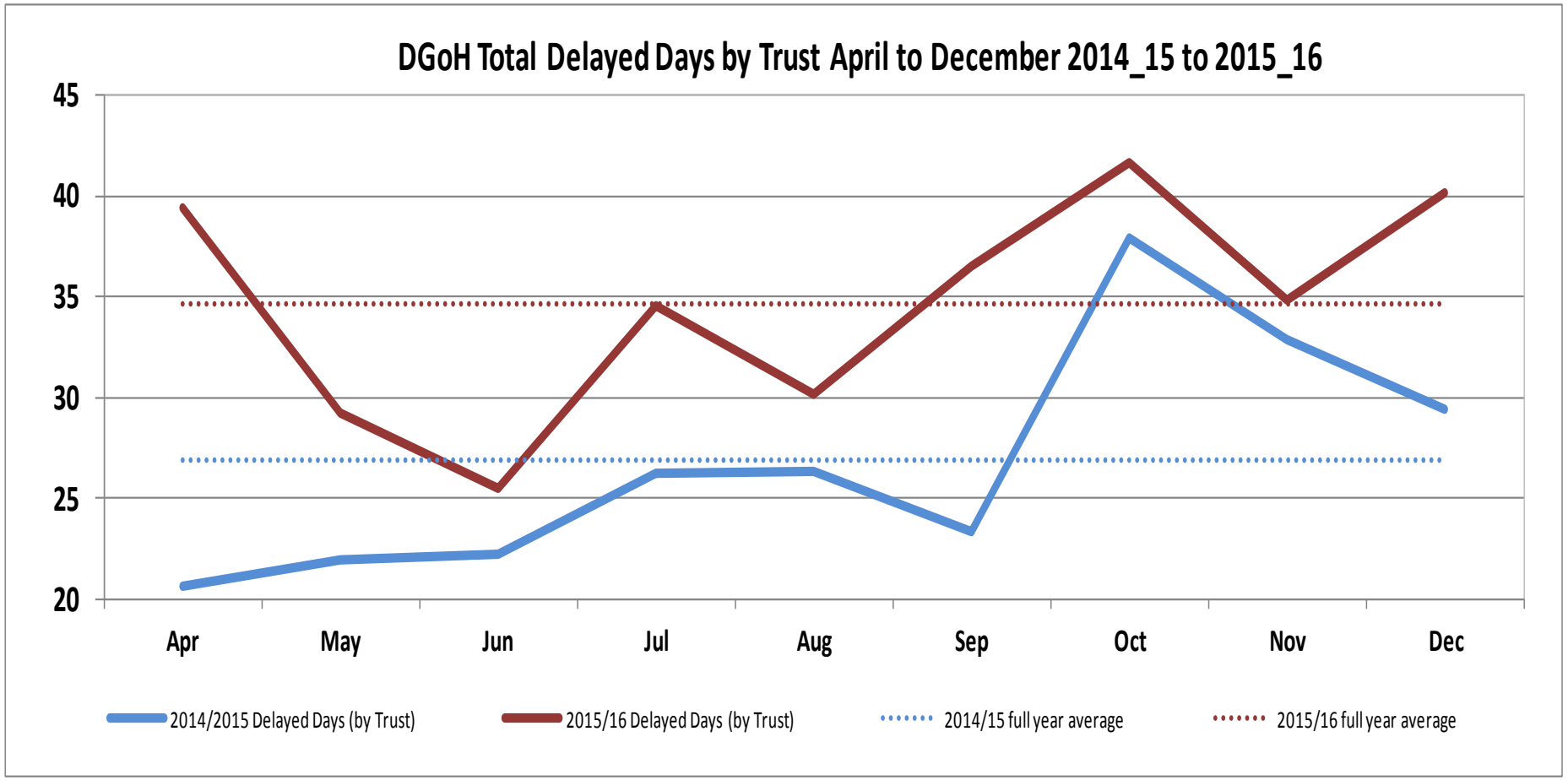
- Physical decline and loss of mobility/muscle use.
- Increased patient dependence on support for daily care needs.
- Increase in the amount of care a person may require on discharge.
- Loss of a person's re-ablement potential.
- Frustration and distress to the person and or family, of not knowing when a discharge will occur.
- Increase in pressure within the whole health and social care system.

## Reasons for delay

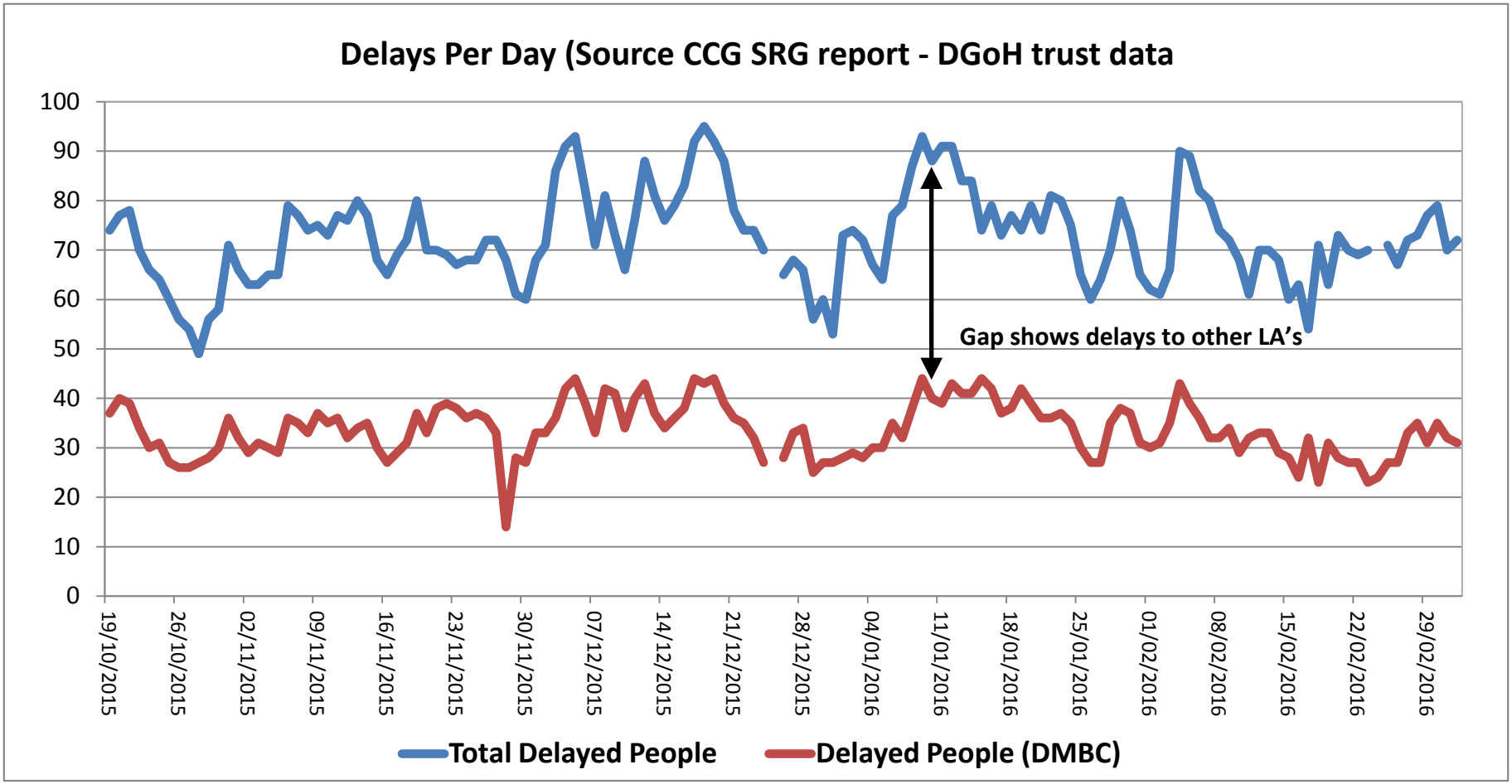
- Complexity of a person's needs - This can include Dementia, Behavioural issues, Mental Health issues, require further assessment e.g. Mental Capacity, Best Interest or Deprivation of Liberty Standards, issues around PoA, CoP, CHC funding and other legal/financial matters.
- Family decisions or person choice - What setting a person's follow on care is delivered, can be a very emotive subject. Families may not think along the same lines as the person in hospital or vice versa
- Assessment capacity – Hospital activity is increasing as national figures and pressures show. Assessment capacity has remained fixed or reduced in some areas.



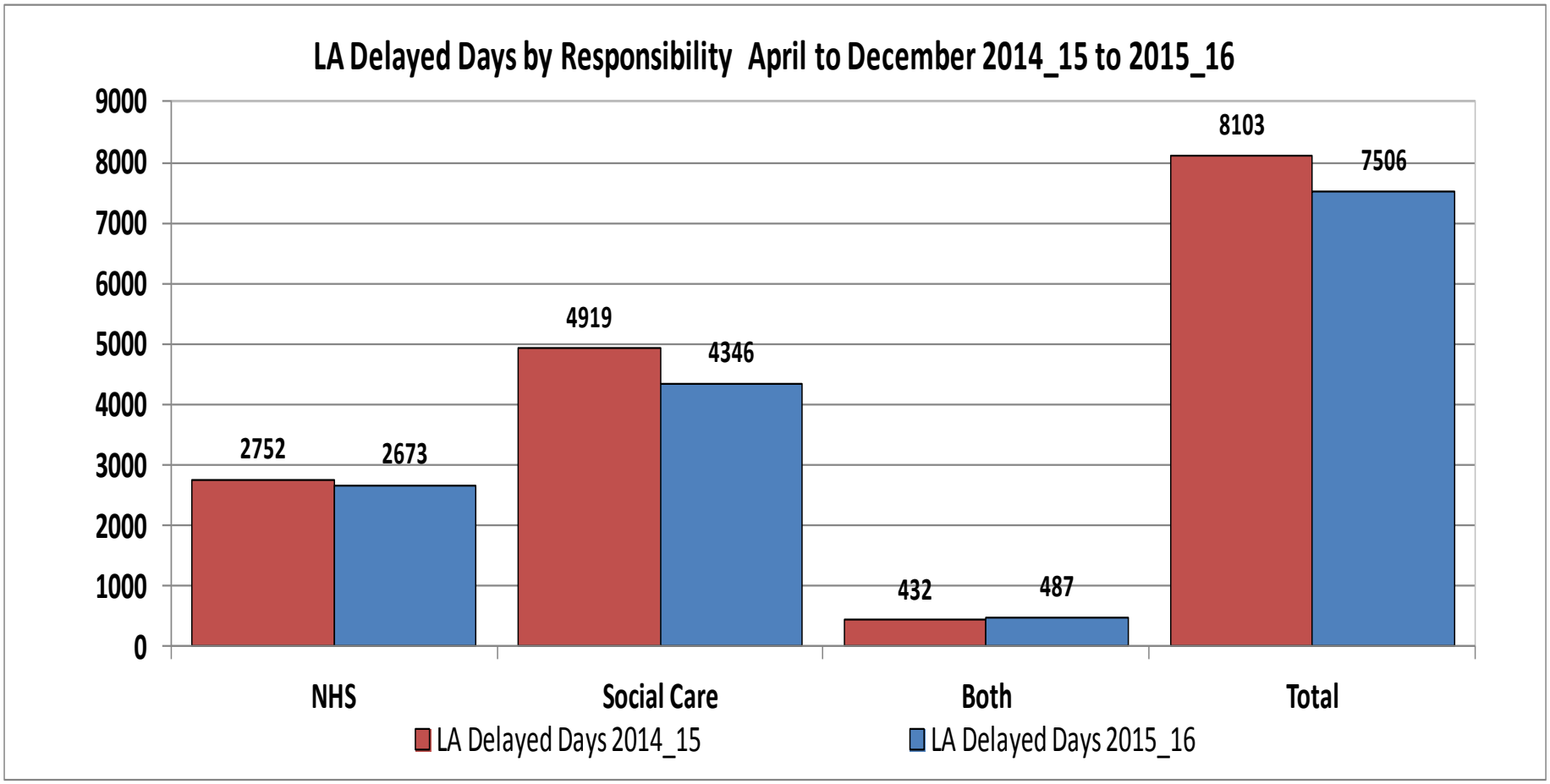

- DMBC Delayed Days have reduced (21%) across the April to December period 2014/15 to 2015/16.
- For added context, In Russells Hall Hospital, admissions from A&E have shown a slight increase of 0.4%




- DGoH Delayed Days have increased (28.9%) across the April to December period 2014/15 to 2015/16.
- This increase in Delayed Days has to be linked to other LA's activity in Russell's Hall Hospital.

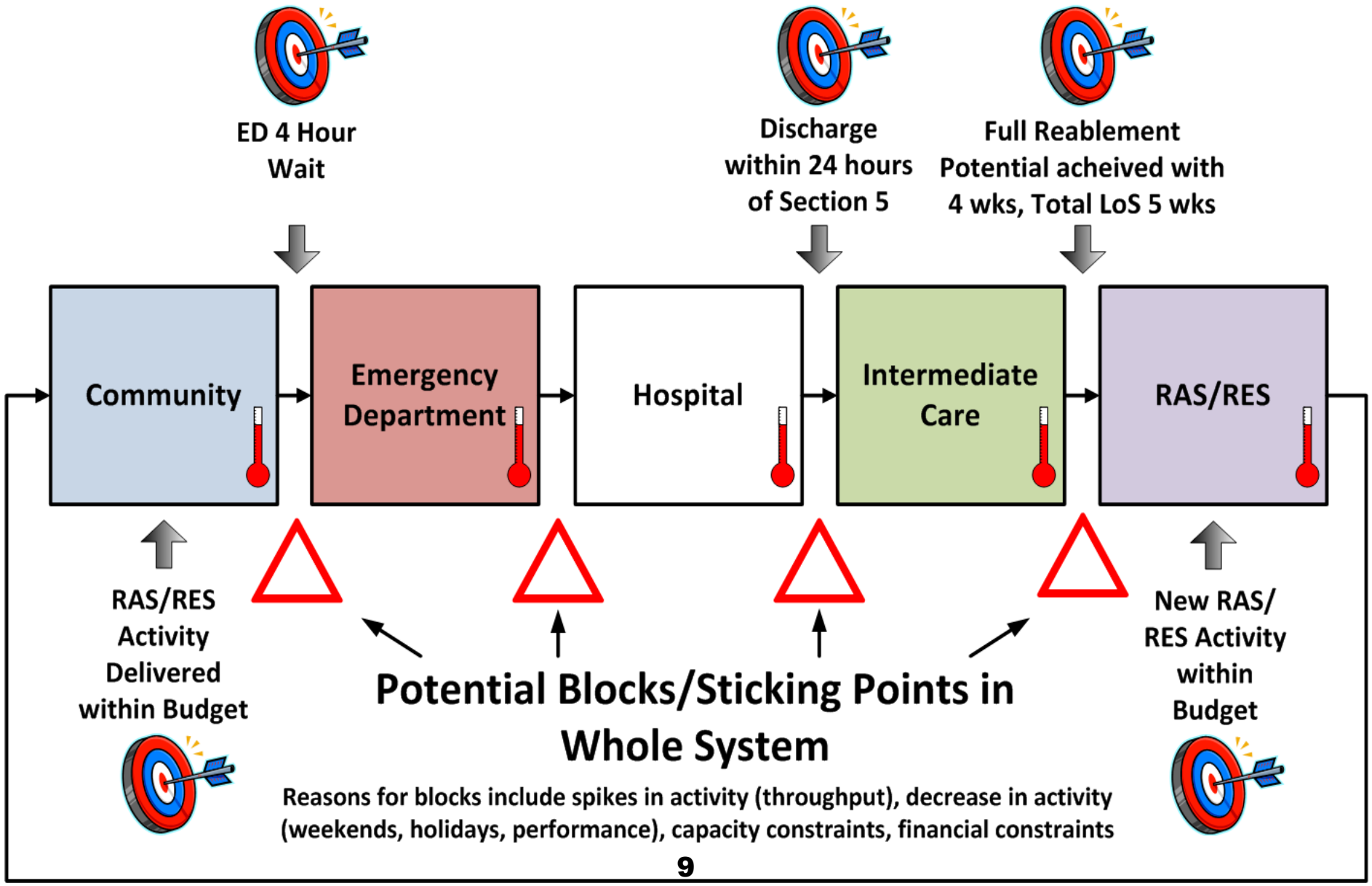



- Of the DGoH Delayed people 19/10/2015 to 03/03/2016, 53.8% were other LA's responsibility.
- Remember that on average, 70% of the patients within RHH are DMBC citizens.

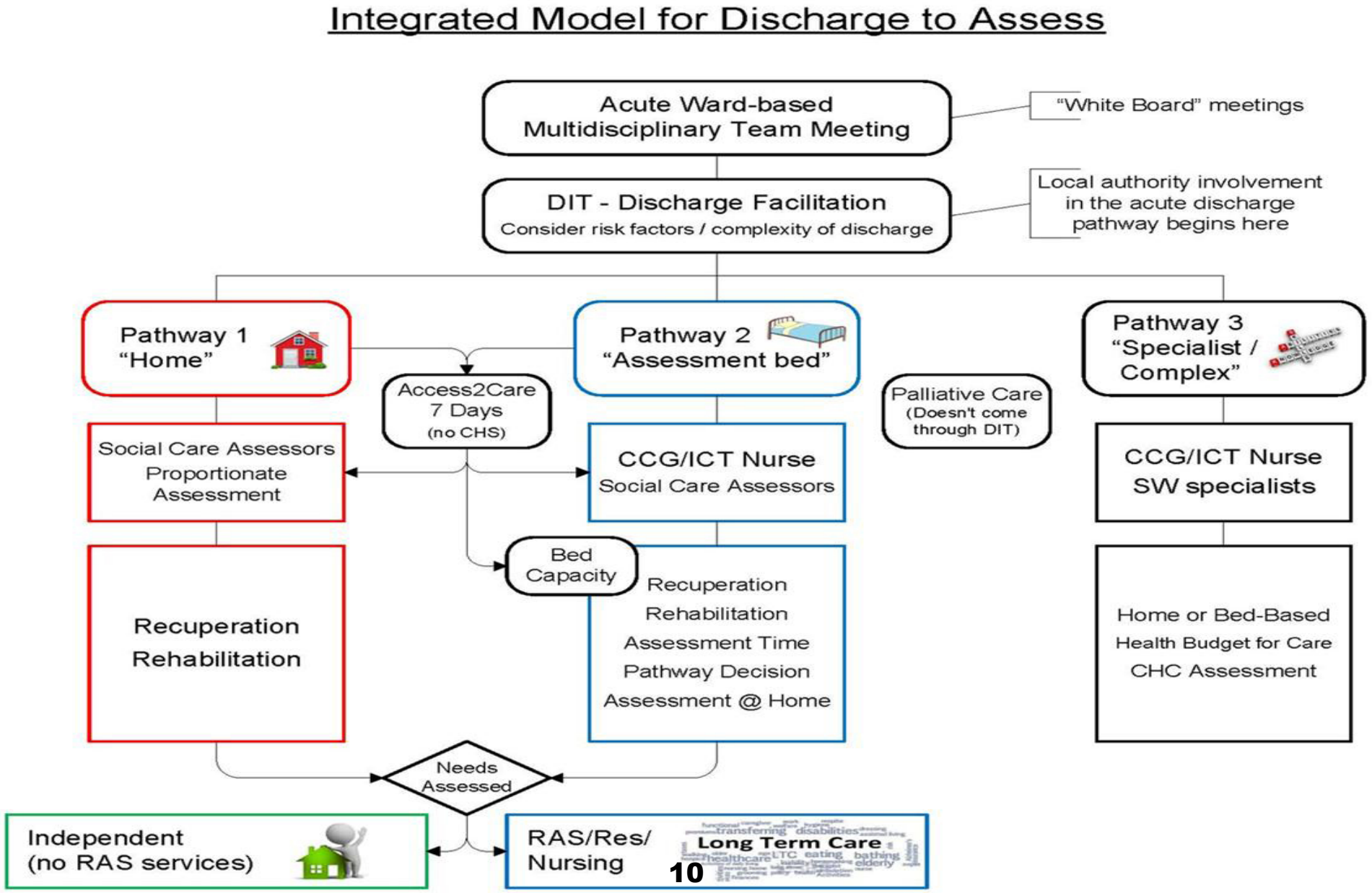



- Of the DMBC Delayed days, 35.6% were NHS responsibility for April to December 2015/16.
- Dudley's Health and Social Care economy have taken a whole system approach to DTOC to focus on the person.

# A move to an integrated approach to discharge



# Discharge To Assess (D2a) was introduced in January 2015.

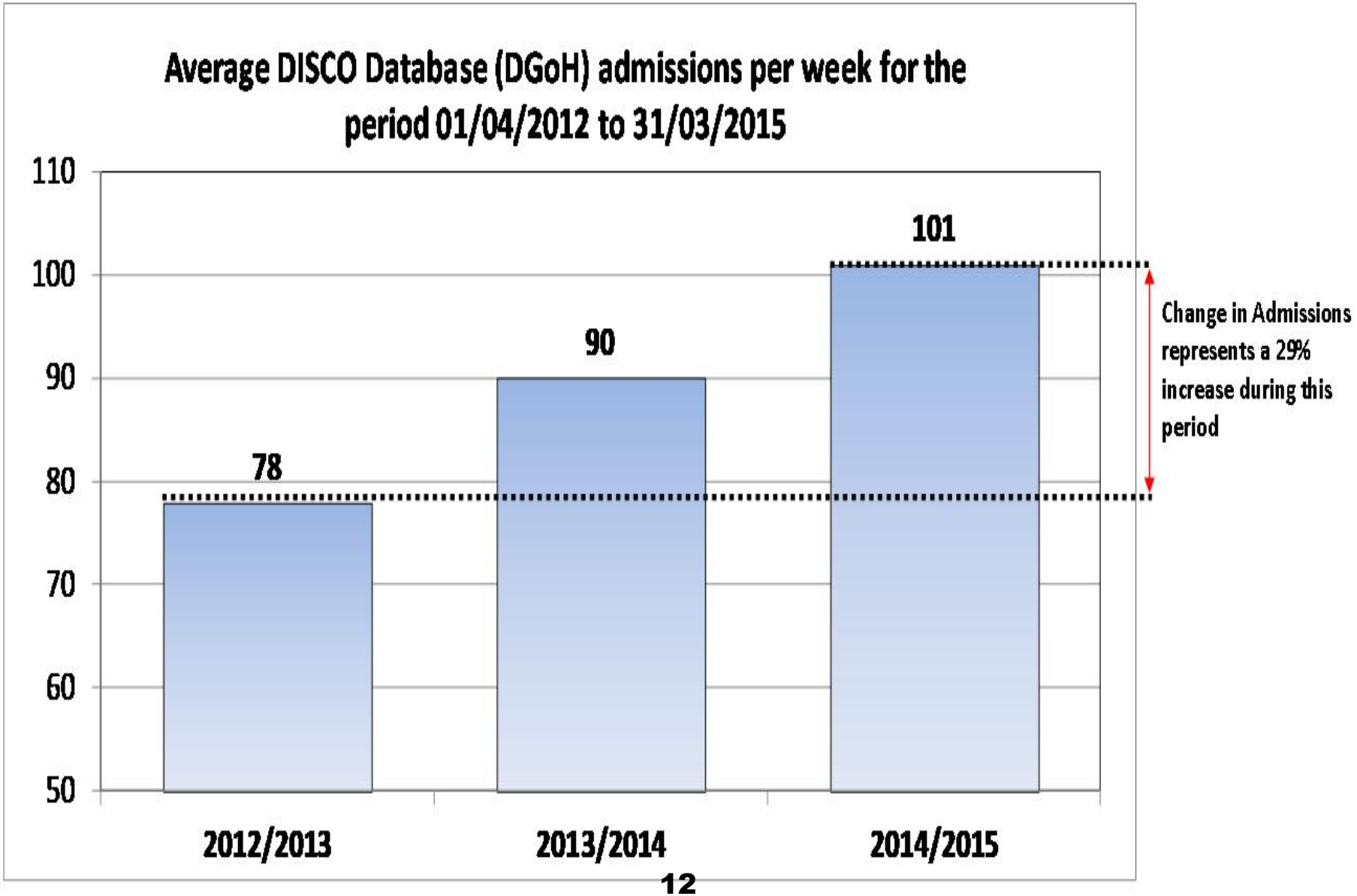


**D2a's core principles are "Discharge to assess" as soon as the acute episode is complete, to plan post-acute care in the person's own home and provide comprehensive assessment and re-ablement during post-acute care to determine and reduce long term care needs.**

- **Pathway 1: Home with Care.** Is the default pathway for discharge for those patients needing support on discharge.
- **Pathway 2: Care in a intermediate community bed.** Where home is not an option at the point of hospital discharge but permanent residential care is not inevitable.
- **Pathway 3: Where patient needs are very complex.** Continuing Health Care funding is a possibility or the likely need of permanent care but not inevitable.

**Benefits from D2a include more people able to return to their own home, to resume independent lives and a more operationally and financially sustainable system.**

# Activity Levels from Hospital



## Activity Levels from Hospital

- In 2015/16 on average DMBC has discharged 43 people per week at a cost of £5 Million.
- This current level of activity is not sustainable using council resources alone
- DGoH have set out a requirement for 63 DMBC discharges for 2015/16, this is a 43% increase in activity and would potentially lead to a 43% increase in the associated Long Term Care cost.
- Any further increase in discharge activity will need to be met through other sources within the Health and Social Care economy.

## Memorandum of Understanding

- MoU is an agreement between DGoH/CCG/LA of performance targets that enables discharge flow.
- Previous MoU was in place and focussed on levels of delays and discharge in isolation. **This is too reactive.**
- A different approach has been agreed by all parties. Targets and performance must be set, agreed and monitored across the admittance **and** discharge process.
- Avoidance **is just as important** as discharge.
- We are jointly looking at a shared approach, demand model, activity date and resource requirement.
- We need **£4.8 million** from the economy to enable LA to meet the expected targets.

**Continued Improvements - What 2016/17 will bring;**

- BCF will continue to focus on priority areas such as re-ablement and prevention.
- MoU model approach for flow will take a further step to integrate the intermediate care discharge pathway.
- Ability to drive recoup and rehab further for the person.
- Reduce the need for long term care home placements.
- Stop duplication in process, procedure and resources.
- Improve the MDT approach alongside the CCG Value Proposition to achieve better avoidance/diversion.
- Improved person experience and leaner/clearer pathways.
- Greater coordination of services which span 7 days.

Agenda Item No. 7

**Health Scrutiny Committee – 24th March, 2016**

**Report of the Head of Commissioning of Dudley Clinical Commissioning Group**

# CLINICAL COMMISSIONING GROUP DRAFT OPERATIONAL PLAN 2016/17

## Purpose of Report

1. To consider CCG's the draft Operational Plan for 2016/17.

## Background

2. National Planning guidance requires the production of a five year Sustainability and Transformation Plan (STP) and a one year Operational Plan. The Operational Plan is intended to inform year one of the STP.

3. This report describes the main issues addressed in the Operational Plan attached as Appendix 1.

## EXISTING STRATEGY AND PLANS

4. The CCG's existing strategic vision is "to promote good health and wellbeing and ensure high quality services for the people of Dudley" based upon 3 objectives:-

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

5. In addition, the CCG's strategic intent describes 4 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

6. In addition, the CCG commissions services for vulnerable groups – children, the elderly, people with mental health problems and people with learning disabilities.

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

- making our services healthy
- making our lifestyles healthy
- making our children healthy

- making our neighbourhoods healthy

8. Our approach to planning for 2016/17 is also based upon our commissioning intentions published in September 2016, which set out the basis upon which we intend to commission our new model of care with effect from the 1 April 2017.

9. The Operational Plan has been developed against the background of these existing plans and strategies as well as the national planning guidance.

**COMPREHENSIVE SPENDING REVIEW**

10. As a result of the Comprehensive Spending Review (CSR) there is a requirement placed upon the NHS to: -

- implement the Five Year Forward View
- restore/ maintain financial balance
- deliver core access and quality standards
- close the "gaps" – health and wellbeing, care and quality, finance and efficiency.

11. This Operational Plan represents the CCG's contribution to that process.

**MUST DOS**

12. The 9 "must dos" set out in the planning guidance and addressed in the Operational Plan are as follows:-

- deliver the STP
- deliver financial balance
- provide a local plan for the sustainability and quality of general practice
- meet A&E and ambulance waiting/ access standards
- meet referral to treatment times standards
- meet 62 day cancer waits standard and improve 1 year cancer survival rate
- achieve and maintain new mental health standards for early intervention in psychosis and IAPT and the dementia diagnosis rate
- enhance community provision and reduce inpatient capacity for patients with learning disabilities
- develop and implement an affordable plan for improvements in quality

13. These 9 requirements are all addressed in the plan.

**NEW CARE MODEL**

14. The centre piece of the Operational Plan is the development and commissioning of our new care model – the Multi-Speciality Community Provider (MCP). Key features of the MCP include:-

- integrating health and social care services at practice level
- developing and enhancing primary care
- commissioning services as an alternative to secondary care admission
- integrating physical and mental health care
- commissioning best care pathways for planned care and urgent care
- enhancing community and voluntary sector provision

- developing an effective relationship with citizens and service users

15. A number of features of the care model meet the requirements of the national planning guidance.

**CLOSING THE "GAP"**

16. The plan also identifies a number of initiatives designed to close the health and wellbeing care; quality and finance; and efficiency gaps.

17. In particular, the plan identifies a number of targets in relation to specific health and wellbeing issues identified in conjunction with public health. These cover alcohol, smoking and obesity. In addition, we anticipate that the CCG's new primary care contractual framework will contribute to these targets.

**NEXT STEPS**

18. Discussions are still taking place with our main NHS providers regarding the contractual arrangements we will enter into for 2016/17. These must be concluded by 31 March 2016. The final Operational Plan will be submitted to NHS England on 11 April 2016.

**FINANCE**

19. The financial implications of the plan must be met within the CCG's budgetary allocation made by NHS England.

**LAW**

20. The Operational Plan has been produced in accordance with the requirements of the Health and Social Care Act 2012.

**ENGAGEMENT**

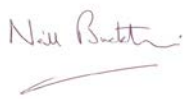
21. The plan will be subject to a one month consultation process.

**EQUALITY IMPACT**

22. The Plan identifies a number of specific actions to reduce health inequalities.

**RECOMMENDATION**

23. That the CCG's draft Operational Plan for 2016/17 be noted.



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**Neill Bucktin**
**Head of Commissioning**
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Email: neill.bucktin@dudleyccg.nhs.uk

**List of Background Papers**

*Thinking Differently*

NHS
Dudley
Clinical Commissioning Group



# Developing and Commissioning a Sustainable Model of Care

# Operational Plan 2016/2017

**Version 1 – Initial Draft March 2016**

## Contents

# Dudley Clinical Commissioning Group

## Operational Plan 2016/17

### Developing and Commissioning a Sustainable Model of Care

## Background

In February 2014, the CCG approved its Operational Plan for 2014/15 – 2015/16. This was refreshed for a further year as part of the CCG's original Strategic Plan. This Operational Plan now represents the first year of what will become our **Sustainability and Transformation Plan (STP)** both for Dudley and the wider Black Country footprint as agreed with NHS England.

This plan is designed to:-

build on our achievements in implementing our plan for 2015/16;

implement our plans heralded in our commissioning intentions for 2016/17 and 2017/18;

fully implement our new Dudley model of care, establishing integrated health and social care services with primary care at its heart;

reflect the work we are doing as the local leader of the NHS, in conjunction with our NHS providers, our local government partners and the voluntary/community sector;

meet the expectations placed upon us through the national planning system;

take us to the next step in our development as a clinically led commissioning organisation, responding to the significant clinical, service and financial challenges of the coming years.

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

- discussing proposals with our GP membership on a regular basis;
- engaging with patients and the public through our Health Care Forum and Patient Participation Groups;
- sharing the key requirements of the planning guidance and our emergent plans with the Health and Wellbeing Board and the Overview and Scrutiny Committee;
- seeking the Health and Wellbeing Board's support for key system changes including our plans for our new care model and the Better Care Fund;

- sharing our plan with our three NHS service providers, our local government partners and the voluntary sector, through our System Resilience Group.

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

In the sections below we have:-

- reaffirmed and developed our objectives;
- identified the financial performance, and health challenges we face.
- explained how our commissioning priorities will position us to have a sustainable local health and care system, centred upon the delivery of a new model of care – a Multi-Specialty Community Provider (MCP) - and meeting our vision for population health and wellbeing;
- demonstrated how we will ensure we meet the highest standards of quality and patient safety.

We have demonstrated how we will:-

- reduce the health and wellbeing gap
- reduce the care and quality gap
- reduce the funding and efficiency gap

We have described how we will deliver the 9 national “must dos”.

1. developing and agreeing a STP, with this plan being year 1 of the 5 year STP.
2. delivering aggregate financial balance.
3. ensuring the sustainability and quality of general practice.
4. achieve A and E and ambulance access standards.
5. improve and maintain the 18 week referral to treatment target.
6. deliver the cancer waiting standards and improve one year cancer survival rates through improved diagnosis.
7. achieve and maintain the first episode of psychosis and IAPT access standards, continue to meet a dementia diagnosis rate of two-thirds of the estimated number of people with dementia.
8. transform care for people with learning disabilities.
9. make improvements in quality.

The main focus of our plan is to develop and commission the MCP in a manner that is consistent with the “5 principles” that support the delivery of the Five Year Forward View:-

- care and support is person-centred: personalised, coordinated and empowering;
- services are created in partnership with citizens and communities;
- there is a focus is on equality and narrowing health inequalities;
- carers are identified, supported and involved;

- voluntary, community, social enterprise and housing sectors are key partners and enablers;
- volunteering and social action are key enablers.

**PLAN ON A PAGE TO BE UPDATED**

## 1. Vision and Objectives

### a) Our Vision

Our vision is “to promote good health and wellbeing and ensure high quality health services for the people of Dudley”

Our objectives which underpin this are to:-

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

### b) Strategic Intent

Our strategic intent is based around four particular types of care which patients may require, each of which displays separate characteristics but which ultimately 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.

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

Our new service model will be designed to deliver these categories of care. This represents our strategic intent and is reflected in our plan.

## c) Our 6 key Principles

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

### i) Patient and public involvement

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

### ii) Clinically Led

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

### iii) Primary Care at our heart

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

### iv) Working with partners in our communities

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

### v) Focus on quality and continuous improvement

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

### vi) Live within available resources

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

### d) 5 Year Vision

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

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

These principles will be carried forward into our contribution to the Black Country STP and our local Dudley STP. We have agreed with our Black Country partners that the following areas will form the focus of the Black Country STP:-

- urgent and emergency care
- maternity services
- mental health
- developing the MCP

This CCG will take a lead for the MCP development element of the STP. The Dudley STP will be overseen by the Health and Social Care Leadership Group. This is led by the CCG and chaired by the CCG's Chief Accountable Officer. It brings together:-

- our local NHS partners;
- our local government partners – adult social care, children's services and public health;
- our voluntary and community sector partners.

In conjunction with our adult social care partners, we intend to have in place plans to integrate health and social care by 1 April 2017 and this will be a key feature of our local STP

## 2. The Challenges

### a) System Challenges

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

- growing demand for healthcare from a population where, over the next two decades, the number of people over 65 will grow by 25,100 and the number over 85 by 9,900;
- the financial sustainability of our NHS partners;
- budgetary challenges facing Dudley MBC, in relation to public health, and adult social care and children's services;
- the specific issue of budgetary pressures in adult social care and the potential impact on system equilibrium, affecting the ability to secure safe and timely discharges from hospital;
- need to secure effective transformation in leadership and cultural terms at a local level to ensure our new model of care 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 system wide approach to information management and technology, including shared records and data sharing.

### b) Financial Challenges

The CCG's financial plan for 2015/16 to 2020/21 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 all of its statutory and local financial duties, delivering a planned surplus of £6.3m per annum. To achieve this, however, a QIPP programme has been developed that provides real, cash releasing savings as well as delivering improvements in productivity, outcomes and quality. The value of the internal QIPP programme (excluding provider tariff deflator) is £29.4m – MG TO CONFIRM over 5 years. The value for 2016/17 is £XXX. The main focus of initiatives in 2016/17 is a reduction in emergency/ED activity and the reducing the cost of elective care. This will be undertaken by 3 main initiatives: continuing the implementation a community rapid response service to reduce admissions to hospital through the Better Care Fund; the expansion of scope of the urgent care centre to triage patients arriving at ED by ambulance; and a number of initiatives to make elective care attendances at hospital more appropriate. There are also a number of separate qualitative schemes within the programme.

A key task for the CCG and our providers, over the next 2 years is securing value for our patients whilst implementing our new model of care. 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 and this will continue for 2016/17. We will support providers in doing so and this is to ensure a continuous assessment of the efficiency of services used by GPs when making referral decisions. This will be done in a way, however, that does not detrimentally impact on any procurement required to implement the new model.

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 ones being increasing financial instability in the provider sector nationally (and potential mandate from NHSE to utilise CCG reserves to support the sector); increasing demand; and not fully achieving a challenging efficiency programme, including the Better Care Fund.

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 and to fully implement our new service model that will deliver long term financial sustainability in Dudley.

### c) Performance Challenges

Our commissioning contracts with providers have been constructed to ensure that all NHS Constitution standards are met.

There are specific performance challenges in relation to:-

- referral to treatment times for Urology, ENT, T and O;
- diagnostic waiting times for CT, MRI and non-obstetric ultrasound;
- waiting times for some community services including physiotherapy, phlebotomy and counselling;
- delayed transfers of care.

In order to address these, the following initiatives are being undertaken:-

- we are working with Dudley Group NHS FT to review care pathways of 'challenged specialties' with the aim of improving the efficiency of the pathway to improve both 18 week performance and the patient experience;
- we are commissioning additional diagnostic capability;
- we are exploring the potential to shift to an 'open-access' model for physiotherapy and counselling services;
- we are actively working with all relevant bodies to improve the discharge of patients and this will be a key element of our Better Care Fund plan;
- we will continue to use all available mechanisms in contracts with providers to ensure they are held to account for their performance. This will be done with the aim of supporting providers to improve such performance to enable the delivery of high quality services to patients.

**d) Health Status and Health Inequalities**

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

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

- nearly 20% of our population have a limiting long term illness or disability, this has increased since the 2001 census and is worse than the national average;
- the gap in life expectancy for the least and most deprived areas of Dudley has widened, mostly due to CHD, COPD and lung cancer in men;
- the mortality rate in the 60 -74 age band is significantly higher for males;
- female life expectancy is 82.7 years – similar to the national average, whilst male life expectance is 78.5 years – lower than the England average of 78.9;
- male life expectancy varies across Dudley. Halesowen South has the highest at 82.1 years, Netherton, Woodside and St. Andrews have the lowest at 73.9 years – a gap of 8.2 years;
- female life expectancy varies across Dudley. Belle Vale has the highest at 86.7 years, Castle and Priory has the lowest at 79 years – a gap of 7.7 years;
- nearly a quarter of deaths in the 40 – 59 age band are due to cardiovascular disease, smoking, obesity and lack of physical activity;
- mortality from respiratory disease is significantly higher than the national average. Lower respiratory tract infection is the major condition;
- mortality rates for alcohol related diseases are significantly higher than the national rate and the years of life lost in the under 75s from chronic liver disease, including cirrhosis, is significantly worse than the England average;
- emergency admissions for alcohol specific conditions increases from the 40-59 age group;
- 12.1 % of adults aged 16+ participate in sport for 30 minutes 3 or more times per week, showing a downward trend and below the national average of 17.4%;

- the percentage of people aged 16+ with a high BMI is is significantly worse than the England average;
- nearly two thirds of ED attendances are for people living in the 40% most deprived group in Dudley;
- the next two decades are forecast to see an additional 25,100 people over the age of 65 and an extra 9,900 over 85;
- uptake rates for both cervical and breast cancer screening are below the national target of 80%;
- disease prevalence rates as determined by primary care disease registers are low compared to modelled prevalence, however, these have improved – most markedly for COPD;
- the rate of delayed hospital discharge attributable to social care is higher than the national rate;
- the CCG is in the worst performing fifth of CCGs for the percentage of ED attendances that result in emergency admission;
- emergency admissions for gastroenteritis and lower respiratory disease are increasing for the 60 – 74 age band;
- emergency admissions for gastroenteritis in the 75+ age band are increasing;
- 20% of single person households are in the 60+ age group;
- with the ageing population there is an increasing number of older people who are carers of older people, or who are carers of adult children with learning or physical disabilities;
- the rate of deaths at home or in care homes has fallen from 53.05% to 51.9% but there is a higher percentage of terminal admissions that are emergencies than England;
- Marmot indicators show that Dudley has a higher rate for long term claimants of Job Seeker's Allowance than the rest of England and a higher percentage of high fuel cost households in fuel poverty.

For our children and young people:-

- the infant mortality rate is 4.5 per 1,000 live births, compared to 4.3 for England and Wales;
- male babies born in the most deprived areas of Dudley are up to 4 times more likely to die than those from the more affluent areas;
- the percentage of pupils in school Reception and Year 6 with a healthy weight is significantly worse than the England average;
- emergency hospital admissions for 0 – 4 year olds have risen. This is particularly prominent for lower respiratory tract infections in the most deprived areas;
- the proportion of 9 and 11 year olds with a high self-esteem score has risen, though 25% of pupils reported bullying. The proportion of 13-15 year olds reporting being bullied has risen to nearly 20%;
  the CCG is in the worst performing fifth of CCGs for the rate of young people aged 0-18 with 3 or more mental health admissions per year;
- the looked after children prevalence rate is significantly higher in Dudley and double the national rate;
- smoking at delivery was 14.3% in Dudley, higher than both England and the West Midlands;

- Marmot indicators show that Dudley is significantly worse than the rest of England for children achieving a good level of development by age 5; the percentage of pupils achieving 5 or more GCSEs at grades A*-C; percentage of pupils eligible for free school meals achieving 5 or more GCSEs at grades A*- C;
- breast feeding initiation rates at birth and at 6-8 weeks are lower than in England. These are also lower in the more deprived parts of Dudley and in younger mothers.

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

- cancer
- heart disease
- stroke
- liver disease

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

- gastroenteritis
- cancer and tumours
- CVD
- mental health problems
- musculoskeletal problems
- endocrine, nutritional and metabolic
- vaccine preventable conditions
- falls
- ambulatory care sensitive conditions
- frail elderly
- admissions via A and E with a primary mental health diagnosis

present opportunities for health status, service and cost improvement.

**e) Our Assets**

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

Mapping community assets through the JSNA process and building on these as a means of creating sustainable communities is an issue the CCG will pursue in its contribution to partnership working and addressing the wider determinants of health. This is a feature of our approach to the development of our new care model (see below).

**f) JSNA – Key Messages and Actions**

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

- We have specific health inequalities for the male population both in terms of mortality rates in the 60 – 74 year age band and alcohol specific problems for the 40-59 year age band.
- This is contributing to a widening of life expectancy gap between the most and least deprived parts of our population.
- We need to ensure our locality based service delivery model provides an appropriate, differential intervention at neighbourhood level to respond to local health inequalities.
- Interventions in relation to cancer, heart disease, liver disease and stroke are required.
- We must ensure that our practices perform well in delivering smoking cessation services.
- Improved case finding, uptake of screening services and uptake of vaccination programmes are critical. Exploiting the potential of EMIS will assist this.
- The systematic management of patients with long term conditions in primary care and community health services will be a major contributor to our success, including the management of diabetes. Our new long term conditions framework, forming part of our primary medical services contract, will be designed to support this.
- Detection and prevention of alcohol related disease needs to be part of this.
- The care pathway for COPD requires attention to reduce unnecessary admissions.
- The local alcohol harm strategy needs to be fully implemented by all partners.
- The integration of maternity services with pre-conceptual, health visiting and school nursing services, together with primary care and the voluntary sector will improve outcomes across the life course.
- Child health inequalities can be reduced by promoting the uptake of breast feeding and the prevention of smoking.
- The commissioning of maternity services should be designed to prevent adult and childhood obesity.
- We have a growing frail elderly population, we need to improve the care pathway to prevent unnecessary admissions and create the conditions to enable people to be re-abled and retain their independence in their communities.
- The end of life pathway needs further review to increase the number of people who die at home and to reduce admission to hospital at the end of life.
- We require a continued focus on mental health and the relationship between mental health, physical health and the management of long term conditions. Keeping people in work should be an outcome of this.
- Our Multi-Disciplinary Teams need to identify those at risk of fuel poverty and refer to the winter warmth service.
- We need to ensure that our approach to prescribing and the input of our practice based pharmacists continues to improve our performance in relation to the use of drugs to reduce cholesterol, reduce blood pressure and manage atrial fibrillation.
- We need to ensure that our work on the systematic management of long term conditions, redesigning urgent and planned care pathways and integrating services in our localities is sensitive to the needs of our child population.
- As part of our approach to the Equality Delivery Scheme, we need to facilitate work with those groups protected by legislation where the difference in health outcome and need is greatest, as well as analyse the barriers to improved patient access and experience for these groups. This will be reflected in our Equality Objectives.

- We will include undertake a programme of health equity audits, in conjunction with the Office of Public Health, to identify inequities in healthcare experienced by a number of excluded groups and those with protected characteristics, including people with mental health problems. Each equity audit will identify specific inequalities, the action necessary to reduce them and will set equity targets which will be monitored over time.
- We will use an asset based approach to our work with partners in addressing the wider determinants of health.

This is reflected in our plans.

### 3) Prevention – Reducing the Health and Wellbeing Gap

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

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

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

- increasing the prescribing of drugs to control blood pressure and cholesterol – there has been a 33% increase since 2008. We have set our local quality premium targets to address the evidence based treatment of hypertension and identification of patients 'at risk' of developing diabetes. In addition we will develop a systematic approach to the management of long term conditions in primary care and work with the Office of Public Health and GPs to improve the uptake of vascular checks;
- increasing anticoagulation treatment for atrial fibrillation – our standardised mortality rates for all circulatory diseases have decreased by 12.8 compared to the England and Wales average We will ensure we have a sustained approach to the prescribing of new oral anti-coagulants which will transition into primary care in the future;
- improving blood sugar control for diabetes – in 2014/15, 70% of patients had an HbA1C equal or less than 59 mmol/mol, 77.9 equal or less than 64 mmol/mol and or less and 87.4% The commissioning of our new model of care which includes more community based provision for diabetic patients will continue to address this issue;
- increasing smoking cessation services. We will work with the Office of Public Health to encourage improved performance from general practice in delivering these services.

We will develop a life course approach to joining up our plans with the Office of Public Health. This will be based upon:-

**Giving every child the best start in life:-**

- joining up 0-5 year public health service with early years children's services;
- developing early years settings, schools and colleges as healthy places;
- designing and commissioning an integrated young people's wellbeing service.

**Enable healthy behaviour in adults:-**

- embedding evidence based healthy working practice;
- design and deliver health and wellbeing enhancing places;
- develop and deliver an integrated adult wellness service.

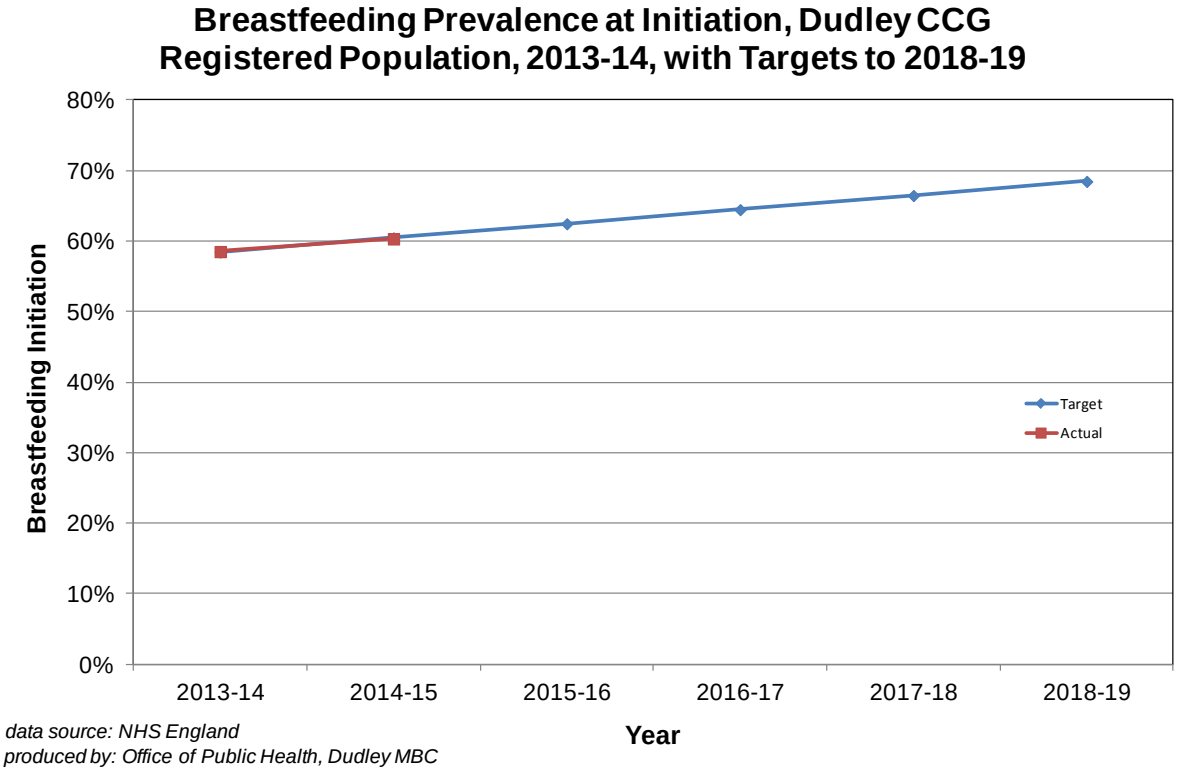
**Promote healthy aging:-**

- raise awareness of the symptoms of long term conditions and cancer, promoting early presentation;
- develop and implement an integrated healthy aging programme.

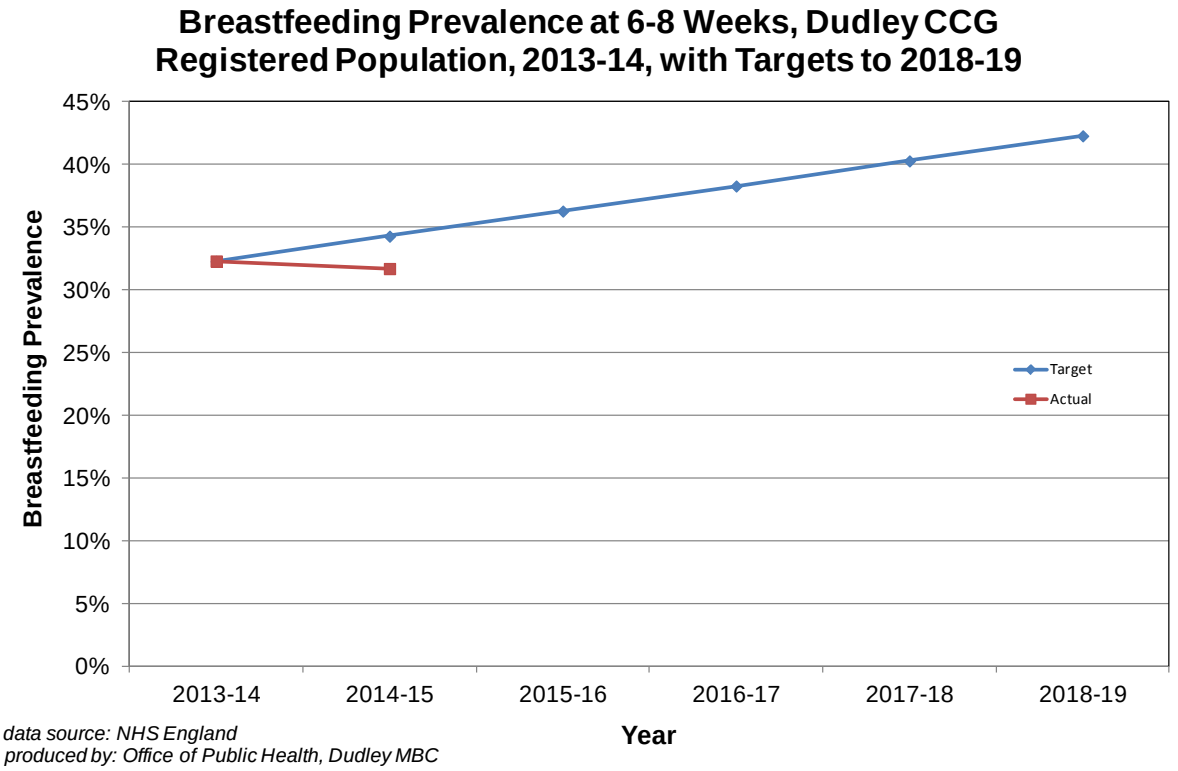
We have agreed specific targets with the Office of Public Health, broken down by locality and practice for obesity, tobacco control and alcohol. These are shown below:

**a) Obesity**

**i) Shared breastfeeding targets (baseline 2013-14)**

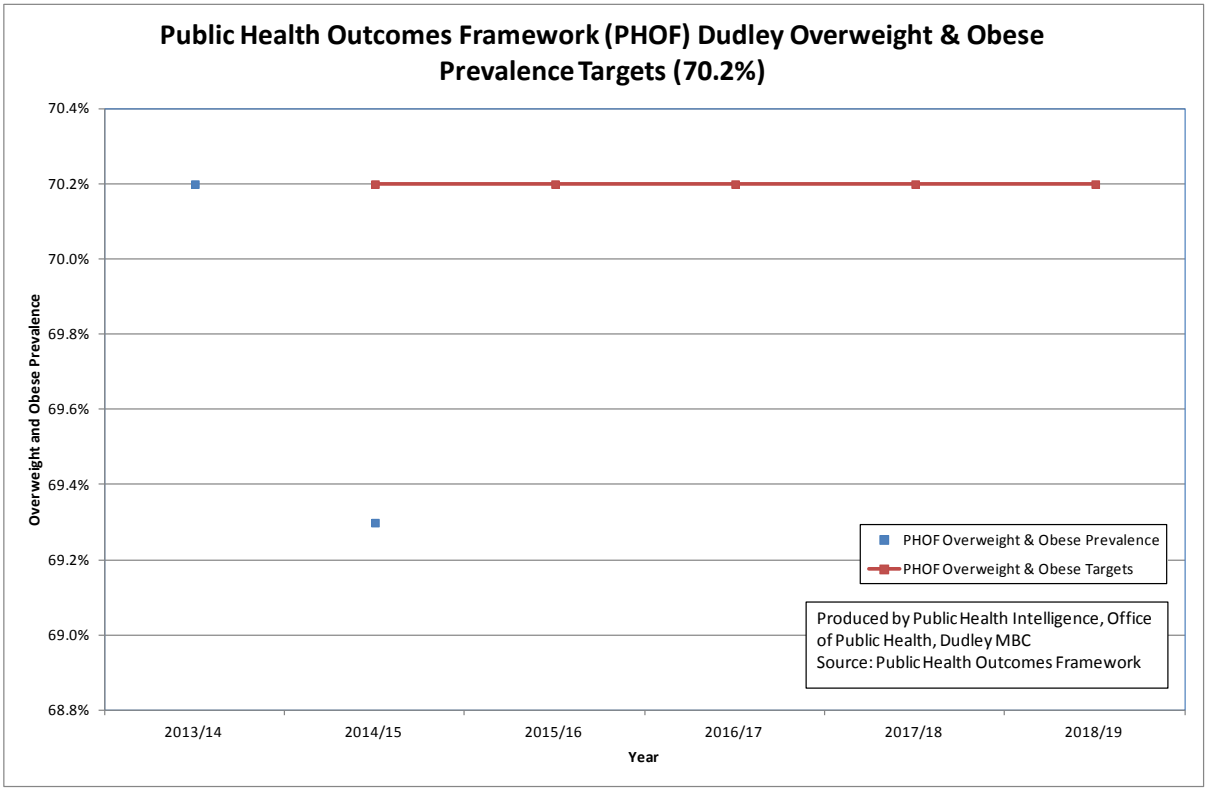



*data source: NHS England*
*produced by: Office of Public Health, Dudley MBC*

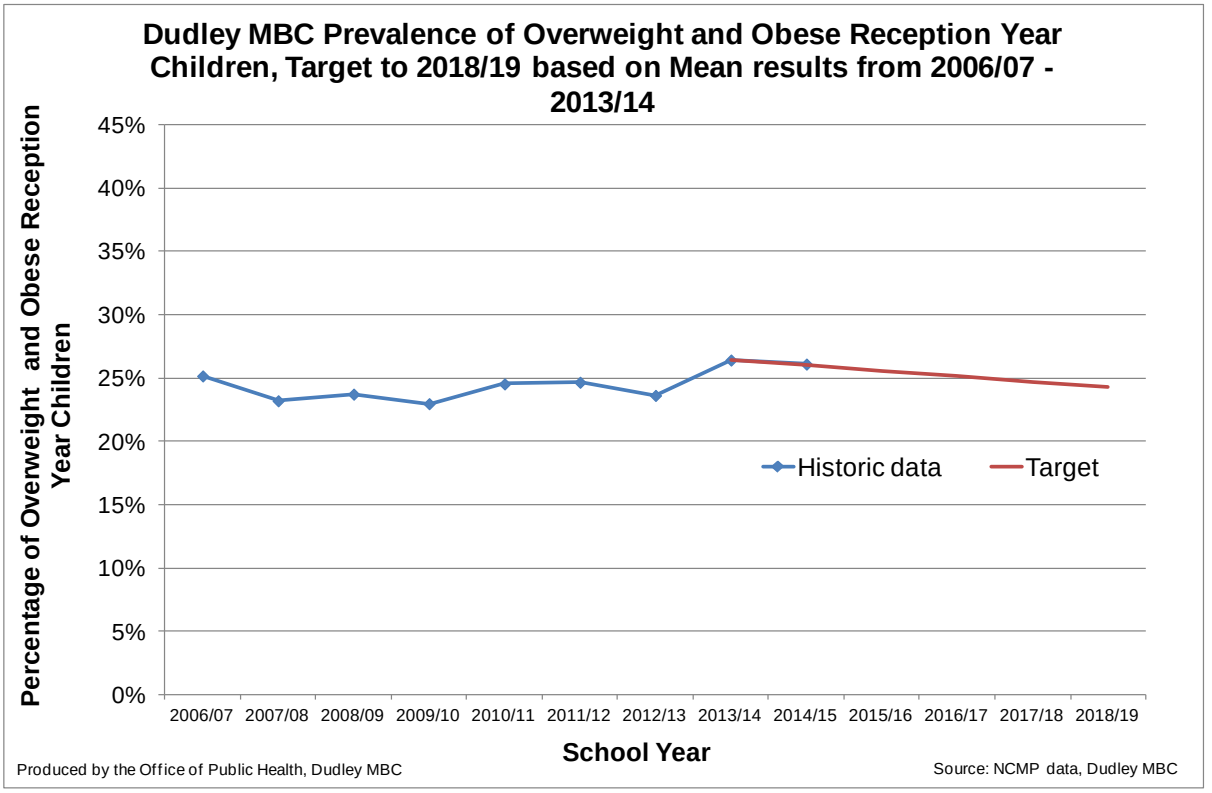


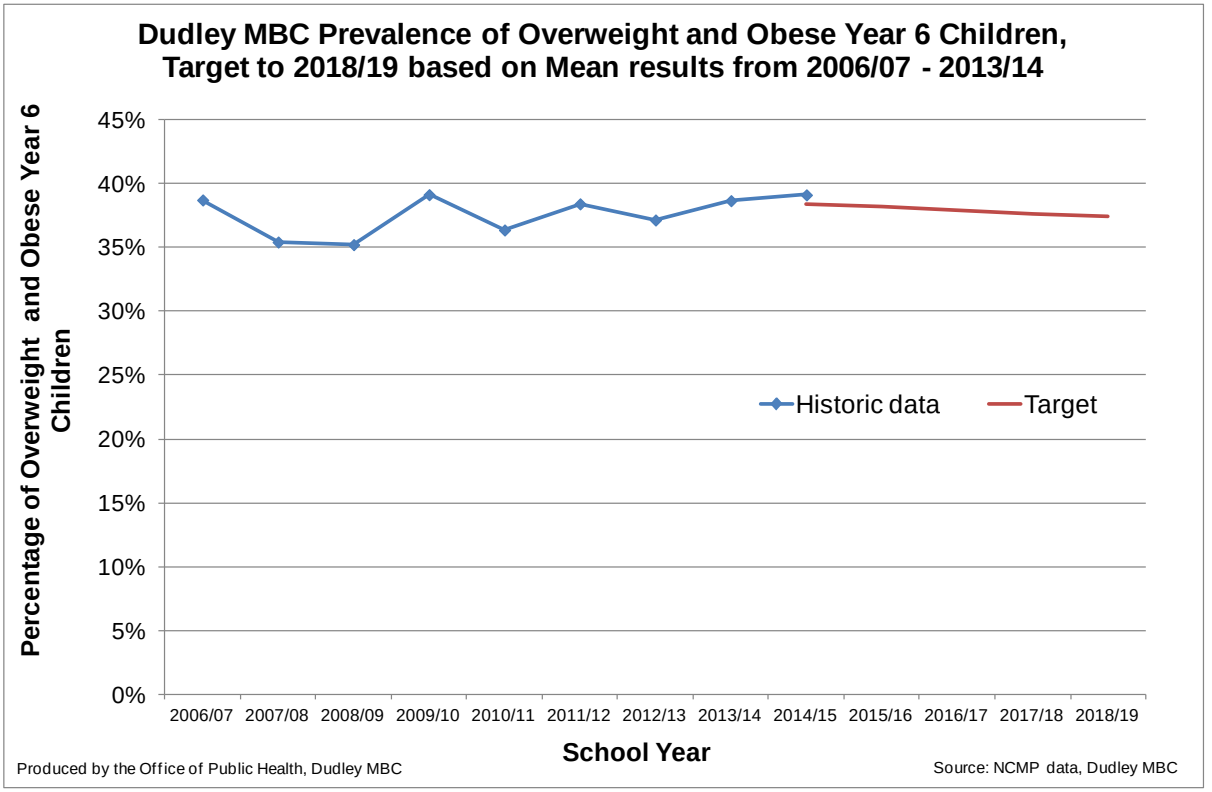

*data source: NHS England*
*produced by: Office of Public Health, Dudley MBC*

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



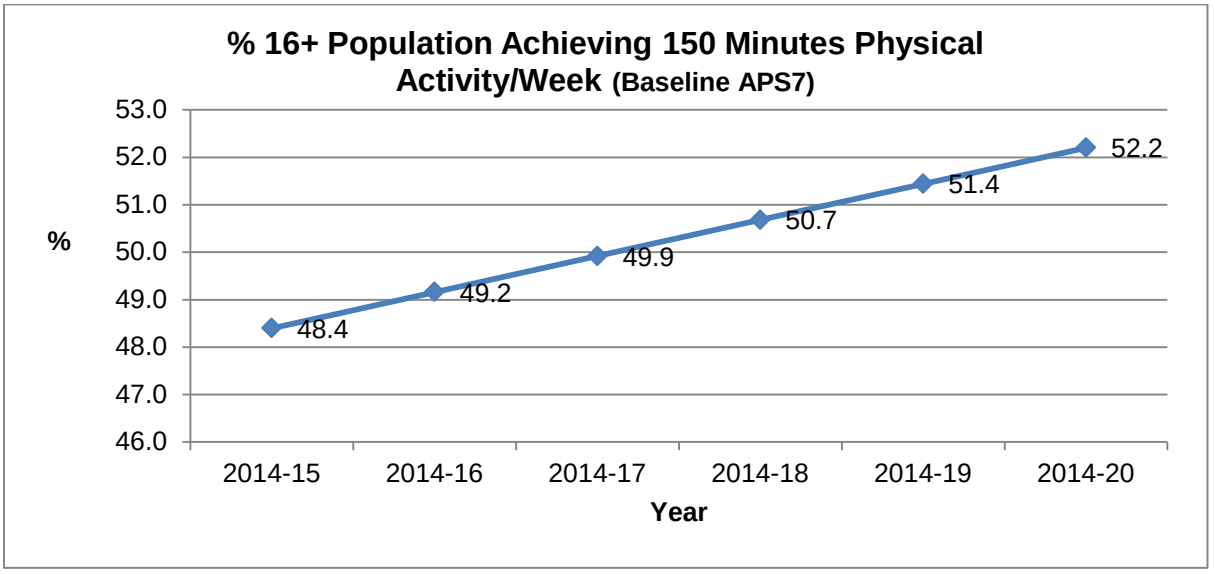
## iii) Shared child excess weight targets (baseline 2013-14)



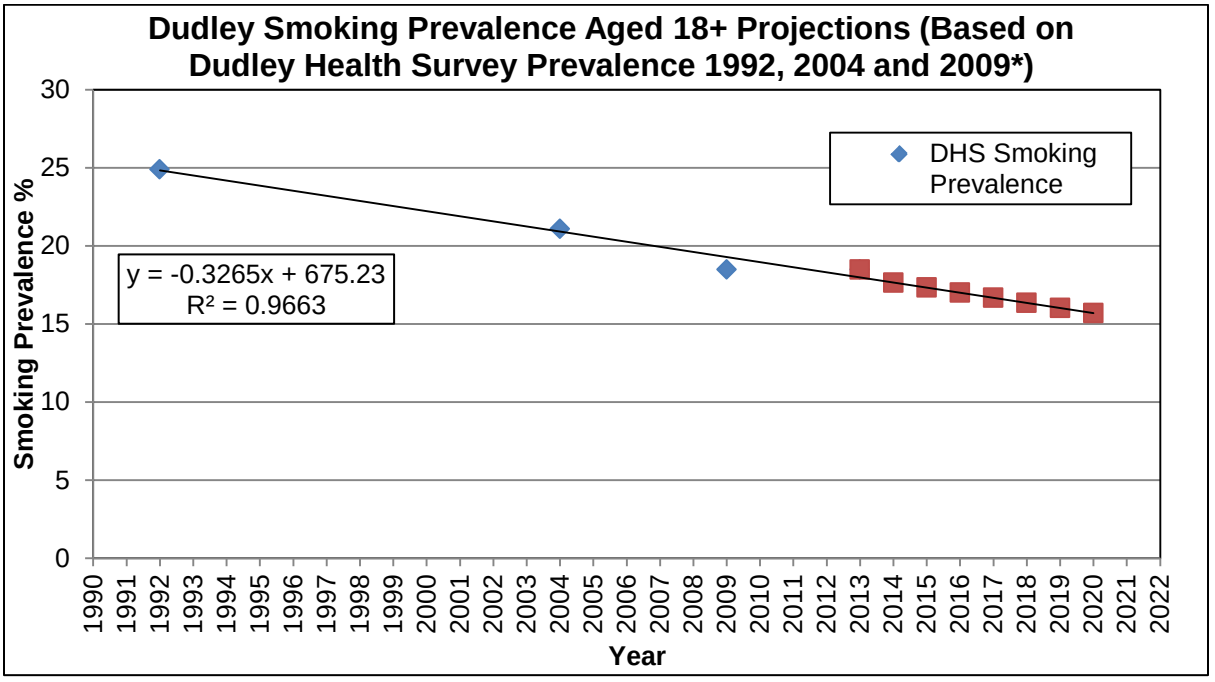
### iv) Physical Activity

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




## b) Tobacco control

### i) Smoking prevalence

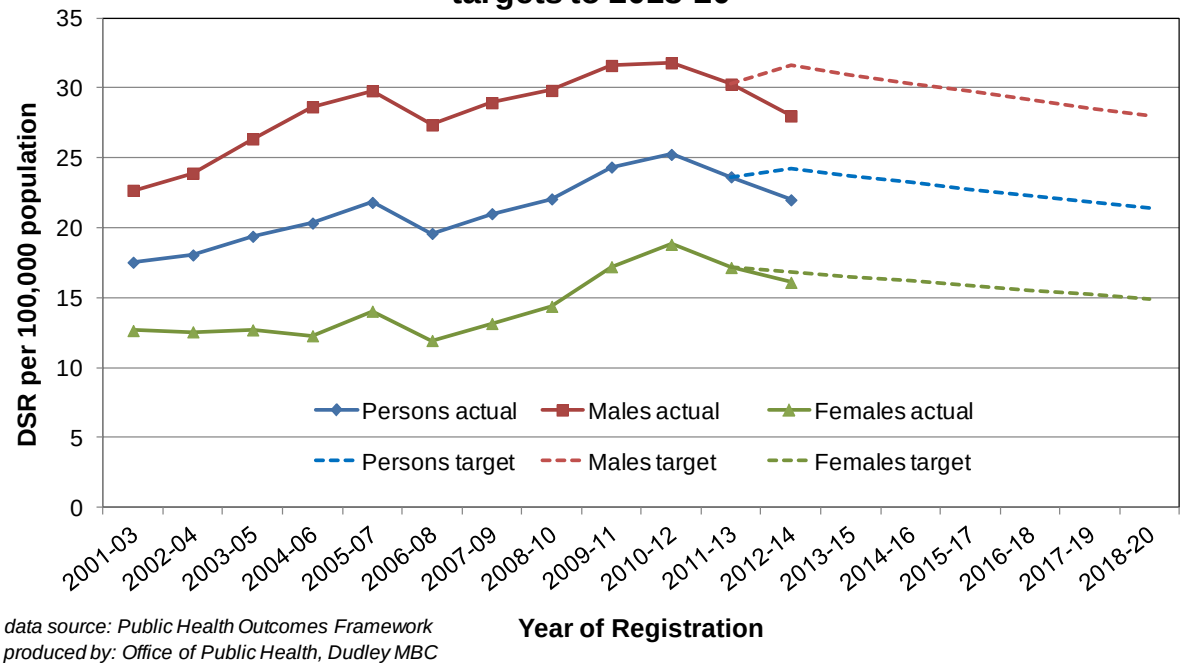



* Prevalence was assumed to have remained constant between 2009 and 2013. Based on ONS Integrated Household Survey data

## c) Alcohol

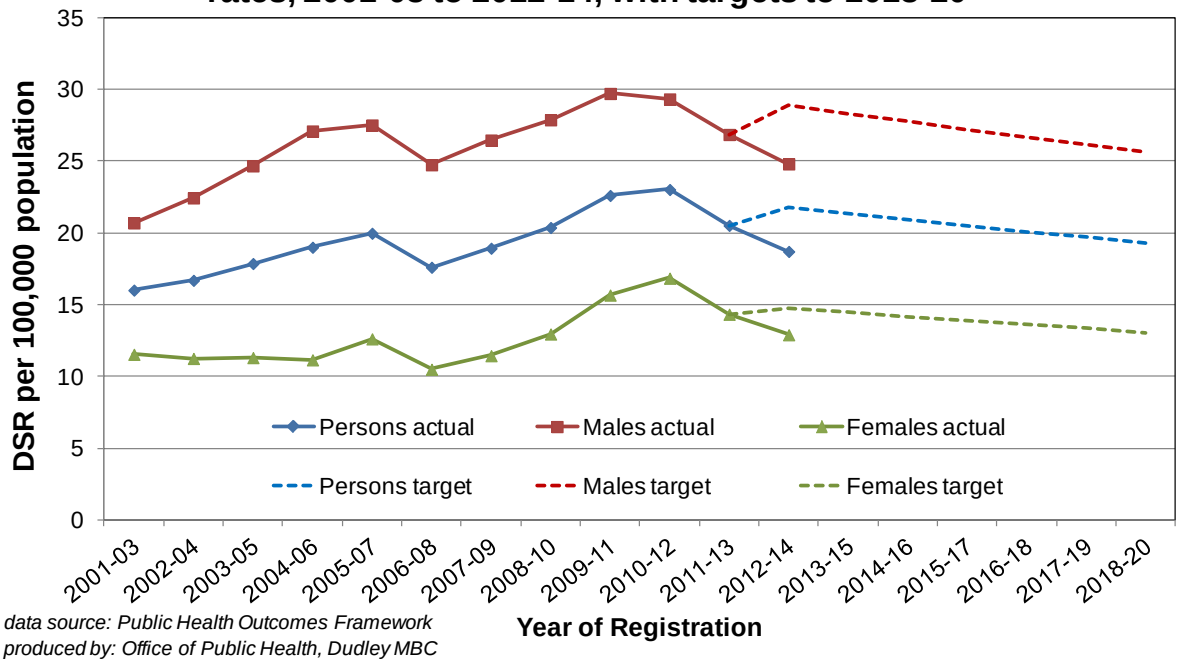
### i) Alcohol mortality targets

**PHOF 4.06i - Under 75 mortality rate from liver disease (DSR per 100,000), Dudley, 3 year rates, 2001-03 to 2012-14, with targets to 2018-20**



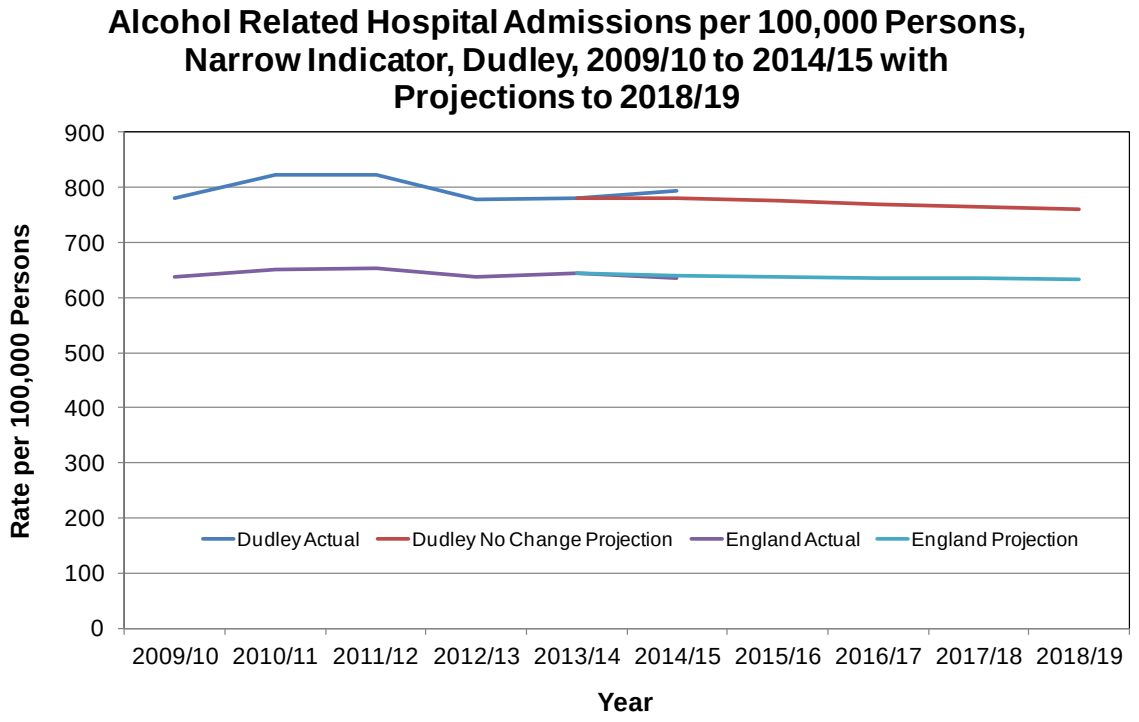

*data source: Public Health Outcomes Framework*
*produced by: Office of Public Health, Dudley MBC*

**PHOF 4.06ii - Under 75 mortality rate from liver disease considered preventable (DSR per 100,000), Dudley, 3 year rates, 2001-03 to 2012-14, with targets to 2018-20**



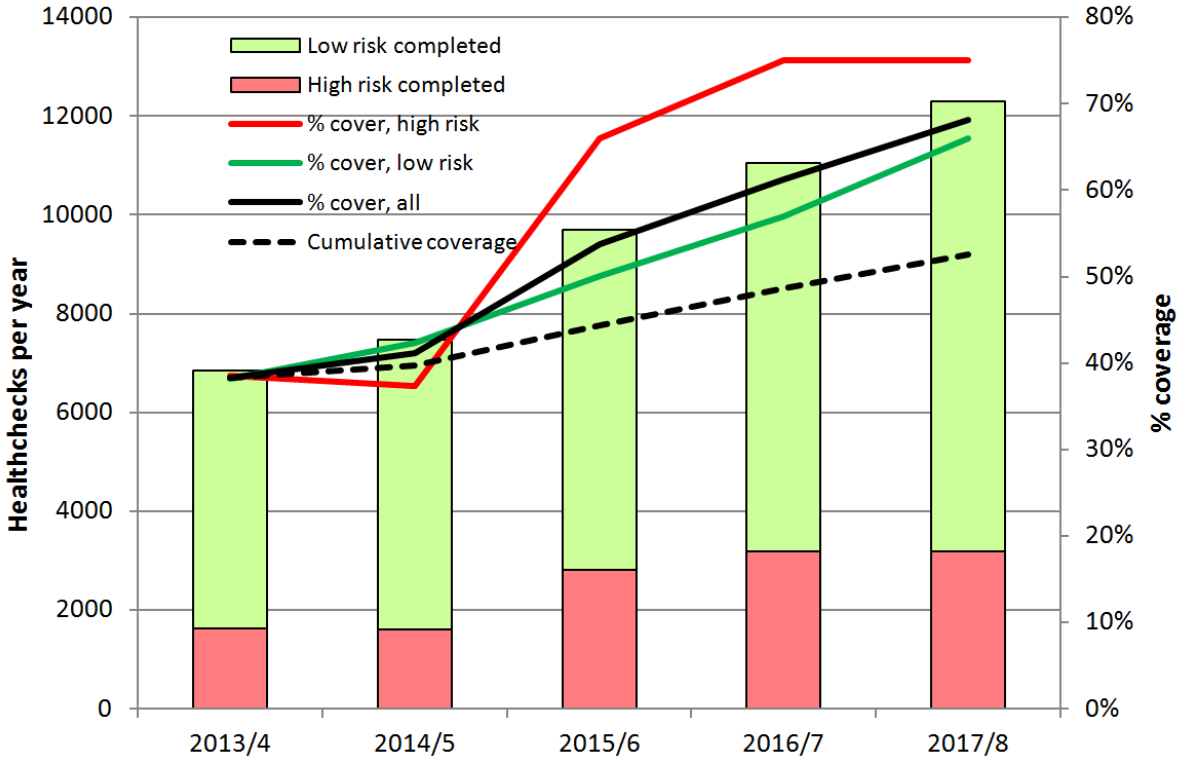

*data source: Public Health Outcomes Framework*
*produced by: Office of Public Health, Dudley MBC*

## ii) Alcohol related hospital admissions




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

## d) Health checks



Practices have been classified according to whether they lie within one of the wards with the highest quintile of under-75 cardiovascular mortality. Targets for coverage (the proportion of the population who have a Health Check as a percentage of the eligible registered population) have been set separately, with the intention being to reach the Public Health England (PHE) “aspirational target” of 75% for people having a health check in 2016/7 in the highest risk areas and to reach the PHE “intermediate target” of 66% by 2017-8 for the other practices.

The direction of travel over the period 2013-5 has diverged for the highest risk versus the rest; coverage in the highest risk is actually on course to be slightly lower in 2014/5 than in 2013/4 for the most at-risk populations, whereas the lower risk populations are receiving more health checks in 2014/5 than 2013/4. This has the potential to exacerbate health inequalities, hence the choice of a more stretching target for the highest risk practices. This is potentially achievable with additional targeted support to a small number of practices.

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

- providing grants to local community groups to increase levels of physical activity;
- Including referral rates to physical activity schemes on our practice scorecard;
- looking to incorporate the inclusion of gyms in future premises development;
- building on our workplace health scheme for CCG employees and holding our providers to account for ensuring their staff have access to similar schemes.

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

For our practices, their local community’s health and wellbeing will be at the heart of everything the team does, consistent with our approach to population health and wellbeing. They will promote a healthy living ethos and deliver high quality public health services, such as smoking cessation, sexual health, NHS health checks and advice on alcohol and weight management. A number of services currently commissioned by the Office of Public Health will be incorporated into our new primary medical services contractual framework.

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

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

The model will include:-

- each surgery having a Healthy Living Champion (with a Royal Society of Public

Health qualification), who keeps up to date with community health services and spreads this knowledge throughout the team and a practice manager who has undertaken bespoke leadership training;

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

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

As part of our new contractual framework for primary medical services, we will implement a new long term conditions framework making best use of the EMIS web system to support a systematised approach; case find; manage call and recall and extract data. The system will be implemented from 1 April 2016, replacing elements of the QOF and existing enhanced services. This will make a significant contribution to the early diagnosis of cancer and our one year survival rate; as well as the early diagnosis of other long term conditions.

Our plan is to promote symptom recognition and case finding among those more likely to present later with cancer symptoms, through engagement with local communities about cancer signs and symptoms and by supporting general practice to address some of the perceived barriers that our communities face to presenting early.

We wish to monitor the impact of this work by tracking cancer survival rates at practice level. We will work with our Council and Public Health England partners to secure cancer survival data at practice level and put in place the necessary data sharing arrangements to enable the local public health intelligence specialists to undertake the necessary analysis. Access to services is a major determinant of health status. We will enhance access to services in a number of ways:-

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

We have self-assessed against the “Better health outcomes” and “improved patient access and experience elements of the Equality Delivery System (EDS2). As well as the areas of action identified in this plan to deliver better outcomes and improved access and experience, we will, following a period of stakeholder engagement , review

an agreed range of services in relation to these EDS 2 goals.

In addition we will:-

- implement the service specification for the redesigned Dudley Respiratory Assessment Service (DRAS), aligned to our 5 localities and providing a step down service from the Community Rapid Response Service;
- review the COPD pathway with a view to reducing emergency admissions;
- implement our diabetes model of care with a single point of access and triage for all referrals; the majority of care being provided in a primary care setting and the de-commissioning of routine type 2 diabetic reviews in secondary care;
- take part in the national Diabetes Prevention Programme;
- carry out further work on hypertension building on the outcome of the 2015/16 local quality premium scheme which has increased recording on primary care disease registers by 1%;
- implement a new pathway for anticoagulation services;
- commission IV antibiotics and IV diuretics in the community;
- implement the agreed familial hyperlipidaemia screening process;
- support a systematic approach to self-care programmes using appropriate technology, particularly in relation to COPD and heart failure;
- implement an integrated heart failure pathway across acute and community services, 7 days a week.

## 4. Community and Clinician Engagement

### a) Community Engagement

Our key plans have all been shaped by the views of patients and the public, through research, specific consultation exercises and through our Patient Participation Groups, our Patient Opportunities Panel and our Healthcare Forum.

We have also been informed by the priorities contained in the Joint Health and Wellbeing Strategy and specific spotlight events run by the Health and Wellbeing Board in relation to their priorities.

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

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

are all reflected in our key service and outcome priorities.

To develop a collective understanding of the context, scope and boundaries of our new model of care and the contents of the operational plan we have carried out a range of engagement activities. We have consulted on our commissioning intentions and we are currently conducting a further listening exercise which will be followed by a series of public consultations where required.

Through our conversations with the public and other key stakeholders, we have identified four key requirements:-

- better **communication** both to patients and between staff;
- improved **access** to consultation and diagnostics:
- **continuity of care** in supporting the management of their long term condition(s);
- effective **coordination of care** for the frail elderly and those with complex conditions.

We are committed to the ongoing involvement of people and communities as we develop our new model of care. A communications and engagement strategy has been developed for this work.

**b) Clinician Engagement**

As a clinically-led organisation, our member GPs play a key role in shaping our plans. GPs form a majority of the voting members on our Board. 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 plans, including the development of our new care model have all been developed in partnership with our membership.

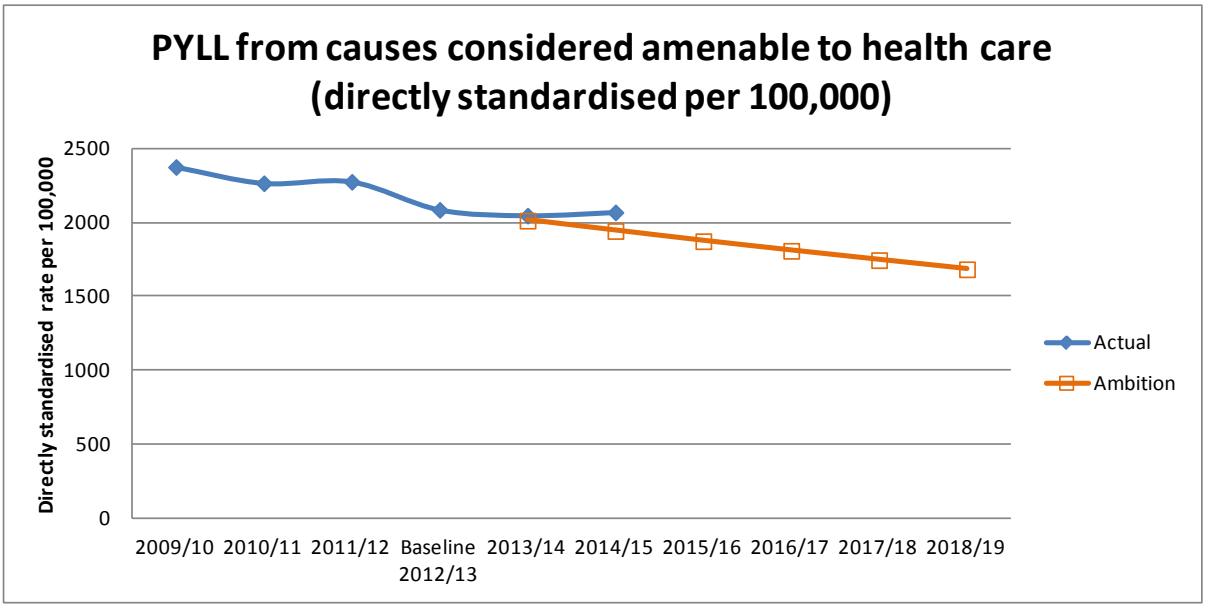
**5. Our Outcome Ambitions – Reducing the Care and Quality Gap**

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

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

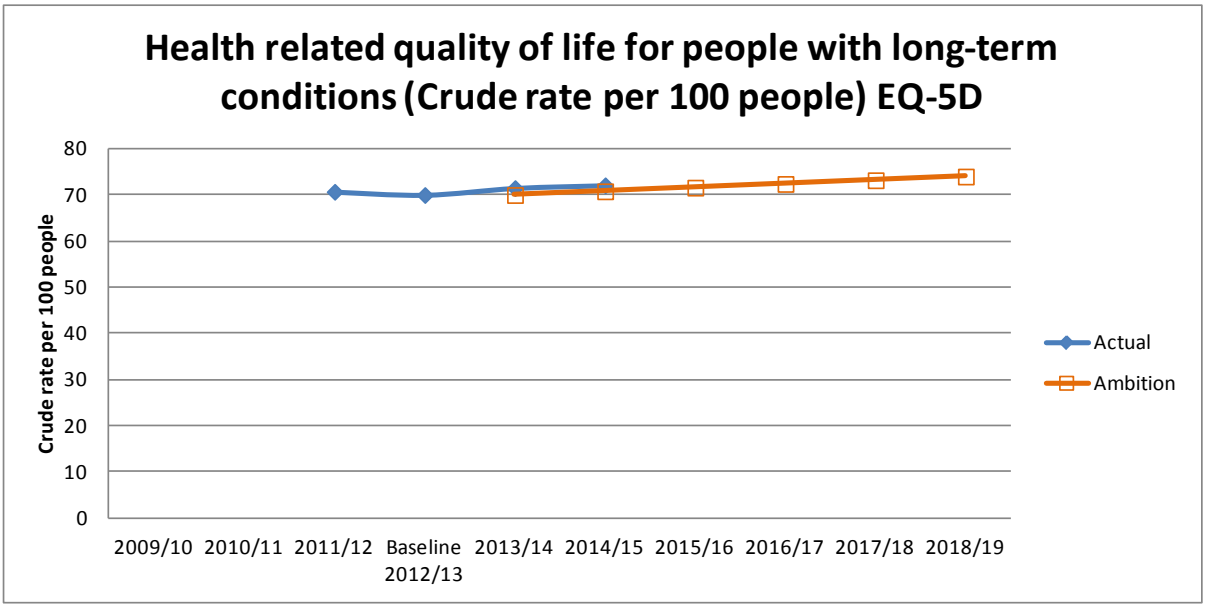
- 3.5% reduction in potential years of life lost (PYLL) per annum from 2087 per 100,000 in 2012/13 to 1943.5 per 100,000 in 2014/15 and 1685 per 100,000 in 2018/19; work with the Office of Public Health to improve the uptake of smoking cessation services in primary care;

- Work with the Black Country Be Active Partnership and Dudley MBC to ensure that general practice contributes to initiatives designed to promote physical activity, as part of our physical activity and sport action plan.



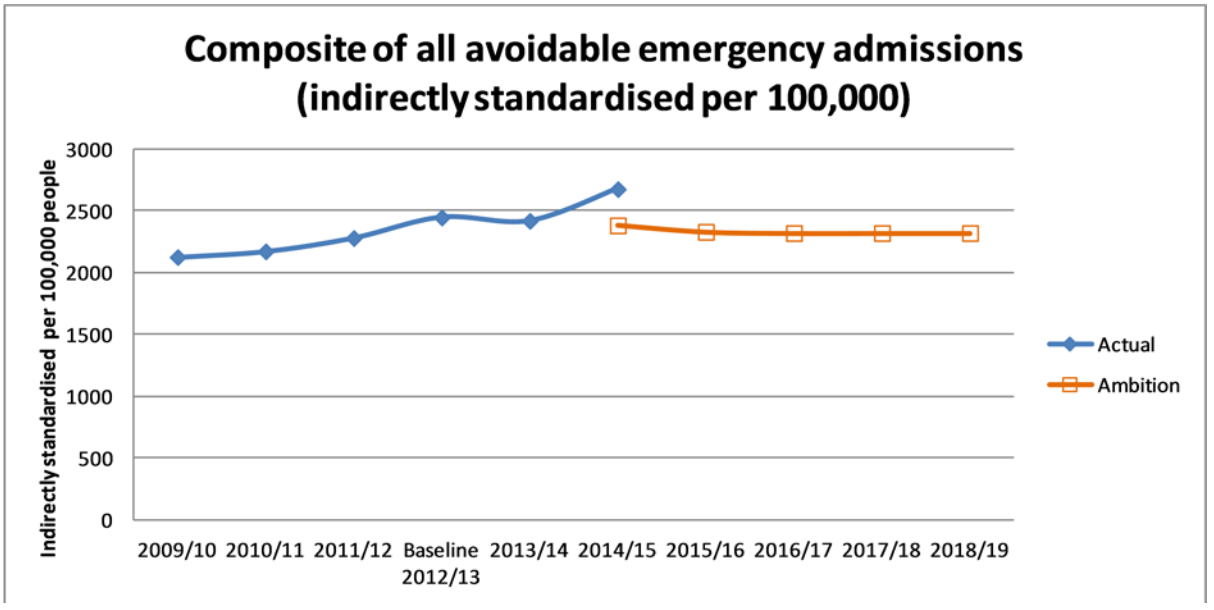

b) **Improving quality of life for 15m plus people nationally with one or more long term conditions:-**

- 70/100 people in 2012/13 reporting improved health status increasing to 71.6/100 in 2015/16 and 74/100 people in 2018/19;
- dementia diagnosis rate to increase from XX at 31st March 2015 to XXX by
- 31st March 2016;
- hypertension diagnosis rate to increase by 1% - current register 55,164 to 55,716 – an increase of 552 (local QP indicator);
- improve recording of disease in primary care registers, in particular for hypertension, heart failure and chronic kidney disease (recorded prevalence 18,838, modelled prevalence 31,398);
- work with the Office of Public Health and primary care to improve the uptake of vascular checks;
- work with the Office of Public Health on initiatives to reduce childhood obesity towards the England average;
- develop the use of personal health budgets.



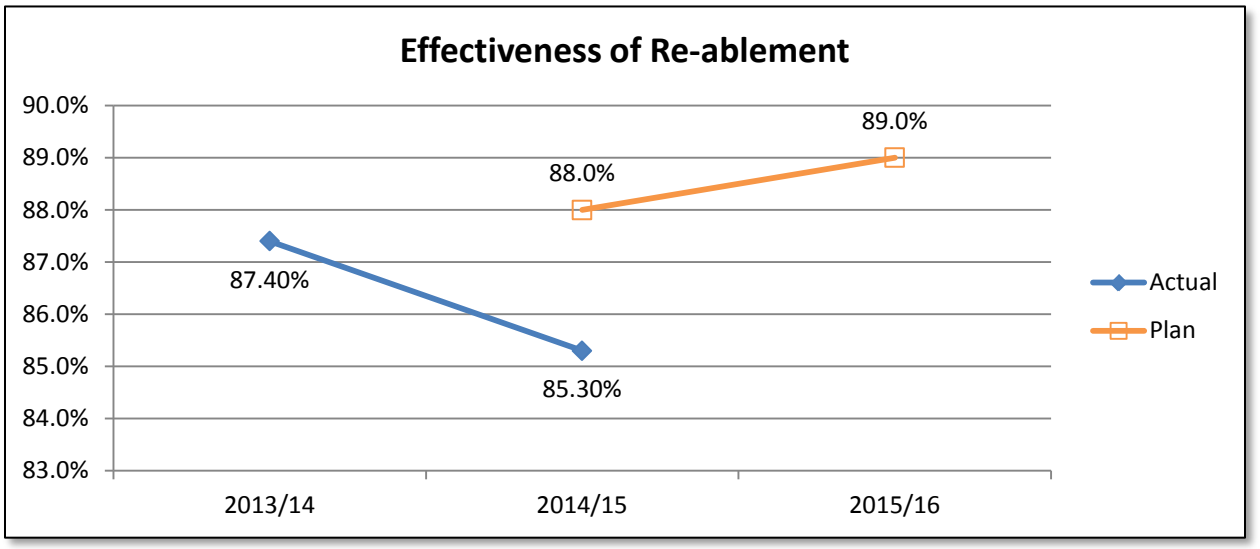

c) **Reducing time spent avoidably in hospital through more integrated community care:-**

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



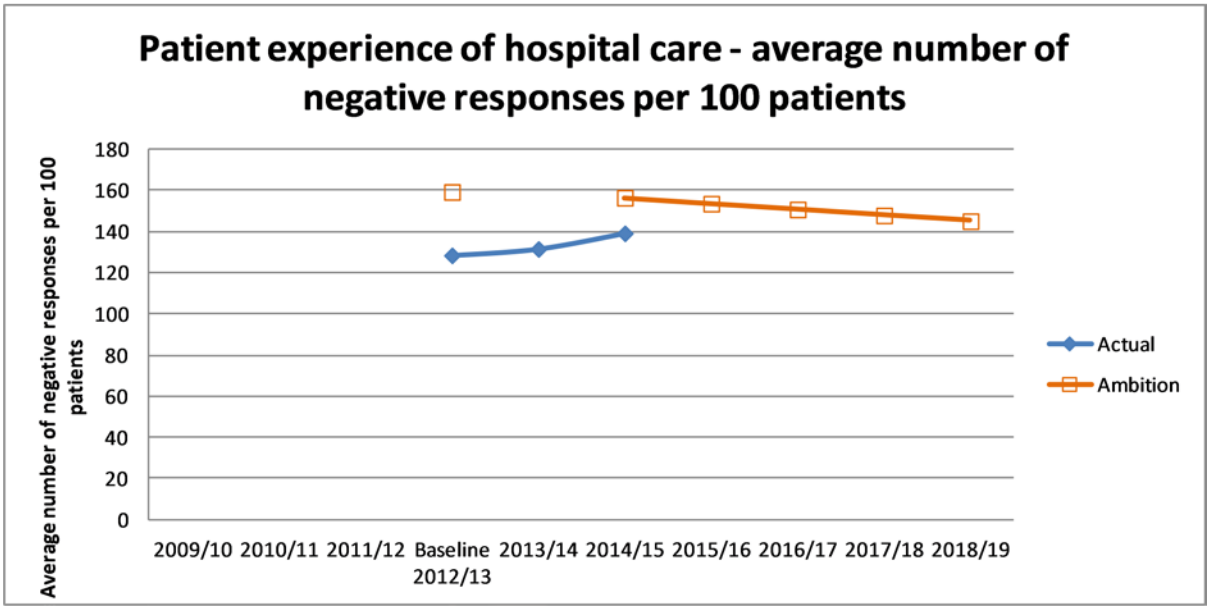

**d) Increasing proportion of older people living independently at home after discharge:-**

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



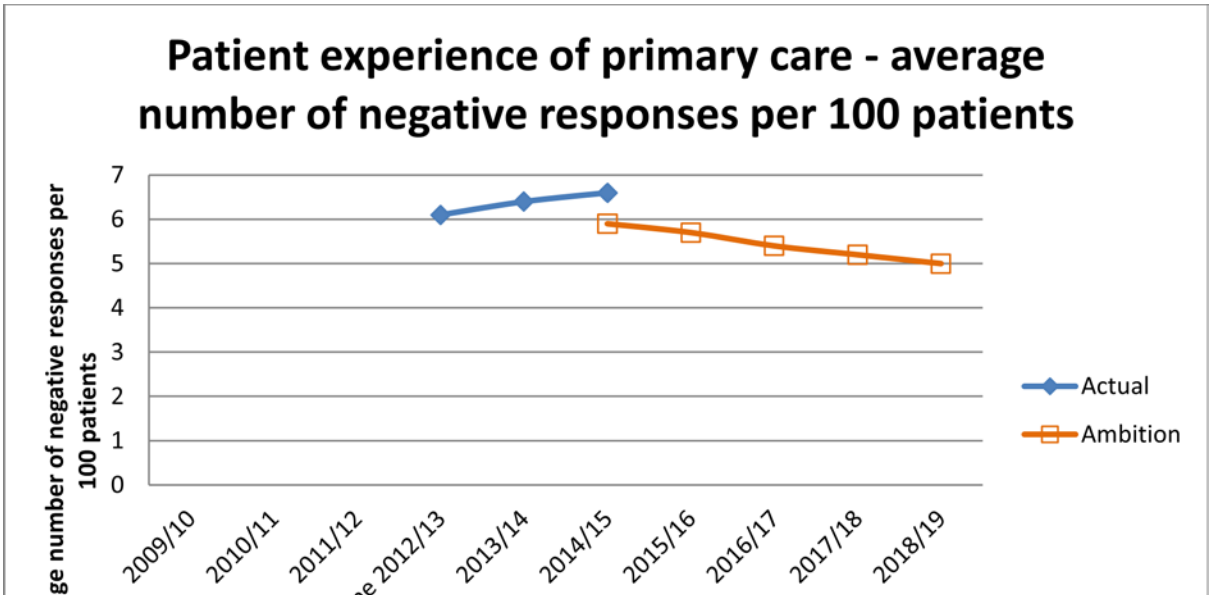

**e) Increasing people's positive experience of hospital care:-**

- reducing the average number of negative responses per 100 patients from
- 159.2 in 2012/13 to 153.5 in 2015/16 and 145 in 2018/19;
- agree a plan with local providers to address issues identified in the 2013/14
- Friends and Family Test results (QP indicator);
- reducing the number of pressure ulcers: - zero tolerance of grade 4s, no increase in grade 3s and a reduction in grade 2s.



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

• reducing the average number of negative responses per 100 patients from 6.1 in 2012/13 to 5 in 2018/19.




**g) Progress towards eliminating avoidable deaths in hospital:-**

- medication incidents reported through the National Reporting and Learning System – quality of the reported learning to be shared;
- development of a reporting system to support the investigation and remedy of medication related serious incidents for which the medicines management team have received root cause analysis training;
- zero tolerance of MRSA.
- Clostridium difficile reduction from XXX cases to XXX cases by March 2017. This is on target to be delivered.

**6. Commissioning for Quality and Safety**

**a) Holding providers to account**

We will develop quality initiatives and use the Commissioning for Quality and Innovation (CQUIN) process to reduce patient harm and improve patient outcomes. This continues and CQUINs have been refreshed for 2016/17.

We will work with our providers to encourage the development of smart dashboards to illustrate the performance of their services and inform patient choice. We will look to work with providers who actively promote their own information to support this. Progress has been made in giving feedback to the public on quality metrics – e.g.

safer staffing levels. This will continue in 2016/17.

We expect all providers to develop clear clinical quality standards for their services and measure their performance against these. In 2016/17 we will continue to focus on outcomes based quality standards for inclusion in contracts and will monitor providers against these mapped to the NHS Outcomes Framework.

The CCG Board will use patient stories as a key mechanism for obtaining feedback from patients and build the lessons learned into the service design process. We have used the CQUIN process to incentivize this for some providers until firmly established.

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

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

In terms of meeting its responsibility for the commissioning of primary care, the CCG will put in place a comprehensive quality monitoring programme to ensure safe care.

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

**b) Francis, Berwick and Transforming Care**

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

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

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

Working in conjunction with our Black Country commissioning partners we intend to commission:-

- a community based assessment and treatment service for those patients who would have traditionally been admitted to an inpatient facility;

- a community based “short breaks” service to prevent placement breakdown and admission.

Through our primary medical services contractual framework, we will be ensuring that the physical health needs of people with a learning disability are met. We will also look to support people with learning disabilities through the use of personal health budgets.

**c) Staff satisfaction**

We have used a CQUIN based on the American Association for Healthcare Research and Quality (AHRQ) report to inform and assist in the understanding of the patient safety culture as a means of influencing staff satisfaction. In 2016/17 we will continue to build on this work and use nationally reported staff surveys to focus efforts and engagement.

**d) Patient safety**

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

All our commissioned providers are expected to be committed to the “Sign Up to Safety Campaign” and this is monitored through our CQRMs.

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

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

- quality exceptions reported (such as whistleblowing, serious case review, adverse media reports);
- review safeguarding issues;
- review a suite of key indicators including HCAI data; complaints; patient experience; safety thermometer; quality visits; reports on CQRMs that have taken place including any exceptions to be brought to the attention of the Quality and Safety Committee; and a quality dashboard.

The Quality and Safety Committee also receives reports based on themed reviews according to an agreed reporting matrix. This covers:-

- children's safeguarding
- adult safeguarding
- infection, prevention and control
- maternity services
- cancer outcomes
- mental health
- mortality, including unexpected death / suicide
- themes from incident reports, for example falls
- patient experience data, complaints and national surveys
- NHS Continuing Health Care
- nursing homes
- clinical visits
- quality in primary care
- commissioning for outcomes
- training and education (including Deanery visits)
- audit reports
- staff surveys
- workforce data
- medicines management / incidents
- information governance
- health & safety performance
- public health
- policies for ratification
- quality team work programme
- equality and diversity update

There are also ad hoc reports produced in response to events, such as national reports, public inquiries, and inspection reports from the Regulators

**e) Safe and effective prescribing**

Our prescribing policies and guidelines are overseen by the CCG's Prescribing Sub-Committee and the Area Clinical Effectiveness Sub-Committee, the latter including representatives of primary and secondary care. This oversight includes our guidelines on the prescribing of antibiotics.

Antibiotic prescribing rates remain a national public health concern. The national quality

premium includes objectives relating to the volume and nature of antibiotics prescribed in primary care. While excellent progress has been made in Dudley in previous years to reduce the volume of broad spectrum antibiotics, our biggest challenge for 2016/17 will be to achieve a further reduction in the overall number of antibiotic prescriptions issued. The CCG will be working with the Office of Public Health to support GPs and their patients, through awareness raising; education; use of technology such as our Antibiotic Guidelines app; implementation of our agreed guidelines for the prescribing of antibiotics in the community; and through our agreed Prescribing Incentive Scheme.
We will work in partnership with Dudley Group of Hospitals NHS FT on guidelines and the clinical management of patients.

**f) Seven day services**

Our Service Development Improvement Plans with each of our main providers set out our plans for implementing seven day standards. We have requested each provider to carry out a further stock take in relation to all the standards by 1st June 2016. This will form the basis of a report to both the relevant contractual clinical quality review meeting and the Quality and Safety Committee. As a result of this, we will agree an action plan with each provider for meeting the appropriate standards by 1st August 2015.

As well as assuring ourselves that our providers are putting in place appropriate arrangements for safe 7 day services, our integrated locality service model and our urgent care model operate on the basis of a 7 day service. This will be built into the relevant service specifications.

We will continue to use the standards for community services, developed as a national 7 day working NHS IQ transformational pilot site, within our specifications for all the services within our new care model. These have been shared with NHS England.

As part of the process for implementing our new contractual framework for primary medical services, we will be working with local practices to secure the most appropriate access to 7 day primary care services.

**g) Compassion in Practice (CIP) and the 6 Cs**

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

**Care**

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

**Compassion**

Compassion is how care is given through relationships based on empathy, respect and

dignity. It can also be described as intelligent kindness and is central to how people perceive their care.

**Competence**

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

**Communication**

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

**Courage**

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

**Commitment**

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

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

**h) Provider cost improvement programmes**

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

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

**i) Workforce Planning and the LETB**

We will ensure staffing and workforce plans are safe affordable and meet our strategic requirements.

The CCG is represented on the HEE LETC by one of its GP Board Members. The LETC Chair is a member of the West Midlands LETB and ensures that local issues are fed into the wider education commissioning agenda.

A strategic system-wide workforce plan is being produced to support the delivery of our new care model.

### j) Ensuring Clinical Accountability

Our new model of care aims to develop a team of integrated, GP- led health and social care multidisciplinary teams. This new clinically led care model will see teams working "without walls", taking shared responsibility for delivering shared outcomes centred around the person.

We are committed to a clinically-led system of care and will embed clinical accountability across the system:-

with GPs as the lead co-ordinators of population health and wellbeing:-

- based on the registered patients with their practice;
- working in partnership with other consultants / physicians providing long-term care;
- supported by integrated population-based teams.

with consultants as the lead co-ordinators of pathways of care:-

- providing advice and guidance into population healthcare;
- working alongside GPs in co-ordinating frail elderly care;
- providing value-added treatments in line with best practice;
- supported by efficient communications with and from GPs.

### k) Safeguarding children

#### i) Section 11 audit

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

For the Local Safeguarding Children Board to maintain oversight of the effectiveness of safeguarding children practice across the borough, and of the extent to which it is continuously improving, the key Section 11 agencies are expected to provide information

on the arrangements they have in place to protect and promote the welfare of children and young people. This includes Dudley CCG as a statutory member of the Safeguarding Children Board.

The Designated Senior Nurse has completed the audit on behalf of Dudley CCG and its member practices for the period 2014/15. Overall the CCG is compliant with all of its statutory responsibilities. The CCG has worked hard to raise the profile of safeguarding children within the organisation and is working towards ensuring that safeguarding is fully embedded in all aspects of CCG business including all contracts and service specifications. The correct governance structures are in place and staff have undertaken appropriate safeguarding children training.

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

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

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

**l) Safeguarding adults**

**i) Prevent agenda**

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

The CCG Safeguarding Team has introduced new multi-disciplinary training workshops, training will continue to be offered at regular intervals in the future.

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

**ii) Care Act and NHS Accountability framework**

The NHS Accountability Safeguarding Framework has taken into consideration the Care Act in which adult safeguarding is, for the first time, spelt out in the law. Local authorities must make enquiries or ask others if they believe an adult is, or is at risk of being abused or neglected. The legal framework is to enable key organisations and individuals with responsibilities for adult safeguarding to agree on how they must work together and what roles they must play to keep adults at risk safe. The Safeguarding Adults Board will be a key requirement which includes key stakeholders such as health and the Police. This board will carry out safeguarding adult reviews when people die as a result of neglect or abuse and there is a concern that the local authority, or its partners, could have done more.

**M) The Mental Capacity Act 2006 (MCA)**

The CCG can demonstrate that consideration of mental capacity is part of the safeguarding adults process and where people lack capacity decisions are always made in their best interest.

The CCG expects all providers to comply with the safeguarding standards within the CCG safeguarding policy and the policies and procedures of the Dudley Safeguarding Adults Board.

Providers are required to demonstrate that they have all the appropriate arrangements in place to safeguard people. Safeguarding is integral within standards for all contracts. As a minimum contractual obligation, all providers are required to comply with local safeguarding policy and procedures (NHS Contract, Section E, Clause 24 ,Section C Part 7.2). Contracts specify compliance with CQC Essential Standards and related legislation, including the Mental Capacity Act; the Mental Health Act; Deprivation of Liberty Safeguards and the Safeguarding Vulnerable Groups Act..

Work is in hand to ensure that the recommendations from the MCA Scrutiny Panel's recommendations on the Supreme Court's judgement in the Cheshire West and Chester case are incorporated both operationally and contractually with service providers.

## 7. Parity of Esteem for People with Mental Health Problems

"Healthy minds" is one of our Health and Wellbeing Board's 5 priorities (see above). The Board has an ambition to create a "mental health friendly Dudley, where the social determinants of health and wellbeing are understood and action is taken to tackle inequalities with all partners and stakeholders". The actions identified below are designed to reduce the inequalities gap for patients with a mental health problem.

We will revise our joint mental health strategy to reflect the priorities and recommendations of the Mental Health Taskforce. To deliver parity of esteem we will increase our investment in mental health services by 3.2% in 2016/17.

### a) Mental health at the heart of our integration model

Our MCP service model (see below) is focused on both the integration of health and

social care services, as well as the integration of physical and mental health services. Mental health practitioners are key members of our locality teams, recognizing that physical and mental health problems are interrelated.

Voluntary and community sector services also play a key role in the integration process. The links with local voluntary and community services and our focus on prevention and independence within asset rich communities is designed to reduce the harmful effects of social isolation. Access to locality link workers and a social prescribing scheme enhances this provision. As part of the continued development of our care model, we will develop, in each of our 5 localities, a specific mental health MDT and roll this out across all practices. In addition, we will explore how personal health budgets can be developed to support greater independence, choice and control for service users.

We will work with our practices to improve the recording of patients with mental health problems in primary care disease registers and in turn ensure that these patients enjoy appropriate access to physical health services in primary care. As part of our primary care long term conditions framework, all patients with mental health problems will receive a comprehensive physical health assessment.

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

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

We are working in conjunction with the national new care models team to examine how best to commission and contract for the new care model, including mental health. We envisage all mental health services to be delivered by the MCP and will agree an appropriate contracting and outcomes based payment model to be implemented from 1 April 2017.

**b) Access**

We will work with the Office of Public Health to tackle the issue of poor access by people with mental illness to public health interventions which can increase life expectancy e.g. smoking cessation, screening programmes and immunization**.** This will form part of our work on health equity audits referred to above.

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 commission counseling services on the basis of direct access for patients.

We have taken steps, in conjunction with Dudley and Walsall Mental Health Partnership NHS Trust, to ensure that the new access standards can be met and commissioned the correct levels of activity to secure these. Our contracts, service specifications and information requirements reflect this.

Effective mental health pathways are now a key component of our care mode and we are adopting the same approach to these and physical health pathways, commissioning on the basis of the optimum pathway and reducing unwarranted variation. This is described further at 9 c) below.

In recent years we have focused relentlessly on avoiding the need for Dudley patients to be treated out of area, such that at the time of writing this plan, only 6 patients are accessing services out of area. In addition, clear expectations in relation to outcomes and recovery plans for these patients are set and their recovery to local services managed actively.

**c) A new mental health service model**

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

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

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

Services will be developed as part of this model to enhance their ability to care for patients in primary care and community settings, reducing the reliance on inpatient beds.

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

The development of an appropriate workforce to support this model will be addressed in our system wide workforce plan designed to support the implementation of the MCP.

**d) Pathway efficiency**

We will look specifically at the pathway for early intervention in psychosis with a view to eliminating any unnecessary variation, enhancing pathway efficiency and meeting the new waiting time standards. We will apply the same approach to the IAPT pathway as we seek to meet the new waiting time standards for this service. Our contracts for 2016/17 have been constructed on the basis of meeting the national access targets.

**e) Crisis care**

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

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

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

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

**f) Substance misuse**

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

**g) Dementia**

Specific work on dementia is identified below. We are taking steps to improve the recording of patients diagnosed with dementia in primary care disease registers in order to meet the national target by:-

- sharing individual practice performance at our GP locality meetings;
- providing practices with details of recently diagnosed patients;
- identifying those practices with the greatest potential to improve recording;
- arranging for our 5 GP locality leads to provide specific input to these practices.

**h) Perinatal Mental Health**

We will commission a local service to complement specialist services already available for patients with perinatal mental health needs.

**i) Child and Adolescent Mental Health Service**

We will implement our CAMHS Transformation Plan, refreshing this as necessary in response to the findings of the recent review by the West Midlands Quality Review Service and a new needs assessment. Our investment plans will be updated to reflect additional allocations made available. The implementation of this plan and its associated outcomes will be overseen by the CAMHS Transformation Group, with representatives from the NHS, local government and voluntary sector partners.

Specific immediate priorities in 2016/17 will include:-

- commissioning a camhs tier 3 plus service to prevent the inappropriate use of acute paediatric and mental health beds and prevent the need to access tier 4 services;
- working in collaboration with NHS England to prevent the unnecessary use of tier 4 services;
- commissioning a community based eating disorder service in line with the access and waiting time standard recommended model;
- the systematic engagement of children, young people and their families.

**8. Children's Services**

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

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

- ensuring that the looked after children health assessment pathway meets demand and delivers outcomes;
- promoting breast feeding;
- preventing smoking by pregnant women;
- ensuring that the commissioning of maternity services is designed to give children the best start in life
- work in partnership with the Office of Public Health on initiatives to reduce childhood obesity, including a review of the existing maternity services pathway;
- providing support to carers through a revised carers strategy;
- fulfilling our statutory duty to contribute to education, health and social care plans for children with special educational needs;

- offering personal health budgets where appropriate;
- reviewing existing services designed to meet our statutory duties for safeguarding;
- reviewing the end of life pathway and improving Advanced Care Planning;
- implementing an integrated children's community health service;
- expanding our paediatric triage service;
- introducing "Health Champions" for young people.

## 9. Our Key Priorities – 2016/17

In responding to the challenges we face there are 4 key priorities which need to be delivered in 2016/17:-

- **urgent care** – ensuring our local urgent care system meets the requirements of the urgent and emergency care review. Reviewing urgent care pathways to ensure proper integration across physical health and mental health services, securing better ambulance turnround times and commissioning new services from primary care to avoid unnecessary admission from care homes;
- **planned care** – implementing best practice elective pathways to deliver service efficiencies, meet NHS Constitution targets and eliminate unwarranted variation in our pathways for ENT, diabetes, cardiology, ophthalmology, urology and orthopaedics;
- **integrated care** – implementing our MCP care model through practice based multi-disciplinary teams, transforming the nature of joint working across health and social care and providing out of hospital services as a real alternative to hospital admission;
- **primary care transformation** – commissioning a modern system of primary care capable of managing patients systematically supported by skilled staff, appropriate IT, modern premises and at the heart of our MCP care model.

These are all brought together in our plans to develop and commission the MCP.

### a) Impact on Providers

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

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

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

We will not, however, work with providers that do not share our values or vision.

**b) System Characteristics for Transformation**

In December 3013, NHS England identified six key characteristics which sustainable health and care systems need to demonstrate by 2017/18. Our plan maintains this direction of travel, in the context of moving into a new phase of transformation during year 1 of the STP.

Our initiatives in relation to these key characteristics are set out below. Fundamental to the CCG's transformation programme is the commissioning our new model of care

**c) A new model of care**

We are implementing a sustainable and replicable whole-system change, designed around the person, communities and clinically-led delivery, which enables both mutual-networked care and best practice pathways of care – the Multi-Specialty Community Provider (MCP).

This model is broader than just health and care. It is designed to support and sustain our communities, in partnership with the community and voluntary sector, and enable people to play a fulfilling role within their community. It is consistent with the "six principles" to support the delivery of the NHS Forward View.

- care and support is person-centred: personalised, coordinated and empowering;
- services are created in partnership with citizens and communities;
- there is a focus is on equality and narrowing health inequalities;
- carers are identified, supported and involved;
- voluntary, community, social enterprise and housing sectors are key partners and enablers;
- volunteering and social action are key enablers.

Measured against these principles, our care model:-

- understands the position, needs and motivation of people and communities;
- works with people and communities to hear their voices;
- engages with people and communities to build relationships and offer genuine opportunities for influence;
- embraces the assets of people and communities to create opportunities for co-production, building collaborative relationships that recognise that different roles and perspectives are a constructive force for change;
- empowers staff to lead service changes to benefit people;
- enables people and communities to put themselves at the centre of their care - so that they can make informed decisions about their health - be supported to manage their conditions and stay as independent and in control as possible;
- creates an environment to support people using health and social care to drive change themselves.

Taken together, these approaches will improve health outcomes and allocate resources more efficiently to areas of need and want – especially for those with long term conditions and complex care needs.

We have already made significant progress to implement the main components and key enablers of this care model in 2015/16. Work on this will continue in 2016/17 as we develop the contractual mechanisms and service specifications for all elements of the model.

There are three elements to the model based upon the fundamental principle of supporting population-based health and wellbeing. This starts with the patient registered with their GP – the main co-ordinator of their care. This is delivered through a mutual network of care, best exemplified by the work of the practice based multi-disciplinary team, linked to a series of other community based services. This, in effect, is the MCP, based on the principles of shared ownership, shared responsibility and shared benefits.

The first element of the model is the mutual network of care, to be delivered by the MCP, commissioned around the following themes and outcomes:-

- better **communication** with patients and between staff;
- improved **access** to different types of consultation and diagnostics in the community;
- **continuity of care** in supporting the management of peoples' long term conditions;
- effective **co-ordination of care** for the frail elderly, those with the most complex conditions and at the end of life.

Through the second element of the model, we will support people to remain at home wherever possible by developing evidence based best practice pathways of care. We will reduce variation, so that all services are commissioned and delivered in a way that incentivises optimum outcomes for the patient, shares risk, makes the best use of the resources we have available; and enables effective communication between all stakeholders. To deliver these pathways for both planned and urgent care, we plan to move away from PbR tariffs to a payment that reflects best practice.

The final element is a re-commissioned system of primary medical services. This will be commissioned through a refreshed outcomes based contractual framework, reflecting the themes of access, continuity and co-ordination.

i) **Clinical development**

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

- to maximise people's independence from care through self care and personalisation;
- based upon the registered patient with the practice.
- delivering best practice pathways of care:

- to achieve best possible outcomes from treatment;
- to provide efficient care offering the best possible experience.

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

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

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

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

The first stage, already substantially in place, of delivering this mutual-networked care is to establish across Dudley a joined up network of GP-led, community-based multi-disciplinary teams which enable health, social care and the voluntary sector to work together in "teams without walls" for shared benefits and outcomes, coordinating the care planning for individual patients.

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

**iii) Stage two – aligning specialist services**

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

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

This also includes using our primary-care led urgent care centre as a point of triage for all patients attending hospital. This reduces the need for ED services and connects people back to their local primary care service.

**iv) Stage three – community care led retrieval**

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

This next stage has already been agreed by our clinical strategy board, which includes consultants and GP leadership from across the CCG and our main provider. This will include specialties which support the management of long-term conditions such as diabetes medicine and respiratory medicine. Consultants will

work in partnership with GPs to the same outcome objectives for improving population health and wellbeing. This will include collaborating to deliver improved services to the frail elderly.

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

**v) In parallel – whole pathway care**

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

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

d) **Citizen Participation and Empowerment**

We recognise that if we cannot persuade patients and the public of the need for change, it will be much harder to deliver change at the pace and scale which is required.

We also know that we have a much better chance of seizing the opportunities that the future holds if we can secure the active participation of patients and carers in driving change and embracing those new models of care. This means that effective communication is more important across health and care than ever before.

Effective communication, involvement and engagement networks can break down barriers, build alliances, encourage innovation, share good ideas and create an environment where all of us concerned with improving health and care across Dudley can work together to build a better future.

Our CCG Communications and Engagement Strategy provides an overarching set of principles which we will apply to any programme or project when developing, delivering, monitoring and evaluating any communications, involvement and engagement plan.

Those principles will inform any conversation we have about the future of our health and care services – with patients, carers, the public, partners, other system leaders or anyone with an interest in, or connection to, our NHS, including regulatory and oversight bodies.

Living by these principles in our working lives, should take us on a journey from ‘traditional’ public relations and communications to a new way of working which

will engage our members, staff, partners, patients and the public more meaningfully in delivering safe, high quality, sustainable health and care services which meet the needs of the communities we serve now and in the future.

Our aim is to work with citizens and communities to create person centered care. We see a future in which patients (including patients with caring responsibilities), public and communities will contribute actively, collectively and inclusively to health and wellbeing outcomes underpinned by effective collaborations with, and between, the CCG and its partners.

To achieve this, we have set out six Communications and Engagement objectives which we think are key to us enabling and achieving that vision and supporting the six principles set out earlier in this plan:-

- understand what is important to people locally;
- connect what is happening with those that can bring about change and learning;
- inspire our local teams and partners to listen, take responsibility and make real changes to enable person centred care;
- build relationships and networks to have honest conversations;
- create an environment which supports people using health and care services to themselves drive change;
- develop and grow confidence and trust in local services and NHS leadership.

The cornerstone of our public and patient involvement work is our network of Patient Participation Groups (PPGs). At the time of writing this plan, all of our 46 member GP practices had an established PPG. We are committed to supporting these groups and their practices to give patients a voice. Through our innovative PPG Purse scheme, each PPG can receive up to £1,000 funding to invest in expanding their group, making it more diverse or delivering innovations that benefit patients.

Our PPGs are offered regular opportunities to come together through our Patient Opportunities Panel (POPs) which is chaired by our Lay Member for Public and Patient Involvement who reports directly to our Governing Body on issues raised.

Our quarterly Healthcare Forum (HCF) brings together representatives of a health related service user and community groups. Each meeting is chaired by one of our member GPs and discussions cover a wide range of health topics. Feedback is shared with our commissioners and leadership team.

Although we recognise the limitations of digital communication, we are committed to seizing the opportunities which it offers to reach large numbers of people quickly and cost effectively.

Ongoing development of our website, Facebook page and Twitter feed remain priorities, as does the production of vox pop ‘Feet on the Street’ videos which offer local people a chance to share their views on a health topic and have

those views broadcast to our Governing Body at their monthly meetings and with the wider community via our website.

Key developments for 2016/17 are to:-

- continue to support and develop our network of practice based Patient Participation Groups (PPGs). Maintaining one in each practice and developing a strong link to our models locality focus;
- build on the success of our #mefestival for young people, with a further event for young people in 2016/17 organised collaboratively with Health & Wellbeing Partners;
- actively promote arrangements for online access to repeat prescriptions; appointment booking and coded record information. Working with practices to ensure that these services are available, that patients are supported when their access is enabled and developing programmes of engagement with Barclays Digital eagles to encourage more online access;
- to create a citizen contact database which not only details those people who want to be informed of health service developments but match those individuals to areas of interest. This information can then be used to match people to clinicians and managers at the formative stage of service redesign. This greater insight should encourage co-design of services;
- work in partnership across health and care to use all available communication channels to extend our reach to local citizens. This will be led by a strategic Communications and Engagement group which will sit under the Health & Wellbeing Board and will be complimented by the Communications & Involvement work stream in the New Care Model Programme;
- grow a group of patient and public representatives to support the New Care Model development and link into each work stream. We will encourage those representatives and the wider organisation to work in partnership with Clinical, Management and Public leadership for each work stream;
- act on the feedback from our young people to develop a network of young health champions and strive to make our information more accessible to young people through the internet and social media;
- ensure that we respond to the health needs of new migrants by developing a better understanding of our local communities, working with our partners and building on the JSNA; improving data recording in primary care so that we can more effectively target health interventions;
- identify how we can ensure our engagement approaches are sensitive to the needs of new migrants;
- promote the new Dudley Community Information Directory for Dudley citizens;
- support practice staff to become Accredited Dudley Information Champions;
- procure new accessible websites for the All Together Better Partnership and the CCG;
- actively support our member practices and their PPGs to adopt social media presence;

- seek opportunities to adopt participatory budgeting – allowing people to take the power to make the decisions. This supports co-production in allowing communities to decide what is important to them and allowing them to make the decisions which can affect their health and wellbeing;
- promote staff engagement – staff are our greatest ambassadors and our greatest assets. They are integral to the success of the new care model. We recognise that staff working across the partnership need to be supported to maximise their potential, feel valued and understand how they can contribute to the delivery of a new care model. A series of design jam sessions and workshops based on human centred design will help unlock ambition, bring fears into the open and harness the energy of our staff to create a future that supports health and wellbeing for staff and the new models of care;
- co-produce care pathways - we believe that services created in partnership with Dudley people and communities are best. A patient's experience of care can varying significantly by intervention, however research carried out by Deloitte showed significant variation in a number of pathways in Dudley. To support more effective and patient centred commissioning we would like to identify what issues and barriers exist in the system and explore how we can work in partnership with clinicians, patients and healthcare professionals, to co-produce improved pathways of care. We aim to use this resource to work with an academic institute to facilitate this co-design;
- support the use of personal health budgets for children and young people, and people with learning disabilities, mental health problems and long term conditions.

**I. Measurement – what 'counts' for people rather than 'counting people'**

As we develop new ways of working and we place a much greater emphasis on the person, we must find new ways of measuring the value of those services to that person. This is an area which has traditionally been under explored or invested in. We will focus on the following areas.

**II. Integrated reporting system**

As new services develop, a powerful tool to shape health and care delivery will be feedback from individual patients, carers, families and patient groups on their experience of care. Evaluation will be able to draw on Dudley's Integrated Patient Experience Reporting System, which is being expanded into community and primary care to include all our 46 GP practices and our main providers.The system, which was developed in partnership with our main acute provider, Dudley Group NHS Foundation Trust, is being used to track experiences across their services. This will provide us with an excellent means of examining the vital outcome of improved patient experience.

We will further develop a web portal to display and encourage feedback.

We will roll out the integrated reporting system to all our healthcare providers.

We will ensure that our reporting systems are robust so that the right people are aware of the information and can take appropriate action.

### III. Mi Experience of Care Application

The drive for the NHS to become more digital is supported in Dudley, our ambition is for Wi-Fi to be available in all our GP practices, it is now available throughout the hospital and as a result we want new ways to connect with people in these settings. We have recently launched a feedback app, which captures a person's experience of care by provider. In 2016/17 we expect this option to be available to patients using all our services.

### IV. Patient reported outcomes

This is an area where we have done some innovative work to date with our locally developed PSIAMS system. This system which we have developed with the voluntary sector, enables individuals to both track their progress as well as demonstrate the social value impact of the services they receive.

This work will be further supported through research to develop measures which can be used to measure how engaged the patient is in managing their own health.

We will use the PSIAMS system of personal and social impact action measurement to understand the impact of our commissioning interventions as part of our approach to commission for value. We will develop the PSIAMs tool to empower individuals to assess the impact of commissioning interventions on them.

### V. The lived experience of people and staff

Understanding the lived experiences of people/staff that have been in contact with MCP services are vital to its evaluation. In order to achieve this we will work with a research provider over a 2 year period to evaluate the change for people and staff. This evaluation will involve detailed interviews with patients and staff and will be overseen by an academic research organisation to provide independent authentication of our findings. We also want to be sure that the changes we are making are not negatively impacting on the provider and confidence that people have in health and care services in Dudley. To do this we want to conduct some 360 degree surveys to understand, set a baseline and track opinion over time.

We are actively working to share the benefits of this work this. We have been selected by the Social Care Institute for Excellence (SCIE) to be a site in their Changing Together Work. This programme aims to influence a

policy document to be published in June 2016 which will examine how best to have constructive conversations on the 'wicked issues' of New Care Models.

**e) Wider Primary Care, Provided at Scale**

**i) In 2015/16**

- We have fully exercised our delegated functions for the commissioning of primary care since 1st April 2015.
- All of our Primary Care Commissioning Committee meetings have been held in public session, on a monthly basis from 1st April 2015.
- Our commissioning and governance arrangements for have been audited and assured in our first year of delegation, by NHS England, the Good Governance Institute and internal audit.
- We have developed a new contractual framework with our GPs that has reformed the QOF locally, and consolidated DESs, LISs and public health commissioned services.
- We suspended the current QOF in 2015-16 to prepare for the introduction of the new contractual framework in 2016-17.
- The outcome measures in the new contractual framework have attracted positive and supportive National attention from Dr Martin McShane, National Clinical Director for Long Term Conditions and Ian Dodge, National Director for Commissioning Strategy, NHS England.
- We have developed and implemented a Primary Care Development Programme – a quality improvement programme that has improved practice efficiency; improved knowledge and skills for clinical and non-clinical staff; improved the leadership and change management skills; improved communication, relationships and staff morale; created and embedded the skills within primary care to lead and manage change.
- We will be extending the scope of the development programme in 2016-17 to give practices the capacity and skills to operate at scale – delivering improvements in efficiency and quality.
- We have supported all practices moving to EMIS is to maximise efficiency, this has included developing standard protocols and searches across member practices and enhancing our use of risk stratification tools to identify and manage the frail elderly; reducing unplanned admissions, and co-ordinating physical, mental and social care in the community.
- We have developed, in house, an EMIS template to support the introduction of the new contractual framework. This has been piloted in our member GP practices
- We have developed and commissioned winter pressure schemes including an extended access scheme for additional routine appointments provided at evenings and weekends, and a service to triage and provide home visits to those frail elderly patients in care homes with a view to reducing avoidable admissions.
- We have increased the use of technologies within our member practices, such as telecare, online prescriptions and appointment booking. All of our member practices have online services enabled.

- We have invested in development and training for practice staff, delivering care planning training to support the delivery of the unplanned admissions enhanced service; commissioning eLearning/online training packages to ensure CQC compliance.
- We have continued to invest in mentorship support for our GPs, practice nurses and practice managers.
- We have worked with our practice managers group to develop and implement an annual training programme that has provided annual updates for practice managers, nurses and HCAs. Topics have included CPR, safeguarding, infection control, information governance and employment law.
- We have developed a new primary care quality performance tool – and have been publishing practice level data on performance throughout 2015-16.
- Our approach and investment in GP engagement remains critically important – in 2015-16 the membership engagement team has visited every GP principle in Dudley to discuss and understand the challenges faced by practices including:-

    - workforce challenges – planned retirements
    - workload challenges – sustainability
    - income – personal and practice
    - change appetite – level of interest in co-operation, federation or merger

- Our commissioning intentions for primary care, and our value proposition submitted for the implementation of the Dudley MCP set out how we will respond to the challenges identified by our GP engagement activities.
- We have hosted several events for our members to discuss the future of primary care, and have had guest speakers including Dr Robert Varnam Head of General Practice Development at NHS England.
- We continue to meet with our members on a monthly basis through our locality meetings, and quarterly of the wider membership. We achieve excellent levels of engagement – Dr Robert Varnam commented that he had not seen the same level of GP engagement anywhere else in England.

**In 2016/17**

**Sustainability of General Practice**

The sustainability and quality of general practice is dependent on the implementation of the Dudley MCP new model of care. The key work areas are summarised below, and are set out in more detail in the document “Dudley New Care Model, Developing a Multispecialty Community Provider – Value Proposition” submitted to the NHS England New Care Models Team in February 2016 and our Commissioning Intentions document.

**New Contractual Framework**

The changes in the nature of demand for care have not been matched by changes in capacity. In particular, we need to change the way we care for people with long term conditions, including mental health conditions. To achieve this - and in consultation with our membership - we have designed a new contractual framework to replace QoF, DESs and LISs. This contract will reflect the three themes of access, continuity and coordination. We will use this programme to roll out the framework, with training,

templates and support. This will be evaluated (and published) to maximise learning; it will also be used to establish appropriate shared outcome measures that could be used to align incentives between MCP services and secondary care.

**Access**

- enabling resilience in primary care is critical through the CCG's primary care strategy and primary care development programme;
- we will support practices to work in partnership together where appropriate (for to provide evening and weekend access and same day access for the over 75s;
- working with practices to meet the requirements to enable full access to records for all patients across the system;
- creating a new "back office" function and eliminating unnecessary transaction costs to support efficiency improvement in primary care;
- standardising referral protocols, triage and discharge information to improve the efficiency of communication (both ways) between primary and secondary care;
- ensuring all practices can utilise the full range of options for providing access to their patients (e.g.: online, telephone appointments);
- implementation of our estate strategy to support enhanced primary and community care capacity and capability.

**Continuity**

Through the new contractual framework we will be commissioning:-

- a holistic assessment on at least an annual basis of all patients with long term conditions;
- a named care co-ordinator;
- joint development of care plans with the patient;
- support for access to self-management programmes;
- condition specific outcome targets - many shared with secondary care;
- enhanced management of patients with diabetes and COPD;
- the development, and use of one template through the EMIS system to support the delivery of this.

**Coordination**

Through the new contractual framework we will be commissioning:-

- an annual enhanced assessment of the frail elderly;
- monthly MDT meetings carried out to a consistent format;
- consistent risk stratification process across all practices;
- providing professional advice and guidance to the MDTs;
- unplanned admissions – replication of the existing Directed Enhanced Service;
- support for patients with dementia and palliative/ end of life needs;
- systematic management of patients in care homes;
- systematic management of repeat prescribing.

**Primary Care at Scale**

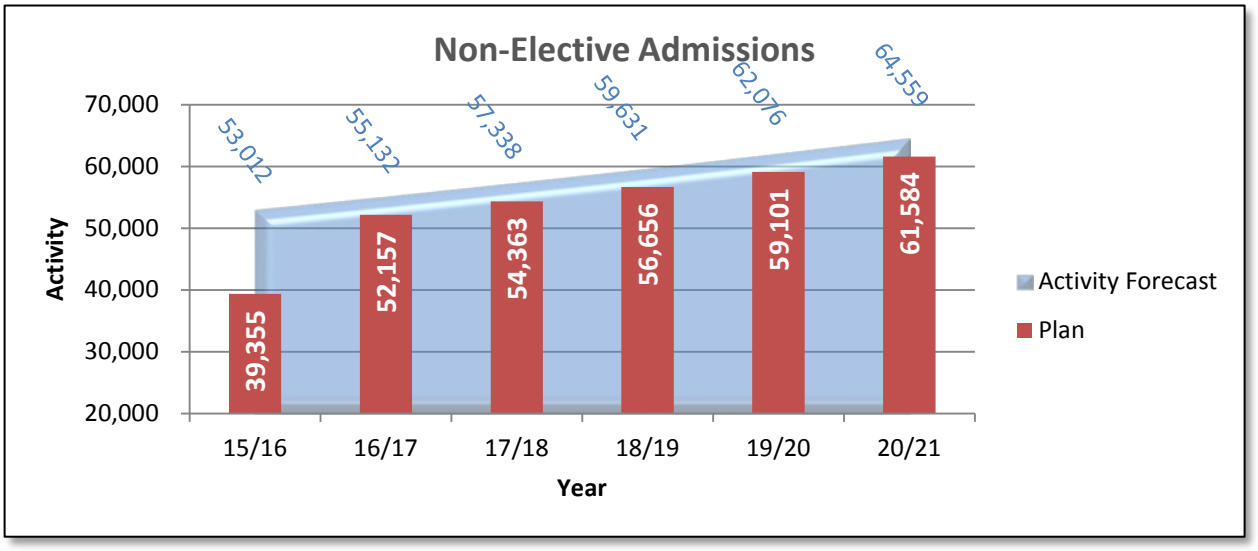
We have made significant progress in primary care: all practices are on the same IT system (EMIS); our 46 practices come together into five localities (each with ~60,000 population) to exchange information / best practice; we have developed, piloted and evaluated a General Practice Development Programme (showing potential efficiencies of ~30% in administrative functions). This needs to be expanded and accelerated. We will therefore scale up and enhance the programme to cover all practices. This will address five topics:-

- education on the new long term conditions framework;
- support for collaborative, cross-practice, working;
- developing options on premises;
- recruitment support and career development;
- back office savings.

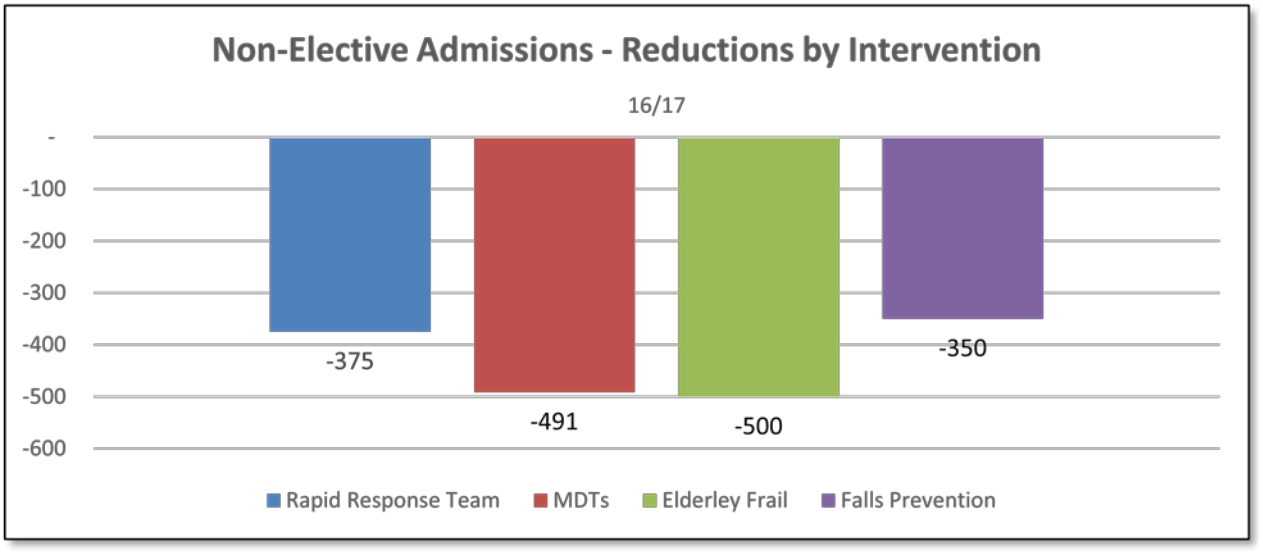
Fundamentally, this will aid the formation of larger-scale operations that will provide resilience, sustainability and quality across General Practice.

**f) A Modern Model of Integrated Care**

- Emergency admissions will be reduced from XXXX to XXXX.
- Avoidable admissions will reduce from XXXX per 100,000 in XXXXX to XXXX per 100,000 in XXXX.
- Delayed days in hospital will reduce by XXX days in XXXX and by a further XXXdays in XXXX.
- People still at home 91 days after discharge to reablement will increase by XX people in XXXXX and a further XX in XXXXX.
- The number of new admissions to nursing homes will reduce by XXX In XXXXXXX and by a further XX in XXXXXX.
- We expect the specialties of general medicine, geriatric medicine, respiratory medicine and endocrinology to be most affected by the reduction in emergency admissions.




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




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

**i) Our model of integrated care**

Our new model of care – the MCP is described above.

This model is designed to ensure that: -

- every Dudley person has a high quality experience of health and care throughout their life journey;
- the health and care system promotes independence;
- prevention and wellbeing are integrated and privileged;
- every unplanned hospital admission is treated as a system failure;

- risk stratification and other tools enable an intelligent approach to service intervention.

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

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

These services will provide:-

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

Specific initiatives which underpin this model are set out below.

**ii) Practice based multi-disciplinary teams (MDTs)** - building on the work of our early implementer sites, we have now rolled out our MDT model across all practices, supported by a comprehensive organizational development programme. General practitioners act as the lead clinicians for these community teams. 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.

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.

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

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

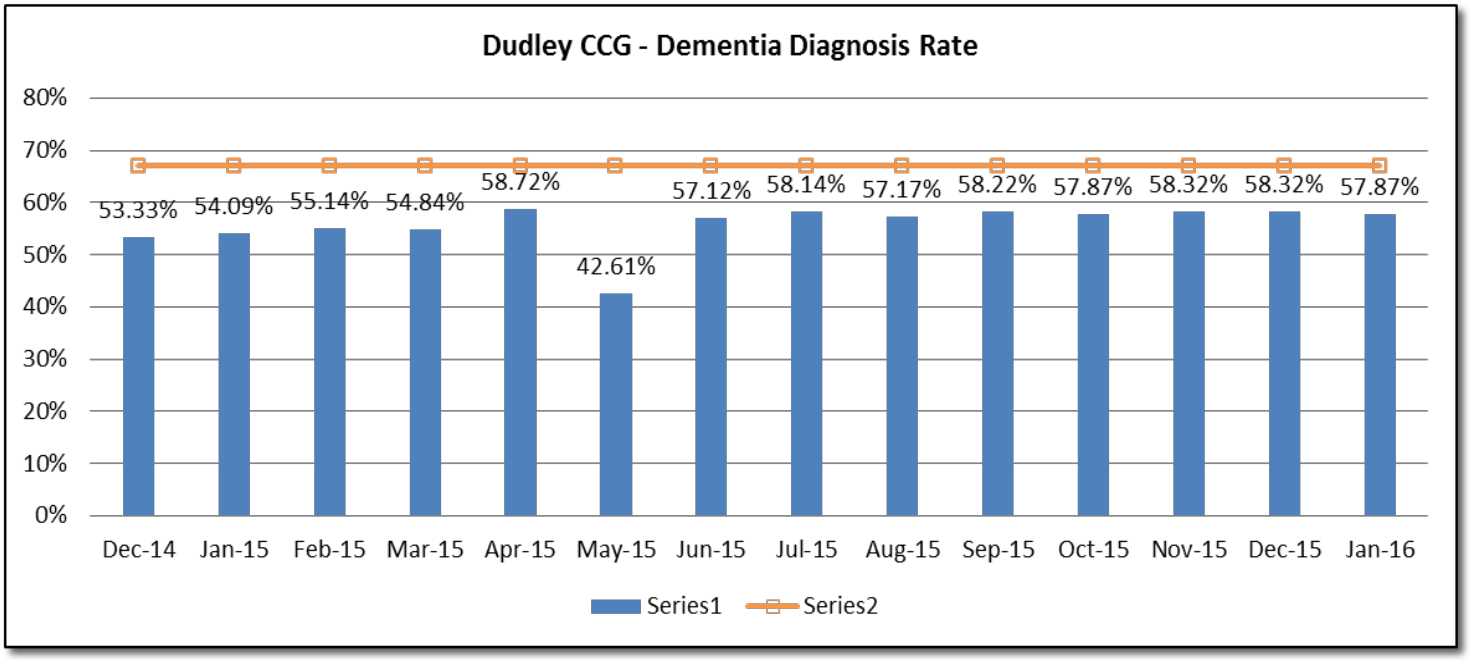
**v) GP locality leadership** – 5 GPs have been appointed. They lead the implementation of our integrated model in each locality.

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

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

**viii) Community Rapid Response Team (CRRT) -** the Advanced Nurse Practitioners in the Community Rapid Response Team have commenced working from the WMAS control centre to access the Computer Aided Dispatch System. This enables the nurses to identify appropriate patients for assessment and prevent admissions to hospital. The team will be up to full capacity by summer 2016 providing a 7 day and out of hours service.

**ix) Dementia support -** the diagnosis rate has increased to 57.87% as at December 2015 and on target to meet the England national benchmark of 67% by the end of 2016/17. A comprehensive programme is in place to achieve the national target. The majority of practices are participating in the National Enhanced Dementia Identification service and are undertaking dementia harmonisation coding.



In addition:-

- a refreshed Dudley Dementia Strategy will be the subject of consultation in June 2016;
- a home treatment and crisis resolution service, as an alternative to hospital admission, will be commissioned;
- patients with dementia will be offered the opportunity to have an advanced care plan.
- MDTs will be trained on caring and managing people affected by dementia;
- minimum waiting time standards from referral to psychiatric assessment will be in place for patients on acute hospital wards;
- we will contribute to the Dudley Dementia Action Alliance and the creation of a Dementia Friendly Community in Dudley.

**x) Elderly care**

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

An Older People and Frailty System Wide Group has been established and to develop a Dudley Frailty Strategy. This includes the following workstreams:-

- workforce and education in care homes
- medicines management in care homes
- effective transition in and out of hospital
- nutrition and hydration
- palliative care
- falls
- the role of the voluntary sector in hospital discharge
- prevention
- social isolation and loneliness

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

**xi) Dudley Care Home Programme**

We will commission a bespoke palliative care and end of life care programme for care home staff. This will focus on the five priorities of care from the Leadership Alliance for the Care of the Dying - recognise, communicate, involve, support, plan and do.

We will build on the success of our pilot reactive care home out of hours service and commission an urgent care clinical response team for care homes. All nursing and

residential homes will have a dedicated out of hours service to contact for clinical triage and home visiting. This will be designed to reduce inappropriate admissions to hospital.

The Care Home Nurse Practitioners and Mental Health Nurse for Care Homes will provide 7 day support to care homes.

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

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

**xiii) Palliative and end of life care**

Recent initiatives include:-

- completion of the Midhurst Project - the Dudley Macmillan Specialist Care at Home Team. The service has now amalgamated the hospital team, the community Macmillan team and Mary Stevens Hospice and is accessed via one single point of access with a central specialist triage team;
- a Local Improvement Scheme (LIS) for primary care for 'end fo life and palliative care' he objectives/outcomes are to enhance the quality of care provided to people requiring palliative care and end of life care with a particular focus on increasing support to the non-cancer conditions; reducing admissions to hospital by increased support in the community; and ensuring advance care plans are in place that include the patients preferred place of care at end of life, with the desired outcome of reducing deaths in hospital;
- launched a new standardised advanced care plan and DNACPR (Do not attempt co-pulmonary resuscitation) form across secondary, community and primary care;
- the specialist community palliative care team now has a palliative care consultant and Macmillan nurse aligned to each of the five localities and attending practice MDTs to discuss and support the care management of end of life and palliative care patients.

Further initiatives to include:-

- the focus in 2016-17 will be on ensuring every resident in a nursing home is offered (and supported) an advance care plan that includes a directive on 'preferred place of care' and medical treatment towards end of life. This initiative

will also extend to residents in residential care homes that have had an urgent care admission during the last year;
- to commission electronic patient care records system for end of life/palliative care that includes the utilisation by WMAS;
- to extend the palliative care service to a 7 day service;
- the specialist community palliative care team is now providing further community capacity to intervene early, prevent unnecessary admissions and facilitate preferred place of care for patients.

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

**xv) Community respiratory service –** a community based service is now in place. Each locality has a named community respiratory nurse linked to the MDTs and palliative care nurses. Palliative care MDTs for patients with advanced respiratory disease and on the palliative care register forms part of this model.

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

**xvii) Neurology -** the community neurology team are now linking into practice MDTs to support the management of patients with complex neurological conditions. Further work has taken place in relation to Acquired Brain Injury; muscular dystrophy, palliative care needs and advanced dementia.

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

**xix) Our Better Care Fund Plan**

This is consistent with the development of our MCP service model, designed to reduce emergency admissions as part of our overall approach to resilience planning 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 key elements of our BCF Plan for 2016/17 will be schemes relating to: -

- delayed transfers of care and an integrated discharge pathway;
- services to support car homes;
- falls;

- support to carers.

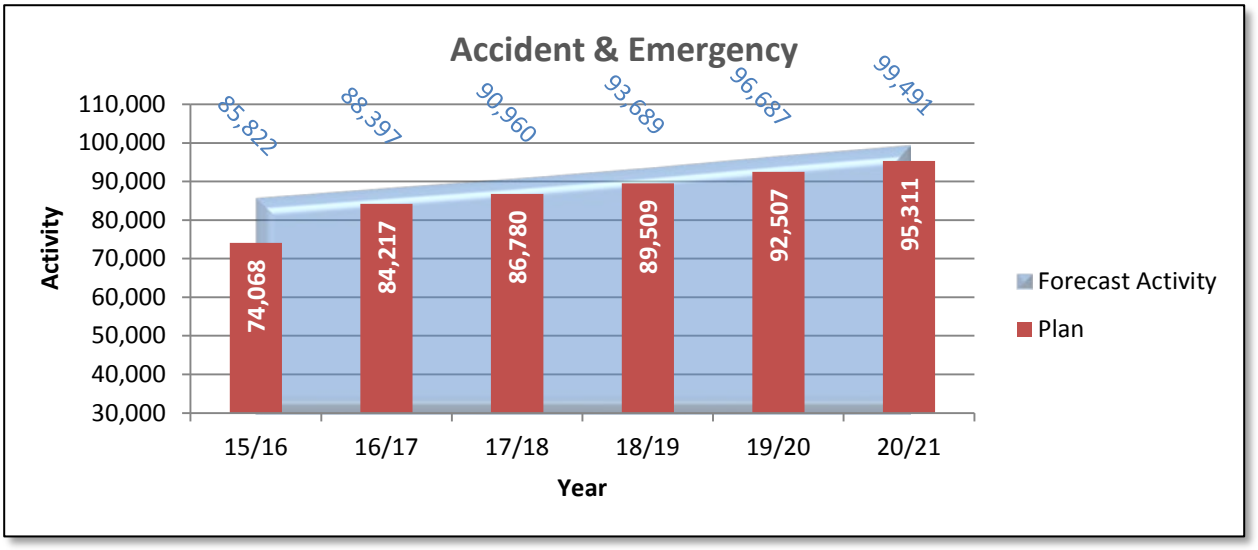
In terms of the key performance metrics:-

- service efficiencies will provide the recurrent investment for the rapid response service and the GP leadership role for the over 75s;
- emergency admissions to reduce by 15% in financial terms by 2018/19;
- Avoidable admissions will reduce by 129 from 8,142 (2,596/100,000 population) in 2012/13 to 8,278 (2,530/100,000 population) in 2014/15;
- delayed days in hospital will reduce by 600 days in 2014/15 and by a further 636 days in 2015/16;
- people still at home 91 days after discharge to reablement will increase by 12 people in 2014/15 and a further 11 in 2015/16;
- the number of new admissions to nursing homes will reduce by 32 in 2014/15 and by a further 36 in 2014/15 and 2015/16.

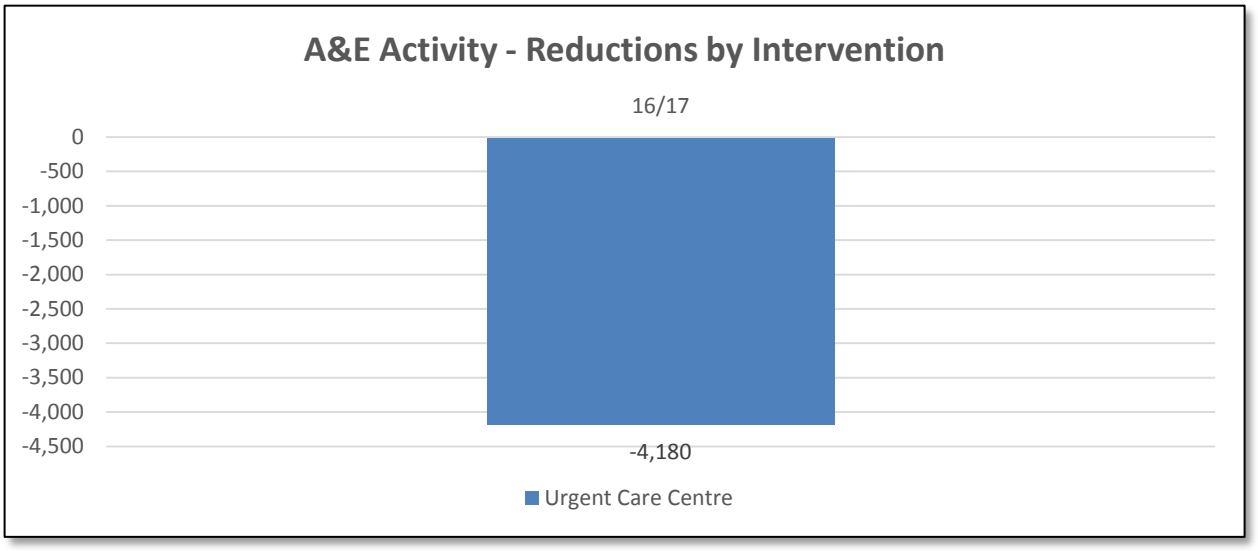
Our agreed contract with Dudley Group NHS Foundation Trust for 2016/17 is constructed on the basis of the required reduction in emergency activity from the BCF.

**g) Access to Highest Quality Urgent and Emergency Care**

- a reduction in ED attendances by 2016/17 resulting from a redesigned urgent care system and the rapid response team.
- delivery of the Urgent Care Centre (UCC). Co-located within ED, the UCC streams all presenting ambulatory patients to ED or the UCC for primary care assessment and treatment.
- a reduction in emergency admissions of 100 cases from the new GP respite pathway.




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

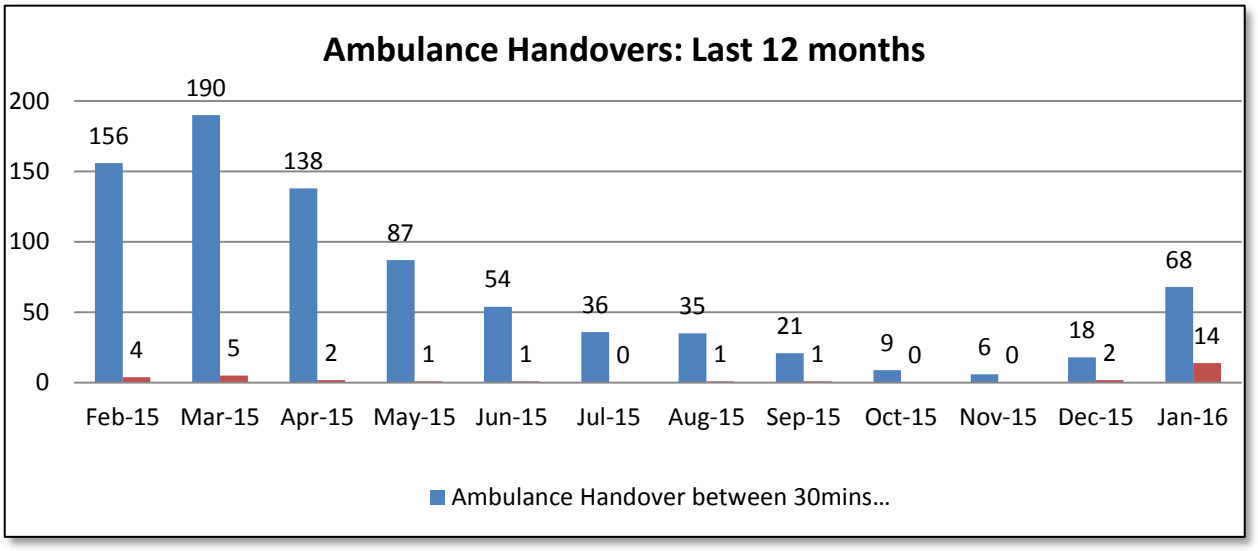



The graph above demonstrates the interventions and the respective impact required to achieve the planned reductions in ED Activity.

### i) A new urgent care model

The new urgent care system for Dudley is now in place, following extensive patient and public engagement and successful mobilisation on 1 April 2015. Dudley urgent care system currently meets all national recommendations and performance measures for urgent and emergency care. Furthermore, whilst there has been some recent deterioration in performance, Dudley Group NHS Foundation Trust is now one of England's strongest performers against the ED four hour wait standard.

Performance in terms of ambulance handovers improved during the latter part of 2015/16 following an intensive piece of work led by the Urgent Care Working Group. This did deteriorate during January when the system was under a high level of pressure. Focus on this performance will be maintained in 2016/17.




The new service model was informed and developed following extensive patient and stakeholder engagement and is in line with the outcome of the national urgent and

emergency care review. Key features of this engagement and as a result core aspects of the current urgent care system in Dudley are:-

- improved access to primary care – patients preferred to see their own GP;
- a simplified approach to access without confusing multiple entry points;
- patients being able to access urgent care 24 hours a day 7 days a week, 365 days a year.

Particular priorities for 2016/17 include:-

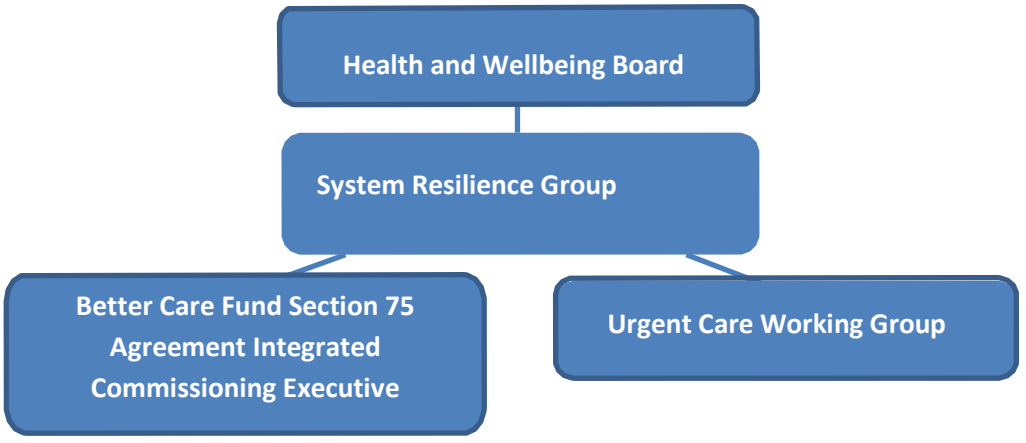
- addressing issues in relation to delayed transfers of care;
- ensuring "see and treat" and " hear and treat" are reflected in our ambulance service specifications;
- remodeling the UCC and ED estate to facilitate the more effective management of patients as they present, including those with mental health needs;
- continuing to address ambulance handover performance;
- commissioning a 24 hour access and assessment service for patinets with mental health problems.

We will continue to work with local partners to enhance and strengthen the pathways of care available within the UCC for presenting patients. The CCG will also work with neighboring health economies and NHS England to implement emerging and future proposals for urgent and emergency care system reconfiguration across the Black Country.

We will continue to work with our partner CCGs across the West Midlands to reconfigure hyper acute stroke services. Until such time as this work is concluded, our planning assumption is that there will be no change to local service provision.

### ii) System resilience

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



The Urgent Care Working Group (UCWG) co-ordinates performance improvement, system redesign and surge and escalation planning for the urgent care system. Throughout 2015/16 the UCWG oversaw the commissioning a number of schemes to increase capacity within the system and ensure Winter resilience. These included:-

- refining the community rapid response service as part of our integrated services model to reduce the number of patients going to ED;
- implementing a discharge to assess model to improve discharges from secondary care;
- enhancing the level of support available to patients with mental health problems at times of crisis; and
- using an agreed model to manage the number of supported and unsupported discharges destined for health or social care, together with an integrated community bed management system.

Alongside these system changes a number of schemes that have been developed to manage demand and facilitate discharge during 2015/16 will be considered for further funding in 2016/17. These schemes are currently under review by the UCWG and a recommendation for further funding will be made to the System Resilience Group in April 2016. The SRG will invest recurrently in those initiatives which are demonstrably effective. This investment will be contained within the SRG recurrent allocation for 2016/17 of £2,015,000.

| **SRG Schemes 2015/16** | **Provider** | **£** |
|---|---|---|
| Frail Elderly Assessment Unit | DGH | £259,600 |
| Care Home Select | DGH | £150,000 |
| Red Cross PTS | DGH | £240,000 |
| Weekend Discharge | DGH | £216,000 |
| 7 Day Streaming is SAU | DGH | £31,200 |
| **SRG Scheme** | **Provider** | |
| Social Care Urgent Response Service | DMBC | £280,000 |
| Falls First Response Service | DMBC | £262,000 |
| **SRG Scheme** | **Provider** | |
| Mental Health Car | WMAS | £53,690 |
| **SRG Scheme** | **Provider** | |
| Mental Health Urgent Care Centre | DWMH | £334,049 |
| Psychiatric Liaison Service | DWMH | £212,050 |
| **Total** | | **£2,038,589** |

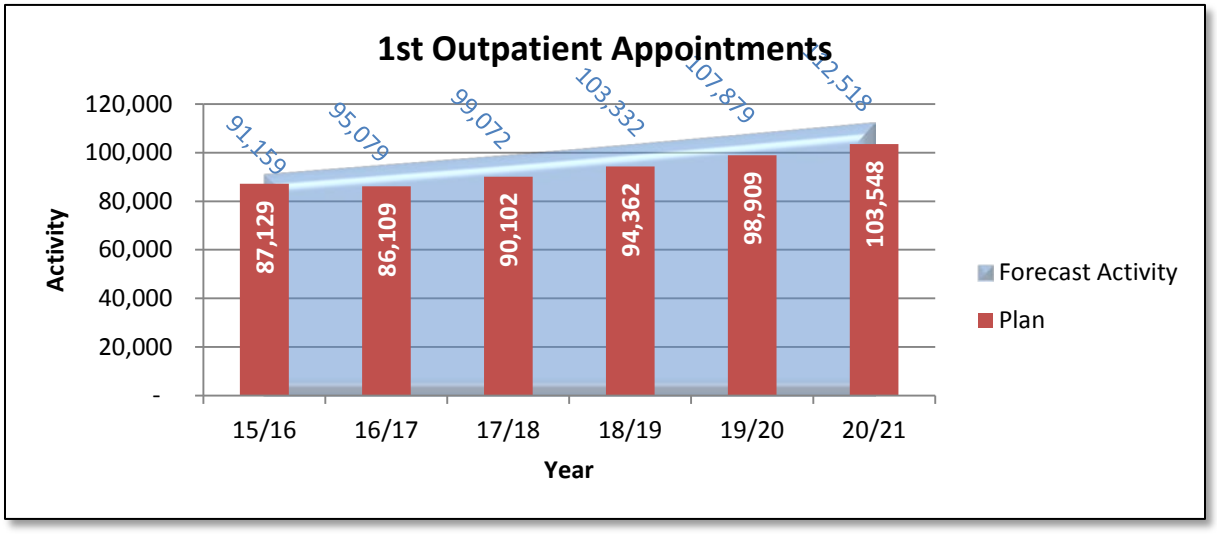
Our expectation is that by continuing to implement the schemes which pass the 2015/16 year-end confirm and challenge process, the current emergency four hour wait performance target will continue to be met.

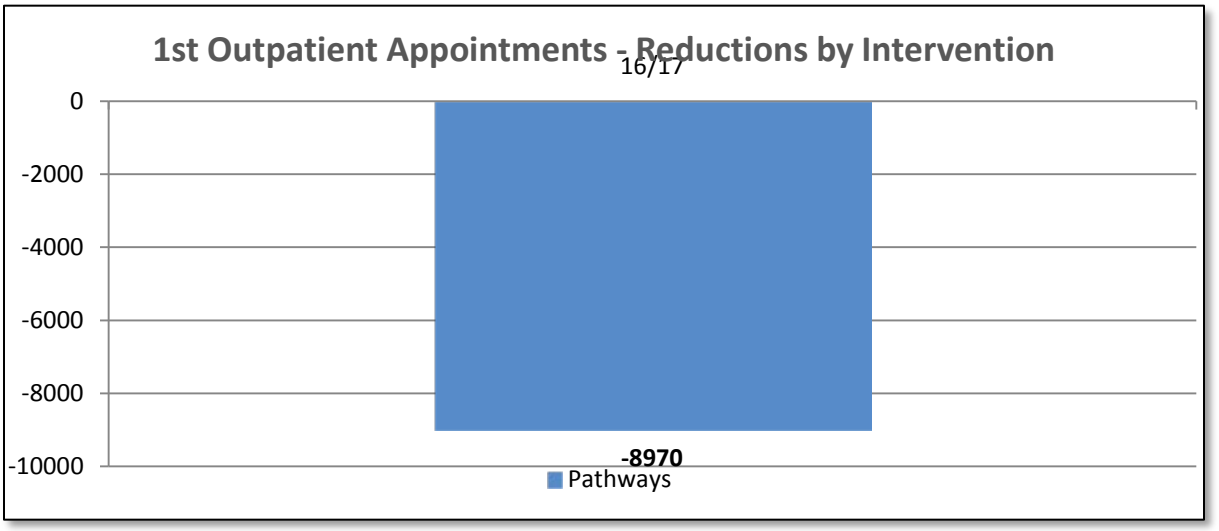
In addition in 2016/17 we will:-

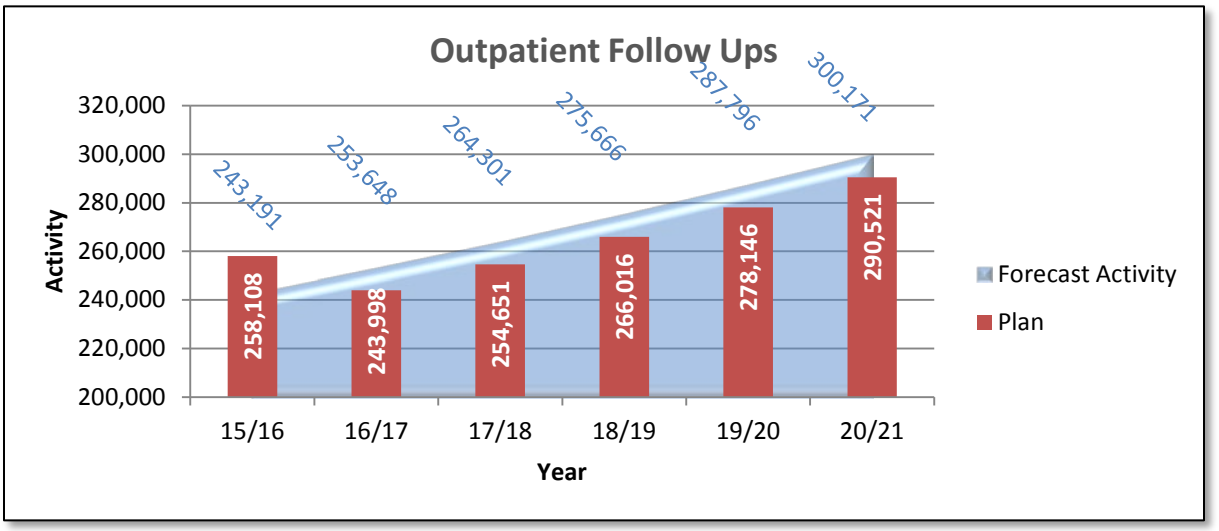
- review the pathways and charging arrangements for the various admission avoidance and assessment units currently linked to the Acute Trust unplanned care pathway;
- re-commission the NHS 111 service by July 2016.

### h) A Step Change in Productivity of Elective Care

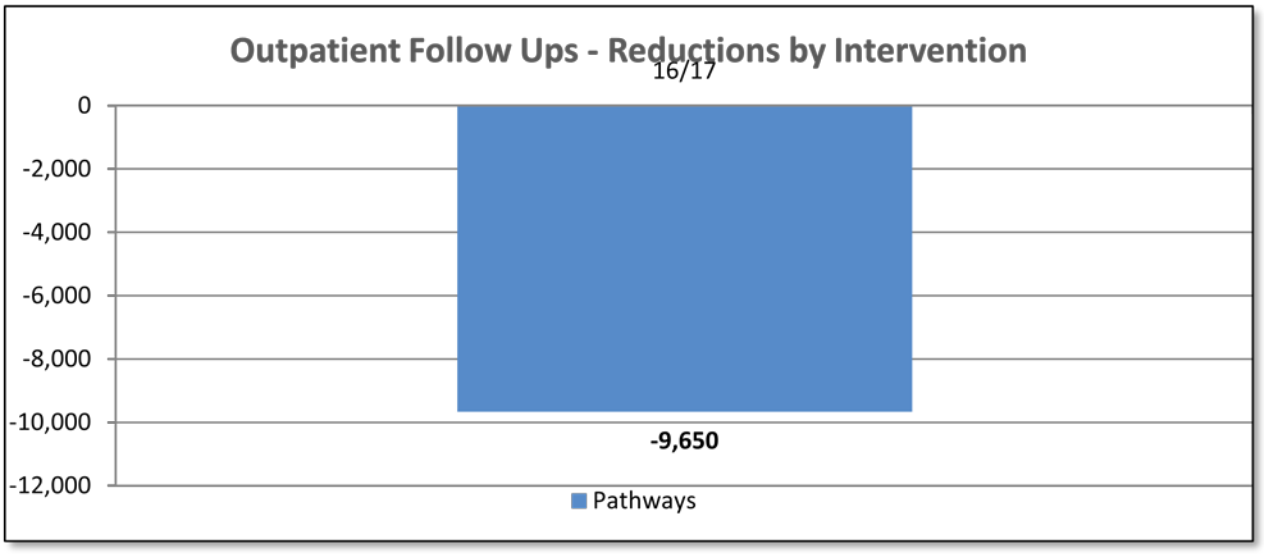
- To be met by a 20% reduction over 5 years, whilst countering a potential £100,000 cost increase, due to demographic change, per year.
- Outpatient follow up attendances to reduce by 8929 by 2017/18.
- Advice and Guidance and Triage to be introduced across all appropriate specialties at the point of referral.
- The introduction of Advice and Guidance and Triage will begin to significantly reduce the need for Outpatient Appointments. As a result, patients who do require such appointments will be seen more quickly.
- Referrals which no longer require an outpatient appointment will be returned to General Practice with a management plan to support management in primary care.



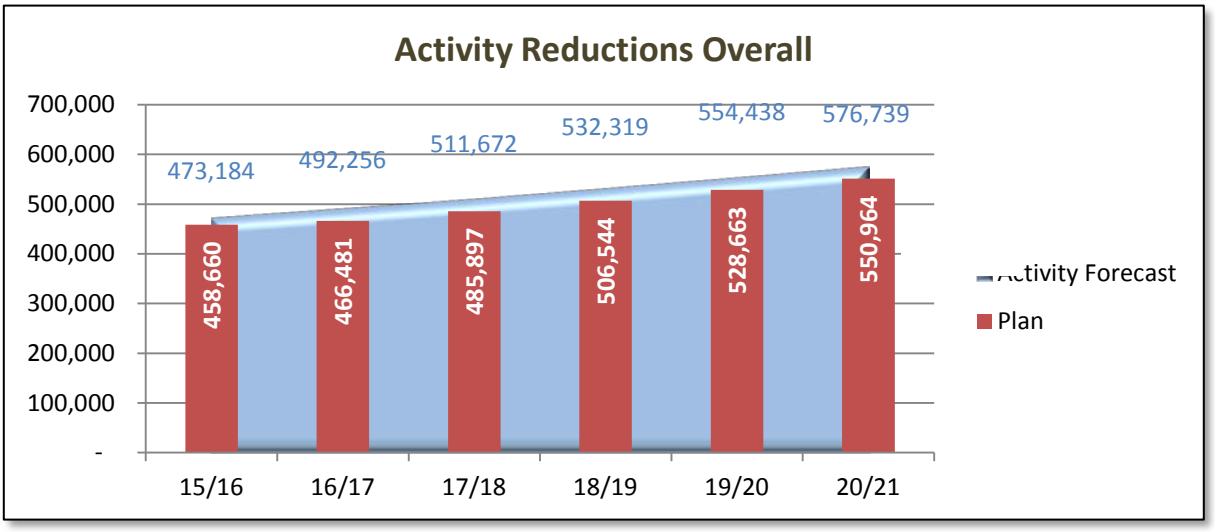


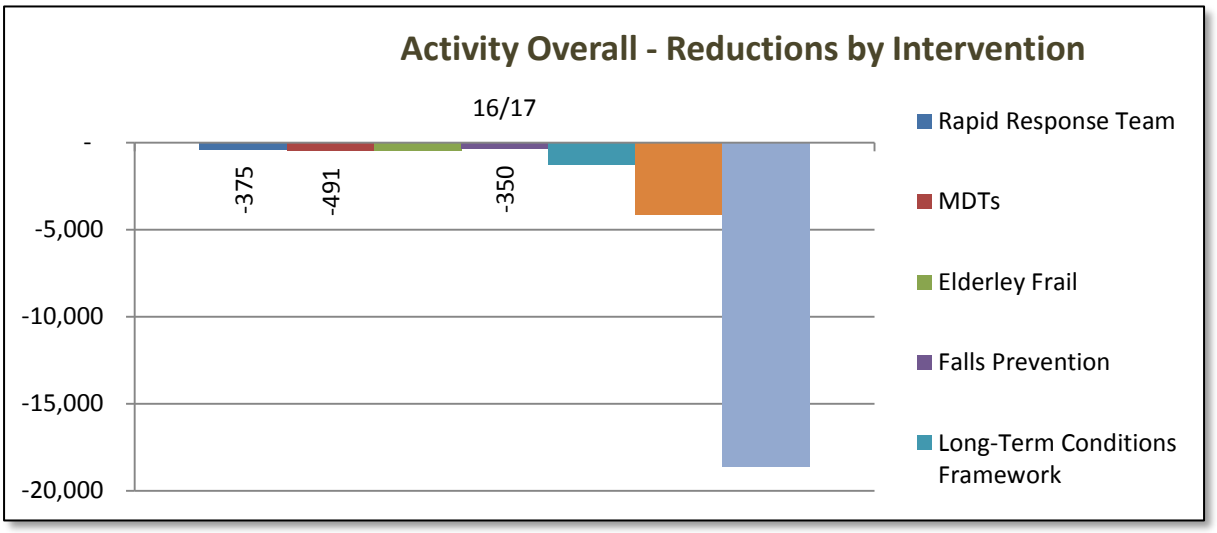




The graph above shows the planned reduction of Elective Activity against the backdrop of predicted activity growth due to changes in demography.




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






Planned care represents our largest area of spend. However, there is a significant variation both between services and between providers in the number of steps that a person may go through in the course of treatment. We will expect each provider to determine how they will improve the efficiency of the services they provide.

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

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

**i) Pathway efficiency**

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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.

In particular, we will:-

- extend access to "advice and guidance" services for GPs across all elective pathways to reduce outpatient attendances;
- work with Dudley Group Foundation Trust to deliver a robust triage service to ensure that outpatient appointments are provided to those that need them;
- ensure that 100% of referrals take place using the NHS e-Referral service;
- establish redesigned services across four key specialties:

ENT

- a more efficiently managed ear pathway for patients and to increase nurse-led follow ups

MSK

- reduce the number of inappropriate referrals to secondary care through use of the Orthopaedic Assessment Service
- permit direct referral by the service to other specialties;
- provide non-specialist management of Fibromyalgia in primary care;
- take the methotrexate and blood monitoring services out into primary care, where the majority of such patients already receive their treatment in primary care.

Ophthalmology

- introduce Consultant-led Triage of all new referrals into Ophthalmology
- introduce Optometrist sessions for low-complexity

Urology

- introduce an Advice and Guidance service to reduce outpatient appointments and free up consultant time for more complex patients and those on the RTT waiting lists.

**i) Specialised Services Concentrated in Centres of Excellence**

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

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

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

- historically specialised services account for £12.2 billion per annum of the NHS allocation. Historically, the growth in cost exceeds other parts of healthcare by as much as 4% per annum. Planning to look at how we work together with NHS England to review and achieve better value for money and improved quality is a key priority. Specialised services will be developing a robust QIPP challenge of its own and the CCG will need to work with NHS England to understand the QIPP agenda on the local health economy;

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

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

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

- identification of opportunities for joint planning and development of care across the whole patient pathway within local plans. Supporting the need for change within an agreed case for change;

- close contract management arrangements with specialised commissioners for providers;

- supporting the development of the local service priorities and/or reconfigurations currently being considered by the Area Team which include camhs tier 4, cancer services, cardiology, paediatric intensive care and high dependency services and neuro-rehabilitation services.

## 10. Innovation

The CCG is strongly committed to supporting and championing innovation at all levels within the organisation. The Chair and Chief Accountable Officer take personal responsibility for ensuring that this process is reflected in our commissioning plans. A GP Board Member has specific responsibility for innovation

and research and in addition the CCG has a designated management lead for research and innovation along with an appointed Clinical Lead for Research. Therefore a strong disseminated leadership promotes innovation throughout the membership of the CCG.

This disseminated innovation has supported:-

- the development of our community rapid response service;
- measuring individual consultant performance and pathway variance;
- having one IT system for all 46 GP practices;
- using the PSIAMS system to understand the holistic commissioning impact from the patient perspective;
- the development of a new integrated performance and analytics platform
- the development of new and user friendly methods for patient feedback on services and interventions.

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

The CCG is committed to utilise and promote the principle that commissioning health services, delivering services and individual patient care are based on best evidence, underpinned by high quality evidence based research.

Professionals within the CCG are expected to hold differing levels of evidence, knowledge and information (dependable on role) to translate and disseminate research and innovation in to practice. Accessing and facilitating appraisal of evidence to support and inform commissioning decisions will be a crucial element. A systematic method of promoting a culture where commissioning decisions are based on evidence will involve the engagement with NICE, PHO, Collaborations for Leadership in Applied Health Research and Care (CLAHRCs) and use of approved research databases. Links with local Higher Educational Institutions (HEIs) , Royal Colleges and other relevant bodies, for example the Academic Health Science Network (ASHN) will be strengthened to support knowledge transfer, the translation of research into practice and rapid implementation of evidence based improvement. Local clinical networks will also be utilised to provide local insights and nurture a

culture of being more research aware to support the use of evidence for clinical improvement and to inform commissioning plans.

The CCG is committed to promoting research, service evaluation and innovation when addressing the healthcare priorities of the population in Dudley to ensure commissioning decisions are based on best available evidence. The CCG recognises that maximising the quality and effectiveness of patient care is best realised through a strategic approach in taking part, attracting and funding research studies that best match the population characteristics in Dudley as well as working towards attracting more high quality commercial studies into this area. Maximising the benefits of research through innovation, income, knowledge improvement are key to improving patient/public outcomes.

## 11. Effective Information Management

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

- enhancements to better enable integrated working within MDTs;
- continuing the creation and implementation of a single view of patient records;
- greater use of existing and introduction of new Enterprise working capabilities within EMIS Web;
- expansion of mobile technology, particularly for our integrated MDTs and GPs to enable remote access to clinical records;
- remote monitoring systems – for heart failure and COPD;
- risk stratification – evaluating the use of other tools including SAS;
- development of applications and infrastructure to support the Single Patient Portal to include primary care, MCP services,111, telehealth and telecare;
- implementation of Wifi in GP practices;
- continued investment in technology refresh in GP practices to maximise performance and service delivery;
- continued development and implementation of EMIS templates, pathways and concepts to maximise consistency and enhance data quality;
- to commission electronic patient care records system for end of life/palliative care that includes the utilisation by WMAS;
- co-ordinate the creation of a digital roadmap to deliver a service that is paper free at the point of care across the Dudley care economy;
- promote the use of Patient online services.

## 12. Governance and Performance

Our commissioning intentions were approved by our Board and shared with our partners in Autumn 2015. Outline planning requirements were shared with the CCG Board and the Health and Wellbeing Board in January 2015.

Key issues already identified in our commissioning intentions will be addressed in our contracts with our main providers.

Our draft plan will be considered by the CCG Board on 10 March 2016. Our final plan will be considered by the CCG Board on 31 March 2016.

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 commissioning – implementation of our primary care development strategy and commissioning intentions;
- 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;
- finance and performance – our financial and QIPP plan and key performance metrics.

We have developed a comprehensive set of performance metrics, linked to a logic model to support the implementation of our new care model. This is overseen by our Partnership Board.

We have a separate but related set of metrics that support the Better Care Fund, reflected in our Section 75 Agreement and overseen by the Integrated Commissioning Executive.

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 commissioning, and finance and performance committees.

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

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

performance reported to our stakeholders through:-

- our Health Care Forum, Patient Participation Groups and Patient Opportunity Panel;
- our GP Membership meetings and the development of our mutuality model;
- our GP locality meetings – particularly in relation to the delivery of our integrated care model;
- Health watch – who we will encourage to act as a "critical friend" in the development of future plans;
  Our NHS, local government and voluntary and community sector partners through the System Resilience Group;
- the Health Overview and Scrutiny Committee;
- 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 care. As described above this will be characterised by locality teams led by GPs, acting as the main mechanism for providing responsive services, capable of enabling people to live independently in strong communities, providing a real alternative to hospital admission. These teams will operate on the basis of distributed leadership, where accountability will be at its strongest within the team itself and performance reported regularly to our GP locality meetings.

## 13. Deliverability

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

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

The development of our primary care system, through the implementation of our delegated commissioning responsibilities, 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 continue to develop our single IT platform for primary care, capable of developing the capacity to intervene systematically to manage a practice population and link with other systems as part of the integrated response process.

We will refresh our programme management functions to deliver this plan, our STP and our new care model to plan and on-budget.

In addition, we will ensure we get the highest quality and best value from our corporate support structures. We will review the range of services we commission from our CSU and ensure we have a management infrastructure that is fit for purpose. This may bring new corporate support providers into Dudley in addition to the external support we currently commission, including support on organisational development, governance, patient experience and primary care. We believe this is the most appropriate model to deliver our aim to continue to innovate and support the delivery of the best services possible to the population of Dudley.

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

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

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

We are committed to being a “healthy board”. We have concluded a comprehensive review of our governance processes and behaviours by the Good Governance Institute and will implement our action plan to refresh our governance arrangements.

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

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

| JSNA | Outcome Ambition | Initiative |
|---|---|---|
| Gap in life expectancy for the least and most deprived areas of Dudley has widened mostly due to chd, copd and lung cancer in men. | Securing additional years of life<br><br>3.5% reduction in potential years of life lost per annum from 2087/100,000 in 2012/13 to 1875.4/100,000 in 2015/16 | • Systematic management of long term conditions<br>• Prescribing for heart disease<br>• Prescribing for cholesterol<br>• Smoking cessation<br>• Weight management<br>• Sport and physical activity action plan<br>• Diabetes LES and diabetes control |
| Nearly one fifth of 40-59 year olds are living with a long term limiting illness | Improving the quality of life for people with long term conditions.<br><br>Average EQ-5D score for people with one or more long term condition to increase by 1.6% from 70/100 people in 2012/13 to 71.6/100 in 2015/16. | • Responsive IAPT services<br>• Diagnosing and responding to dementia<br>• Diagnosing hypertension<br>• Vascular checks<br>• Improved recording in disease registers for heart failure, hypertension and kidney disease<br>• Community based respiratory service<br>• Community based pain service<br>• COPD LES review<br>• Revised diabetes LES<br>• Community diabetes team |
| The rate of delayed discharges attributable to social care is higher than the national rate | Reducing time spent in hospital through more integrated care<br><br>Avoidable emergency admissions to reduce from 8,142 (2,596/100,000 population) in 2012/13 to 8,013 (2,530/100,000) in 2015/16 | • Rapid Response Team<br>• Redesigned virtual ward<br>• Care home CPN<br>• 7 day services<br>• Community respiratory, diabetes and anti-coagulation services<br>• Enhanced telehealth and telecare<br>• Community pain, dermatology and ophthalmology services |
| 20% of single person households are in the 60+ age range | Increasing the proportion of people living independently at home<br><br>People still at home 91 days after discharge to increase by 4% from 86% | • Integrated locality services<br>• Rapid Response Team<br>• Social prescribing scheme<br>• Locality link workers |

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

## GLOSSARY

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

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

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

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| **Agenda item no: 8**<br>**Enclosure no:** | |

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| **Meeting:** | Dudley MBC Scrutiny Committee |

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|---|---|
| **Date:** | 24th March 2016 |

| | |
|---|---|
| **Title:** | Quality Report BCPFT – Health Visiting Update |

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|---|---|
| **Presented by:** | Cheryl Newton |

| | |
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| **Prepared by:** | Cheryl Newton, Vicky Lazaravich, Joy Williams |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Purpose:** | Information | √ | Discussion | √ | Recommendation | | Approval | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Linked to risk register:** | No | √ | Yes | | Datix No: | | H/M/L |

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|---|---|---|---|
| **Additional resources required:** | Yes | √ | No |

This report covers (tick √ all that apply):

| **Strategic objectives:** | |
|---|---|
| We will nurture a culture which provides: **safe, effective, caring, responsive and well led services**. | √ |
| We will **involve and listen** to patients, carers and family's **experience to continually improve services** we provide. | √ |
| We will be a **leading provider** of specialist mental health, learning disability and children's services, proactively seeking opportunities to develop our services, **building partnerships** with others, to **strengthen and expand** the services we provide. | √ |
| Attract and retain well-trained, diverse, flexible, **empowered and valued** workforce. | √ |
| Resources will be used effectively, **innovatively** and in a **sustainable** manner. | √ |

| **Evidences compliance to:** | | | | | | |
|---|---|---|---|---|---|---|
| Health & Safety Executive | | | | | | |
| Care Quality Commission | Safe | √ | Caring | √ | Responsive | √ |
| | Effective | √ | Well Led | | | √ |

| **Have impact assessments been completed for this report / strategy?** | |
|---|---|
| Quality Impact Assessment n/a | Equality Impact Assessment n/a |

| Number of pages in Document | | Number of Appendices | |
|---|---|---|---|

## Executive Summary

Black Country Partnership NHS Foundation Trust (BCPFT) provides healthcare services for people of all ages across the Metropolitan Boroughs of Dudley, Sandwell, Walsall and the City of Wolverhampton and serves a population of 1.3 million people.

BCPFT provides community healthcare services for children, young people and families within Dudley inclusive of Health Visiting and Family Nurse Partnership (FNP).

Health Visiting and FNP are responsible for leading delivery of the Healthy Child Programme (HCP) referring to wider preschool services for additional support to provide early intervention where necessary in order to support the child and their family to achieve best outcomes for their child's welfare from an emotional, health and social perspective. This also includes referral to Social Care where safeguarding concerns are identified again utilising an early intervention approach.

Health Visitors are identified as key to leading delivery of the HCP with a public nursing background and knowledge they have a registered population of children from pregnancy to five years, they know how the health system works, and bring knowledge and understanding of child and family health and wellbeing, and skills in working with individuals and communities.,

Health Visiting and FNP offer appointments and interventions in a variety of settings inclusive of family homes, children's centres, health centres etc, due to the demographic of the FNP families, visits may also occur at at venues of specific client choice inclusive of cafes, schools etc subject to assessment of suitability to facilitate client confidentiality in order to agenda match with the service user. Both services aim to be as flexible as possible in order to meet child and family needs in offering an accessible service.

The commissioning responsibilities for Health Visiting and FNP transferred from Public Health England to Dudley MBC during October 2015. This report outlines the mandated offer required for Health Visiting and FNP and provides an update in relation to key performance indicators and achievement against these.

## Mandated Offer

The national service specification for Health Visiting and FNP (2015/16) requires delivery of the Healthy Child Programme with 5 mandated contacts within the service offer, this consists of following, antenatal contact, 10-14 days new birth visit contact , 6-8 week review, 12 month holistic health, emotional and developmental review, 2-2.5 year holistic health, emotional and developmental review to assess school readiness.

There are 4 levels of health visiting service offer with:

- Community – available to all
- Universal – available to all
- Universal Plus (UP) – families can access timely, expert advice from a health visitor when they need it on specific issues such as postnatal depression.
- Universal Partnership Plus (UPP) – health visitors provide ongoing support, playing a key role in bringing together relevant local services, to help families with continuing complex needs, for example where a child has a long-term condition.

The FNP program is an enhanced intensive safeguarding programme consisting of weekly and alternate weekly contacts and is offered to first time mothers aged 19 years and younger and has been evidenced to provide effective support in relation to safeguarding and school readiness. The FNP programme delivers an antenatal programme and the Healthy Child Programme as listed above until the child reaches their second birthday at which point the child and family are transferred into universal Health Visiting services.

**Performance Indicators**

Key Performance Indicators (KPI's) against the national health visiting specification in relation to the HCP is robustly monitored, quarterly reports are submitted to the 0-5 programme and FNP boards with detailed exception reporting where there is a reduction in performance against KPI's and licence (FNP). For Health Visiting data is collated manually presently with each Team Leader being responsible for their cluster teams data collection this facilitates local ownership of delivery against the KPI's moving forwards electronic data collection will facilitate a less resource intensive approach to data collation. The table below details achievements against the required KPI's.

**Fig 1.KPI's**

| Quality Requirement | Threshold | Method of measurement | Q1 | Q2 | Q3 |
|---|---|---|---|---|---|
| Mothers receiving antenatal visit | 50% | Mothers who received a first face-to-face antenatal contact with a health visitor at 28 weeks or above | | | 64.3% |
| % New birth visits < 14 days | 95% | | 93% | 95% | 95% |
| % 6-8 week | 95% | Percentage of | 96% | 97% | 97% |

| | | | | | |
|---|---|---|---|---|---|
| Review | | children who received a 6-8 week review by the time they were 8 weeks | | | |
| Percentage of children who received a 12 month review by 12 months | 95% | Total number of children who turned 12 months in the quarter, who received a 12 month review by the age of 12 months | 92% | 92% | 95% |
| Percentage of children who receive a 2-2.5 year review | 95% | Total number of children who turned 2-2.5 years in the quarter, who received a 2-2.5 year, by the age of 2-2.5 years of age. | 94% | 93% | 97% |

**Registrant to Resident**

The requirement to move health visiting caseloads from GP registrant to resident within Dudley ( R to R)required significant resource and management, in order to ensure adequate safeguarding and quality assurance.

This process commenced in September 2015 with a total of 730 children being transferred out and 1000 transferred onto caseload, these consisted of the following fig 2.

**Fig 2. R to R transfer.**

| HCP Offer | Number of Children transferred out | Number of Children transferred in |
|---|---|---|
| **Universal** | **700** | **950** |
| **Universal Partnership Plus** | **30** | **51** |

The health visiting teams are awaiting a further 100 records to be transferred into caseload, Child Health are supporting the service with this. R to R transfer resulted in a number of children being 'transferred in' to Dudley who had not achieved mandated elements of the HCP particularly 12 month and 2 year review, details were included within exception reports provided for quarterly health visiting board.

**Service Delivery**

Health visiting services are offered across a variety of settings to include home visiting where appropriate and clinic locations, the venue for contacts will be made in collaboration with parents and carers. Alongside home visiting the service offers access to health visitors at health centres and clinics as detailed below:

**Fig 3. Health Visitor Clinics**

| **Locality** | **Frequency** | **Place** |
|---|---|---|
| Brierley Hill | Weekly<br><br>Monthly<br><br>Alternate weekly | Brierley Hill CC<br><br>Peters Hill CC<br><br>Bromley/Pensnett CC |
| Dudley North | Weekly | Ladies Walk Centre, Lower Gornal HC, The Greens HC, Coesley CC. |
| Dudley Central | Weekly<br><br>Monthly | Cross St HC, Central Clinic, Woodside CC, Netherton CC.<br><br>Priory CC |
| Halesowen | Weekly | Tenterfields CC, Olive Hill CC, Halesowen HC |
| Stourbridge | Weekly<br><br>Alternate weekly | Little Hands CC, Stourbridge CC, Hob Green CC, Butterfly CC<br><br>Lion Health Surgery |
| Quarry Bank | Weekly | Quarry Bank CC |
| Kingswinford | 2 per week<br><br>Weekly | Kingswinford HC<br><br>Wordsley HC |

Clinics are offered on various days and times across the localities, in addition to this there are two monthly evening clinics offered at Gornal Parent and Child Centre and Little Hands Children's Centre, parents are able to attend any of the clinics offered. The Health Visiting service provides a leaflet with all clinic times and venues detailed

and is available to download via the Health Visiting page on BCPFT's website. FNP is predominately a home visiting service,flexibility to suit the service user is maintained in order to maintain service user engagement.

**Service User Feedback**

A Health Visitor Facebook page was developed during 2015 to facilitate improved communication with families, regular posts regarding clinic times and health education messages are posted within this page as well as information regarding events such as the FNP Christmas event.

The service also seeks feedback via the ' friends and family' questionnaire, parents/carers are offered the opportunity to complete this at the key HCP contacts, Specialist Nursing and Children's Additional needs services also offer service users the opportunity complete 'Friends and Family Questionnaires' on a regular basis, the responses from all services are collated by BCPFT patient experience team and shared through internal quality, safety and governance groups as well as the respective HV & FNP Boards and CCG led Clinical Quality Review Meetings(CQRM).

The Matron for Children's Services and Service Managers are working in collaboration with 'We love Carers' throughout 2016/17 to establish further mechanisms for feedback regarding all community services provided for children and families within Dudley and also Wolverhampton and Sandwell for Child Adolescent Mental Health services (CAMHs).

The Family Nurse Partnership team regularly receive feedback from service users throughout the delivery of the program and commissioned work during autumn 2015 with 'Changing our Lives' to assemble feedback and produce a report in relation to service users views of the service, the feedback was extremely positive. FNP have also included a service user interview panel as part of the recruitment process for family nurses which proved a positive experience for both the service users and service alike.

Care plans across all children's services are delivered with the 'voice of the child' in mind, the Children's Matron and service leads are continuing to develop mechanisms to evidence and monitor this through regular records auditing. Patient stories from across the Children's portfolio will be presented at Dudley CQRM through 2016/17 further enhancing the opportunity for feedback and demonstration of child focused care plans and 'voice of the child'. The FNP team provide the opportunity for a service user to feedback through attendance at each quarterly board and this has been embraced by the parents.

Following recent attendance at a BCPFT Board meeting an FNP service user has been invited to become a public governor to further enhance service user feedback and opportunity to engage service users in delivery of services.

**Transition of services to Local Authority Commissioning**

October 2015 saw the transition of Health Visiting and FNP to local authority commissioning, this transition has been positive due to the developed close working relationship between the services leads from BCPFT and Dudley Local Authority Public Health leads. Initial Q3 reporting suggests the transition has not resulted in any adverse impact upon service delivery with delivery against KPI's remaining positive.

All leads recognise the need and potential benefits for an integrated working model for service delivery and are working in partnership to further establish this through focused working groups, the services delivered through BCPFT will continue to monitor service user feedback during this time in order to identify positive feedback and areas for learning.

Agenda Item No. 9

**Health Scrutiny Committee 24th March 2016**

**Report from the Chief Executive Officer, Dudley Clinical Commissioning Group**

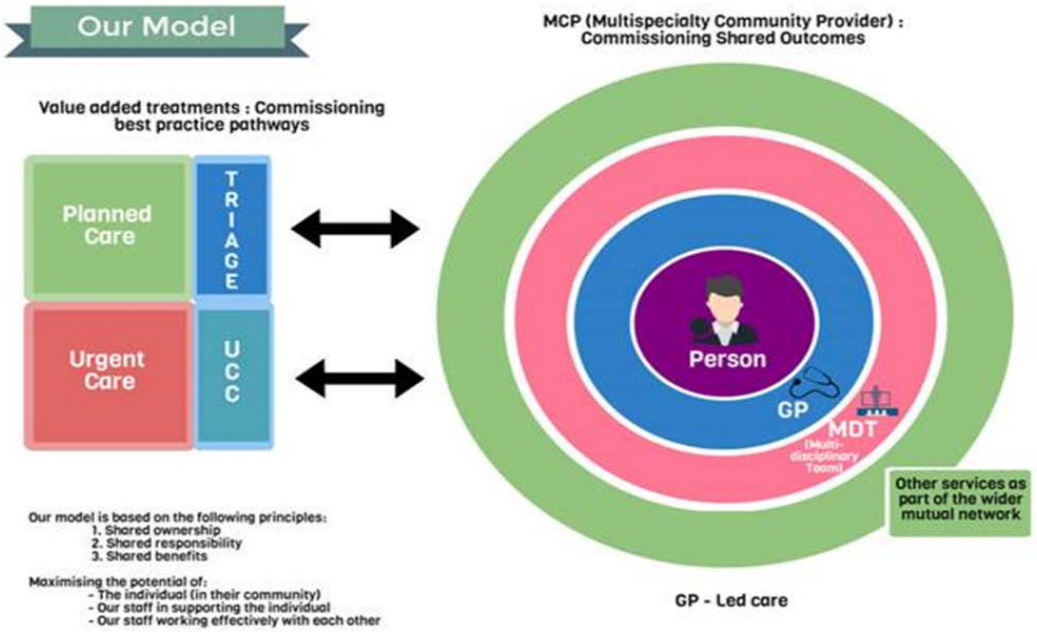
# Dudley New Model of Care (Vanguard) Programme Update

## 1. Purpose of Report

To provide an update on the Dudley New Model of Care (Vanguard) programme.

## 2. Background

Dudley CCG has been participating in the New Model of Care programme as an MCP Vanguard since March 2016. The MCP new model of care is a Multi Specialty Community Provider and our model of care puts the person, registered with their GP Practice, at the centre of the model. The services required are then wrapped around the person, working as one, to keep people safe and well as far as possible in their community setting. Our illustrative model is shown below:

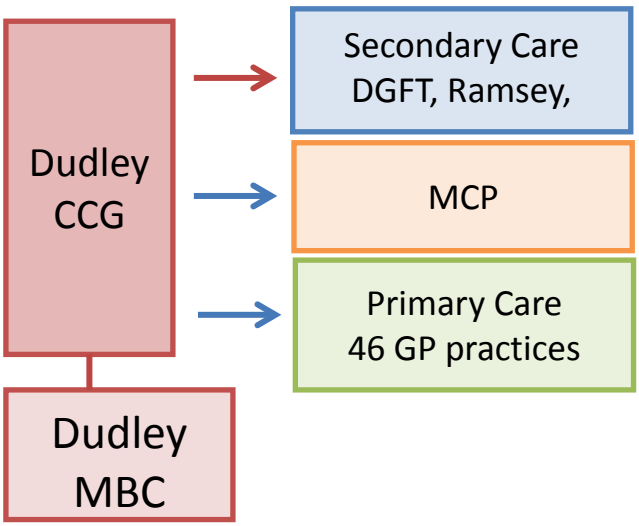


Partners involved in developing the Dudley MCP include:

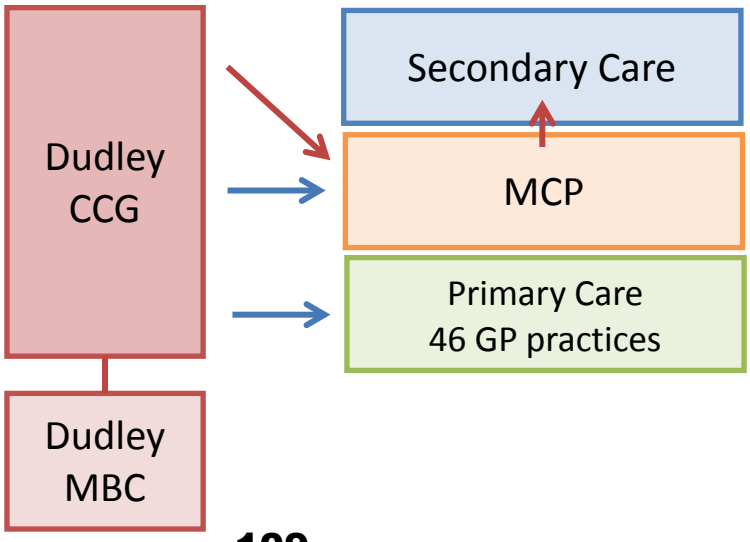
- Dudley CCG
- Dudley MBC
- Dudley Group NHS Foundation Trust
- Dudley & Walsall Mental Health Trust
- Black Country Partnership Foundation Trust
- Voluntary sector organisations

We are currently undergoing a mapping exercise which maps which services will sit either inside or outside of the MCP. This exercise is being undertaken co-operatively with providers and will be completed by the end of March 2016. Dudley CCG and Dudley MBC will be commissioning and contracting for the new MCP from April 2017. The next twelve months will therefore focus on the organisational form of the MCP (of which there are various choices), developing the contract for the MCP and continuing the work in the various workstreams to enable implementation.

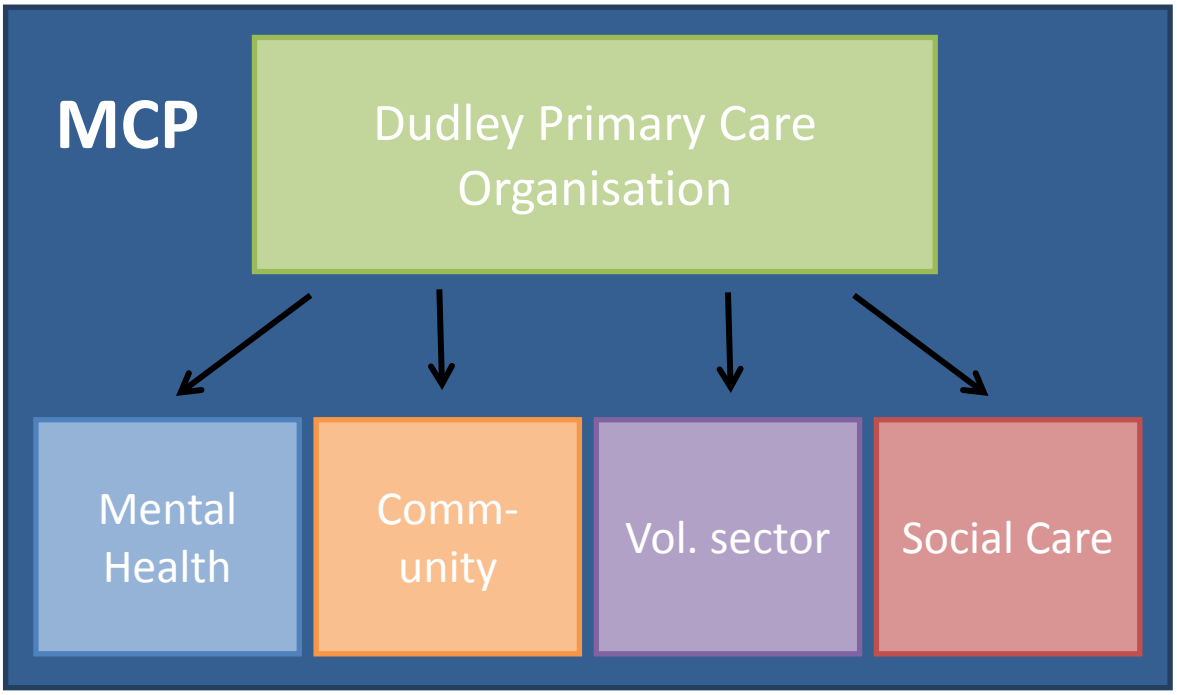
These are not exclusive, but the organisational form could take one the following options:




*A primary care-led MCP enables primary care to coordinate the work of community services but still maintain the independence of individual practices.*



*Risk-share on demand management of all activity gives further influence to primary care; flexibility over provision of all services; and access to greater resources.*




*In this version the primary care organisation holds the MCP contract and then subcontracts with the other organisations for their parts of the model of care.*


*In this version the different organisations form a joint partnership to create a new organisation which is the MCP.*

## 3. Engagement of our Public

### Public Involvement

This programme of work is grounded in the principles of clinical leadership and Public Involvement. We are talking to the public about our plans and to date there has been significant levels of involvement. This involvement has shaped the model and continues to inform the programme as people tell us what successful integrated care means for them.

The Partnership Board approved a Communications and Involvement Strategy in August 2015 which set out the arrangements for involving people in the new care model development.

- On-going Involvement

At the launch of the Five Year Forward View, Dudley CCG held a **Healthcare Forum** to talk with local communities around the publication. We wanted to know views on how people thought the plans could work with an opportunity to discuss challenges and opportunities. A graphic facilitator captured the conversation (appendix 1)

Since Dudley was selected to become a vanguard site, there have been a number of **engagement activities** which have all fed into the New Care Models work. These include a series of focus groups on Access to services and Long Term Conditions; these are diagrammatically expressed in Appendix 2.

A subsequent **Healthcare Forum** took place early December 2015 and approximately 80 participants took part in structured workshops around key work streams as part of the New Models of Care (NMC). Feedback was captured at every workshop and has been fed into the work streams.

At the end of January 2016, a Listening Exercise was launched, by the end of March we will have attended over 45 community groups including:

- All the Community Forums
- Several Patient Participation Group Meetings
- Dudley Women Labour Forum
- Rotary Club (Dudley)
- Young Health Researchers & Dudley Youth Council
- Stourbridge Township Council
- Access in Dudley
- Black Country Housing
- Dudley Carers Forum
- Dudley Mind

This has been an opportunity to talk about the New Care Model and to give participants the opportunity to share their views and opinions and help shape how we form better integrated health and social care. A doodle ad has also been produced for this exercise and promoted via social media.

In addition to supporting Dudley CCG listening events, Healthwatch Dudley is hosting a series of bespoke **Activate sessions** across Dudley borough. These events identify what being healthy, well and cared for means and what helps or hinders people. The sessions go on to explore how this understanding can unlock creativity and potential for everyone to think and work in different ways. Bringing people together helps everyone to think about the active roles that everyone can play. Healthwatch Dudley will collate evidence and learning from all of the listening that takes place into a research report that will be presented to the partnership Board in April.

With the New Care Models work progressing rapidly in Dudley, it seemed the right time to invite people to be part of a **New Care Model Participation Group** that could be focussed and involved specifically with the projects that fall under the New Care Model. We asked people to submit an Expression of Interest (EOI) if they wanted to be involved and were overwhelmed with 60+ responses. Around 25 of those turned up to our first meeting in February and we worked together to look at how the group could work and feel valued and how best to continue.

We are currently collecting information from everyone who submitted an EOI to build a picture and planning our next session for early April. We received some really positive feedback from the meeting and there was a real appetite to do something different and a passion to be involved in designing and co-producing patient pathways. We will be working with the CCG Commissioning team to see how best we can support coproduction of our model moving forwards.

**Commissioning Intentions**

Dudley CCG set out in its commissioning intentions the key elements of the new model of care. These intentions were published to the CCG website, distributed to libraries and referred to at the community forums offering the public a chance to comment on their contents. The questions included in the consultation were as follows:

- Do you feel we clearly explained our commissioning intentions for 2016- 2017?
- What are your views on our commissioning intentions?
- In your opinion, is the implementation of an integrated out of hospital system the best care solution for Dudley's most vulnerable patients?
- Do you have any particular comments or concerns about our commissioning intentions that you haven't covered, and what are these?
- After considering our intentions for 2016- 2017, is there anything you would like to share about what this will mean for you personally?

No negative comments were received in response to these. A full report of results was sent to the Head of Commissioning and the Chief Accountable officer at the end of the consultation.

**Formal Engagement**

As this report sets out, it is likely that we will start our contractual process following our CCG Board Meeting on the 17th July 2016, dependent upon the national process

for developing MCP contracts; to establish the MCP ready for April 2017.

We will be conducting a 4 week engagement exercise to inform the characteristic of the new Multi-Speciality Community Provider (MCP).

This will include a public meeting in each of our 5 localities, a website with feedback forms, a social media campaign to seek opinions and information to the general public via partner networks and Dudley GP surgeries.

All feedback will be presented to the CCG Board meeting in July 2016.

**Public Consultation**

Throughout 2016-17 we will formally consult on the relevant elements of the new care model which includes significant service change. For example, our commissioning intentions detail plans to scope a single number to contact for access to all appointment booking, this has formed part of our involvement to date and will require consultation on whether the public believe it is the right solution.

There are also likely to be changes to clinic locations as we move towards a community focused model of care. This could see some services relocating from the hospital to the community and consultation will take place on these changes.

We are already seeing consultations on practice branch closures as our Primary Care Services struggle to maintain the existing service over a number of locations. We will be consulting with the public on our estates strategy to see what they need from future health and care premises.

**Our Governance**

Our Partnership Board, which has been established for nearly 12 months, continues to meet on a monthly basis. The Partnership Board contains representation from all of the partners in the system (those organisations named at the beginning of section 4). In addition we have our New Care Models Implementation Group which oversees the work of the individual workstreams to enable the model.

Our governance arrangements will be reviewed over the next couple of months as separation begins between the commissioning and provision of this model of care. As a CCG and a lead MCP involved in writing the contract for this model of care, we have accessed legal advice on potential organisational forms and the procurement process that would need to be undertaken.

## 4. Financial Support

Our Value Proposition was submitted on 8th February to the national team. The Value Proposition is a document which details the investment required to enable implementation of the MCP model in Dudley. The proposition was developed in partnership with providers and contains detail on both qualitative and quantitative outcomes of the new model. The financial support requested is as follows:

**2016/17:** £8,770,424

**2017/18:** £10,408,951

We are expecting a decision on our Value Proposition for 2016/17 by the end of March 2016.

## Recommendation

It is recommended that Health Scrutiny Committee receives the report and notes the good progress being made

Note that the new model of care will need to be commissioned jointly by the CCG and Dudley MBC

For committee to recognise the extensive involvement work to date.

For the committee to approve the plan for engagement in June 2016 which will inform the characteristics of the new MCP.

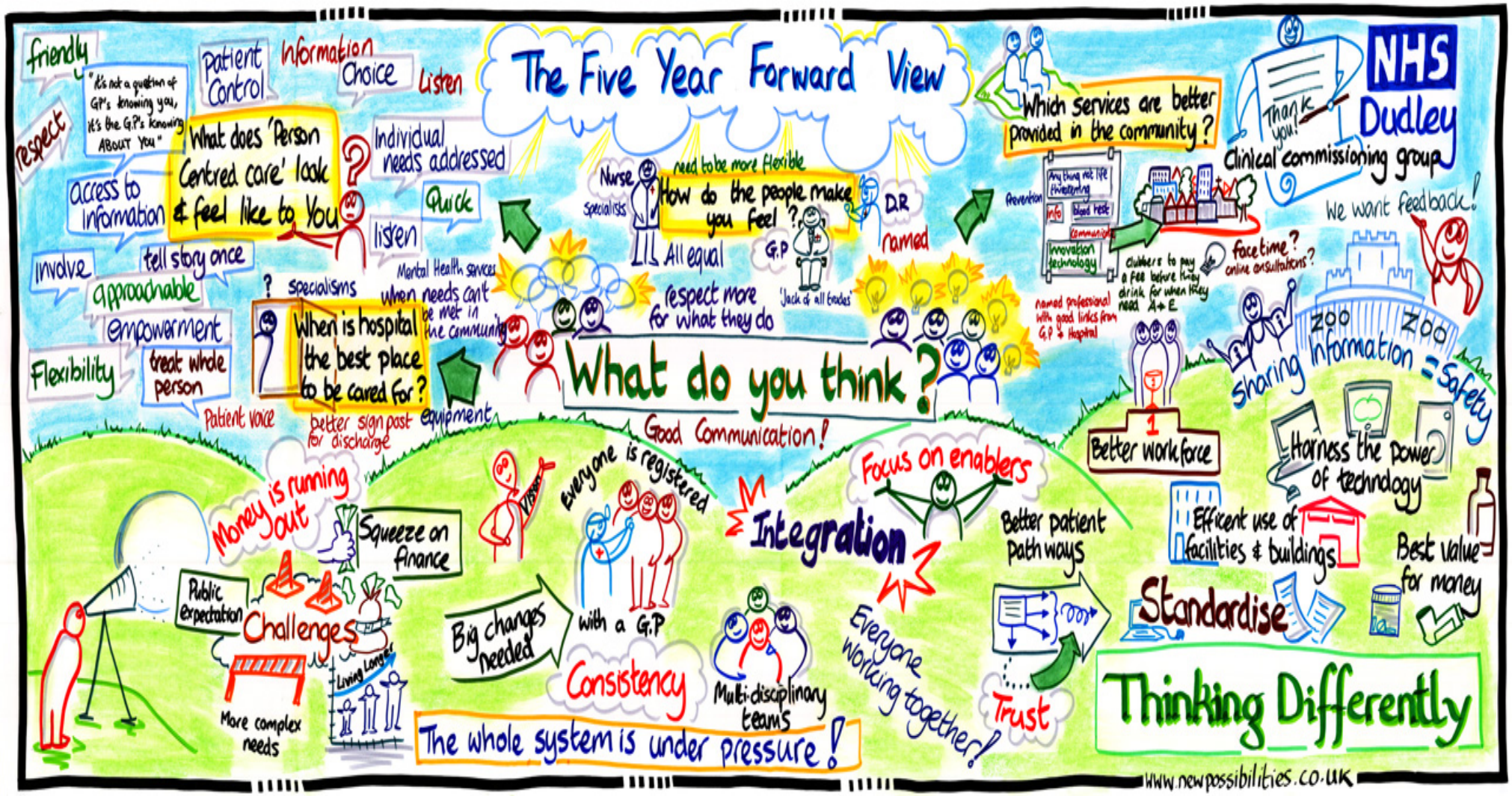
For the committee to be assured that any further significant service change will be consulted on.

……..

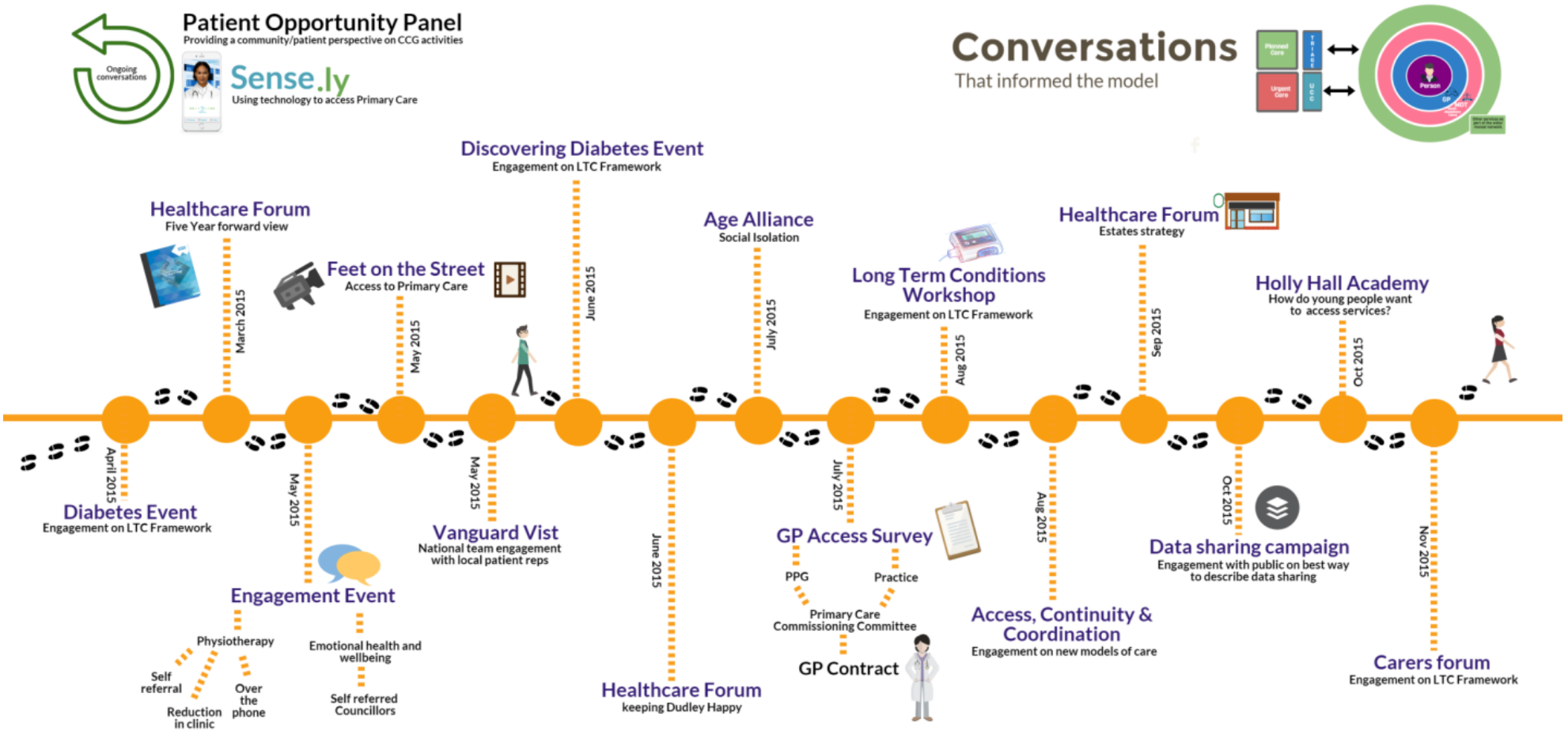
**Paul Maubach**
**Chief Officer, Dudley CCG**

Contact Officer: Stephanie Cartwright
Telephone: 01383 321789
Email: stephanie.cartwright@dudleyccg.nhs.uk

**Appendix 1**
**Feedback from Healthcare Forum March 2015**



**Appendix 2**
**Involvement 2015**



Agenda Item No. 10


# Quality Account 2015-16

# Contents Page

## Part 1



## Part 2



## Part 3

# Part 1 - Statement on Quality from the Chief Executive and Chairman

We are pleased to present the West Midlands Ambulance Service NHS Foundation Trust's Quality Report which reviews 2015-16 and sets out our priorities for 2016-17.

We pride ourselves on the quality of care that patients receive from our service, and quality remains at the forefront of everything we do. We Provide a high quality and responsive service, however we are not complacement and we recognise that there is always more that we can do.

At the end of each financial year, it is always appropriate to look back and reflect on the past 12 months. This quality account demonstrates the quality of care patients received from our service and details those areas where improvements need to be made.

DRAFT

To be completed once final draft is available

To the best of my knowledge the information contained in this report is an accurate account.

**Dr Anthony C. Marsh**
**QAM SBStJ DSci (Hon) MBA MSc FASI**
**Chief Executive Officer**

a. c. Marsh.

**Sir Graham Meldrum.**
**CBE OStJ Chair**

# Statement on Quality from the Medical Director and Executive Nurse

To be completed once final draft is available

DRAFT

Dr Andy Carson
Medical Director

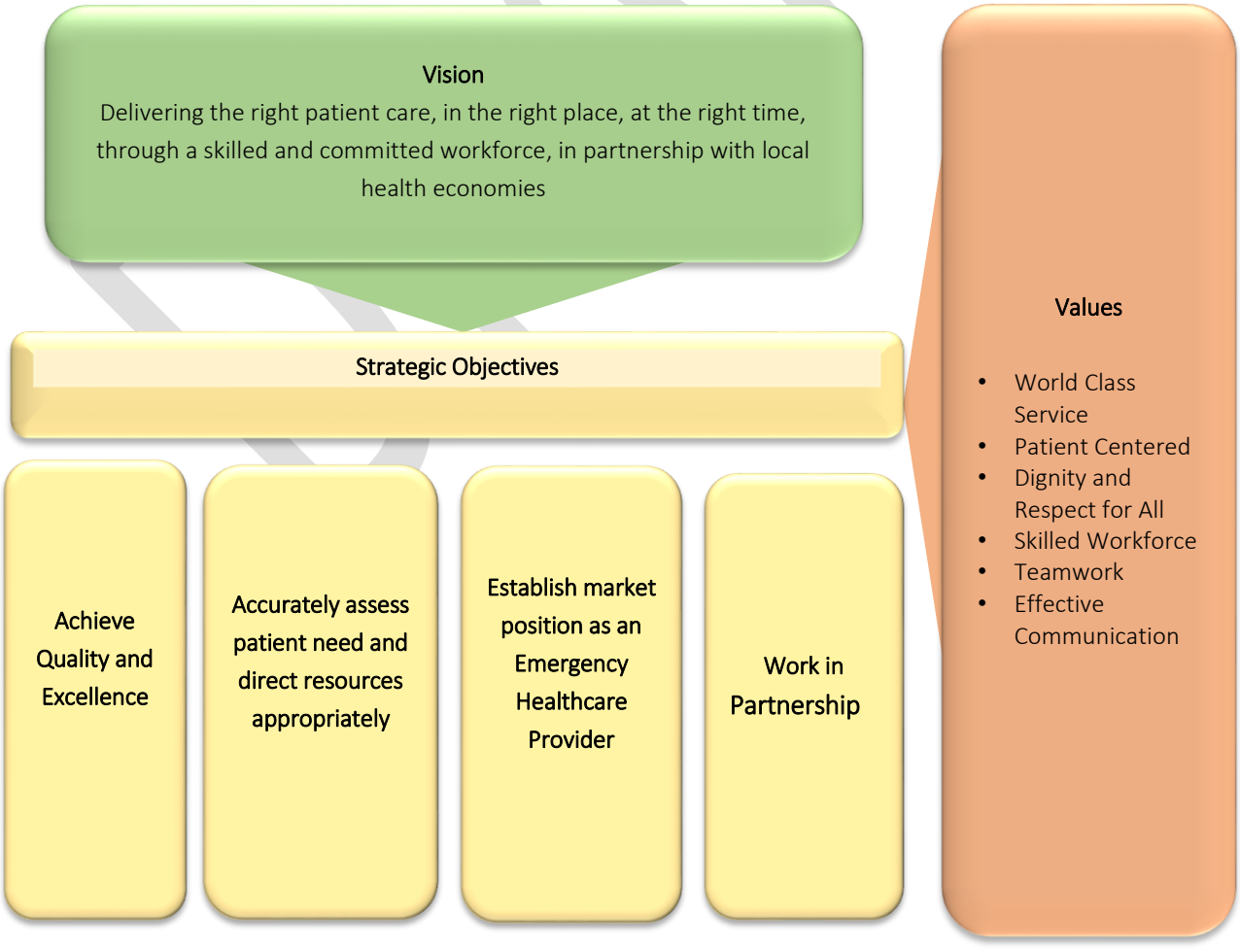
Mark Docherty, RN MSc BSc (HONS) Cert MHS
Director Commissioning and Strategic Development

## Part 1 - Introduction

We have a vision to deliver the right patient care, in the right place, at the right time, through a skilled and committed workforce, in partnership with local health economies. Put simply, patients must be central to all that we do. This means a relentless focus on patient safety, experience and clinical outcomes.

At West Midlands Ambulance Service NHS Foundation Trust we place quality at the very centre of everything that we do. We work closely with partners in other emergency services, different sections of the NHS and community groups. These include General Practitioners, mental health workers, trade associations and local community groups. Together we ensure that the patients remain at the forefront of service provision through uncompromising focus on improving patient experience, safety and clinical quality.

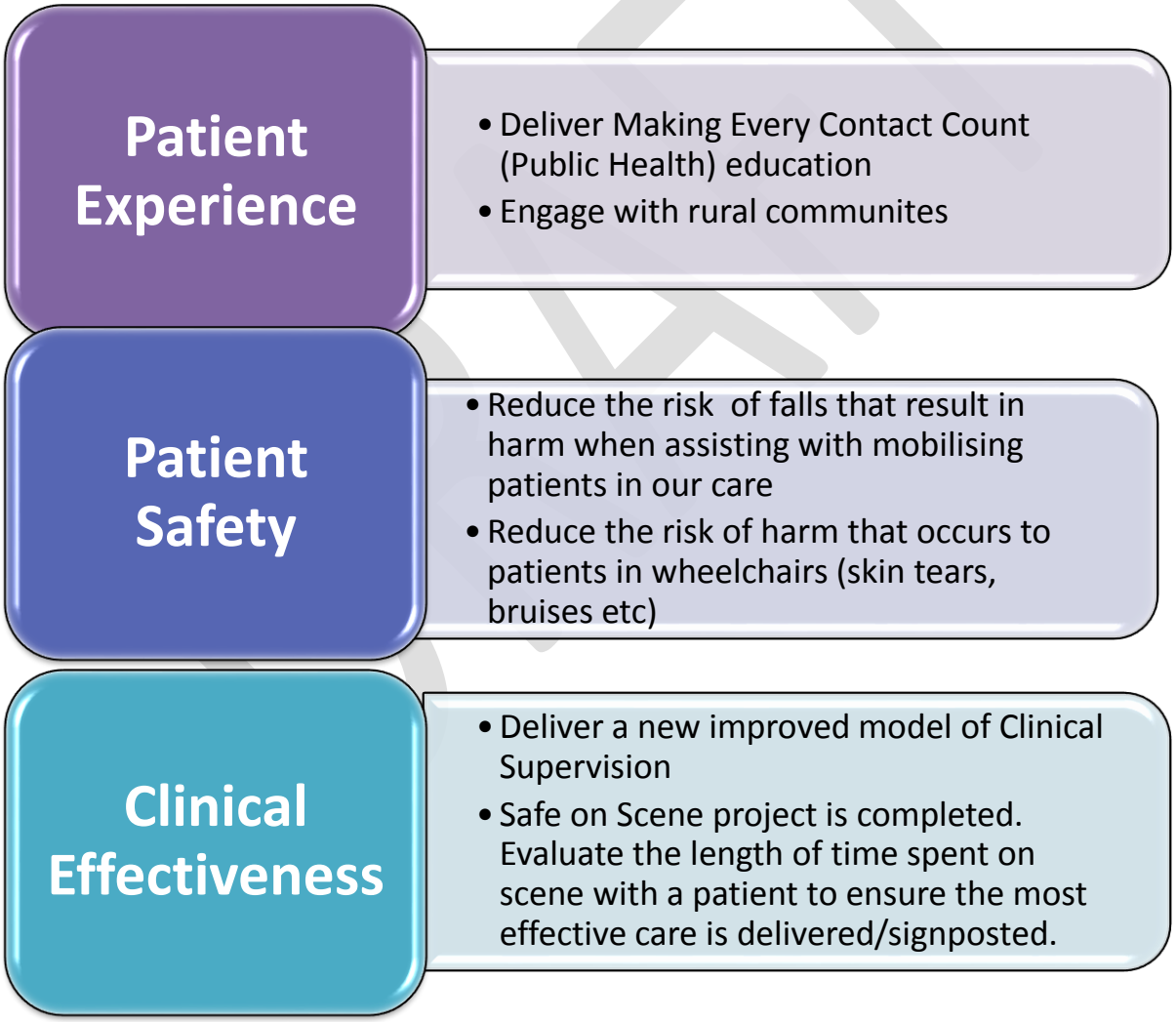
The Quality Account is a yearly report that highlights the Trusts progress against quality initiatives and improvements made over the previous year and looks forward to prioritising our ambitions for the year ahead. We understand as a provider organisation that to continue to improve quality it is essential that our patients and staff are fully engaged with the quality agenda. We continue to reinforce these through our current values.



## Part 2 - Priorities for 2016/17

In deciding our quality priorities for 2015-16 for improving patient experience, patient safety and clinical quality. We have listened to what our patients and staff are telling us through engagement events, surveys, compliments, complaints and incident reporting. We have assessed our progress during the year against last year's priorities and have agreed where priorities need to continue to ensure a high quality service is maintained and continues to improve.

The Trust Priorities for 2015/16 are summarised below.



## Patient Experience

| Patient Experience | Priority | WHY WE HAVE CHOSEN THIS priority | WHAT WE ARE TRYING TO IMPROVE | WHAT SUCCESS WILL LOOK LIKE |
|---|---|---|---|---|
| | 1. Engage with rural communities | Following feedback from the HOSC and Healthwatch engagement event it was agreed that increased engagement with rural communities was required. | Mutual understanding of the rural community expectations and the Ambulance Service ability to respond accordingly. | Feedback from local community groups is positive |
| | 2. Working with Public Health England to deliver Making Every Contact Count (MECC) education across the Trust | Supporting people to make and maintain positive lifestyle behaviour change including our staff is a priority for the Trust. MECC education will enable our staff to encourage others including patients to follow. | Supporting the Public Health England Agenda to improve the health and wellbeing of the population through positive encouragement. | Frontline staff will be educated in Making Every Contact Count |
| | **How we will monitor progress**:<br>1. Progress will be reported on quarterly both internally and to Healthwatch groups across the West Midlands<br>2. Train the trainer education and cascade training will be monitored through quarterly reports. | | | |
| | **Responsible Lead**:<br>1. Head of Patient Experience & Deputy Director of Nursing<br>2. Head of Education and Training and Deputy Director of Nursing & Quality | | | |
| | **Date of completion**: March 2017 | | | |

## Patient Safety

| | PRIORITY | WHY WE HAVE CHOSEN THIS PRIORITY | WHAT WE ARE TRYING TO IMPROVE | WHAT SUCCESS WILL LOOK LIKE |
|---|---|---|---|---|
| PATIENT SAFETY | 1. Reduce the risk of falls that result in harm when mobilising patients in our care. | Through analysis and Learning the Trust has identified high risk incidents and trends relating to falls resulting in injury specifically in our Non-Emergency Patient Transport Service. | We aim to reduce the risk of harm through a renewed safety campaign (successfully promoted 3 years ago). Increased awareness of the reasons why patients fall. | Reduction in incident's, claims and complaints that result in moderate harm or above as a result of falls |
| | 2. Reduce the risk of harm that occurs to patients in wheelchairs | Through analysis and Learning the Trust has identified themes where minor harm has occurred to patients when they are being moved in wheelchairs by Trust staff. | We aim reduce the risk of harm through review of equipment, fleet and education. | Reduction in incident's and complaints that result in all harm to patients whilst being |
| | **How we will monitor progress:**<br>Reporting frameworks have been established for each priority to be assessed on a quarterly basis and progress reported both internally to Learning Review Group and externally via Commissioners and the Trust website. | | | |
| | **Responsible Lead:**<br>Head of Patient Safety | | | |
| | **Date of completion:** March 2017 | | | |

## Clinical Effectiveness

CLINICAL OUTCOMES

| Priority | WHY WE HAVE CHOSEN THIS PRIORITY | WHAT WE ARE TRYING TO IMPROVE | WHAT SUCCESS WILL LOOK LIKE |
|---|---|---|---|
| 1. Deliver a new improved model of Clinical Supervision | The changing Ambulance Service workforce has resulted in greater responsibility for clinicians to manage and often discharge patients on scene.<br><br>The new model will enable greater reflective practice and should improve patient care. | All Ambulance Clinical Performance measurements will improve.<br><br>Staff and patient feedback will be positive | The new model is in place and working effectively. |
| 2. Safe on Scene | Over recent years the time spent on scene managing a patient has increased to an average of 50 minutes.<br><br>The Trust needs to ensure this time is providing the most effective care for the patient. | Transfer decisions are made quickly.<br><br>Time on scene is reduced where appropriate. | Patients requiring immediate transfer are taken to hospital quicker.<br><br>Care delivered on scene including referrals to other agencies is safe and results in a positive patient experience. |
| **How we will monitor progress**:<br>Reporting frameworks are well established for each priority to be assessed against performance on a quarterly basis. Progress is, and will, continue to be monitored within the Trust Committees and to our Commissioners. Reports will be sent to the Trust Board of Directors and these will be published on our website. | | | |
| **Responsible Lead**:<br>1. Deputy Director of Nursing & Quality<br>2. Medical Director | | | |
| **Date for Completion**: March 2017 | | | |

## Statements from the Board

To be completed once final draft produced

DRAFT

## Our Services

The Trust serves a population of 5.6 million who live in Shropshire, Herefordshire, Worcestershire, Coventry and Warwickshire, Staffordshire and the Birmingham and Black Country conurbation. The West Midlands sits at the Heart of England, covering an area of over 5,000 square miles, over 80% of which is rural landscape.

The Trust has a budget of approximately £215 million per annum. It employs over 4,000 staff and operates from 16 Operational Hubs and a variety of Community Ambulance Stations together with other bases across the Region. In total the Trust utilises over 800 vehicles including Ambulances, Response Cars, Non-Emergency Ambulances and Specialist Resources such as Motorbikes and Helicopters.

The Trust is supported by a network of Volunteers. More than 800 people from all walks of life give up their time to be Community First Responders (CFRs). CFRs are always backed up by the Ambulance Service but there is no doubt that their early intervention has saved the lives of many people in our communities. WMAS is also assisted by Voluntary organisations such as the British Red Cross, St. John Ambulance, BASICS doctors, water-based Rescue Teams and 4x4 organisations.

During 2015 -16 West Midlands Ambulance Services Foundation Trust provided 3 core services:

1. **Emergency and Urgent:** This is perhaps the best known part of the Trust and deals with the 999 calls. Initially, one of the two Emergency Operations Centres (EOC) answers and assesses the 999 call. **Emergency Operations Centres** deal with over a million calls each year, over 95% of which are answered within 5 seconds. Each 999 call is triaged through NHS Pathways system to ensure that the patient needs are met.
2. **Patient Transport Services** (PTS)**:** A large part of the organisation deals with the transfer and transport of patients for reasons such as hospital appointments, transfers between care sites, routine admissions and discharges and transport for continuing treatments such as renal dialysis. The Trust completed approximately 640,000 PTS patient journeys during 2015/16
3. **Emergency Preparedness:** This is a small but important section of the organisation which deals with the Trust's planning and response to significant incidents within the Region as well as co-ordinating a response to large gatherings such as football matches and festivals. It also aligns all the Trust's Specialist assets and Operations into a single structure.

## Participation in National Audit

WMAS recognises the importance of ongoing evaluation of the quality of care provided against key indicators. As a member of the National Ambulance Service Clinical Quality Group (which develops National Clinical Performance Indicators and National Clinical Audits), we actively partake in both national and local audits to identify improvement opportunities. As a result, the Trust has a comprehensive Clinical Audit Programme which is monitored via our Clinical Audit & Research Programme Group. The Trust has participated in 100% of national audits and zero of national enquiries.

The Trust submits data to the Department of Health Ambulance Quality Indicators and to the National Co-coordinator for Clinical Performance Indicators.

| | Audit | WMAS Eligible | WMAS Participation | *Number of Cases Submitted | Annual Number of Cases Submitted |
|---|---|---|---|---|---|
| • | Ambulance Quality Indicators (Clinical) | ✓ | 100% | 9135 | The AQIs/CPIs run 2-3 months behind for submission to the DH/national group and so end of year data will be available in June 2016. |
| | Clinical Performance Indicators | ✓ | 100% | 2400 | |
| | Myocardial Infarction National Audit Programme (MINAP) | ✓ | 100% | N/A – Hospitals enter data onto national database | |

*Note number of cases submitted as of March 2016.*

### Local Trust Audit

In addition to these submissions, the Trust produces Local Performance indicators to support local improvements. The Trust is committed to developing links with Hospitals to access patient outcomes.

| | Local Audit |
|---|---|
| Trust Local Clinical Audits | Examining the Delivery of Mental Health Care |
| | Clinical Records Documentation Audit |
| | Care of Patients Discharged at Scene |
| | Management of Acute Coronary Syndrome |
| | Feverish Illness In Children |
| | Management of Head Injury |
| | Management of Obsetric Emergencies |
| | Management of Peri-Arrests |
| | Management of Paediatric Pain |
| | Paediatric Medicine Management |
| | Paediatric Patients Discharged at Scene |
| | Administration of Morphine |
| | Assurance of appropriate administration of extended medications by Specialist Paramedics |
| | Management of Asthma in Paediatric Patients |
| | Management of Acute Coronary Syndrome |
| | Management of Deliberate Self Harm patients |
| | Management of Asthma |

# Learning from Audit

## Care of Patients Discharged at Scene

During 2015-2016 the Trust undertook the fourth re-audit which aims to identify the quality of the assessment and management of patients discharged at scene and specifically looks at the clinical effectiveness and safety of the documented discharge. The Trust recognises that the need to support clinicians when making decisions regarding the discharge of patients at scene.

There have been increases in performance in a number of areas however; the following areas still require additional focus: the quality of documenting pupillary response, pain score, mental capacity, two sets of observations, medication administration and onward referral plans.

An improvement plan was devised following the clinical audit which includes:

- Development of an annual education package for the assessment and discharge of patients at scene.
- Development of local clinical supervision model that includes review of the patients that are discharged at scene.
- Implementation of the Trusts Electronic Patient Record over the next 2 years
- Produce a Poster showing results to go into Clinical Times and Weekly Brief

## Discharge of the Paediatric Asthma Patient

This was the first clinical audit the Trust completed on the discharge of the Paediatric Asthma Patient. The aim of the audit is to identify if paediatric asthma patients that are discharged on scene are clinically safe and within national guidance.

Asthma in the paediatric patient is a common condition which is linked to a high mortality and morbidity rate if poorly managed. Several areas of improvement were identified and the following recommendations were agreed:

- Issue a clinical notice advising staff that if a paediatric asthma patient is given oxygen driven salbutamol on scene they must be transferred to hospital.
- Provide guidance to staff on the assessment, classification and management of the paediatric patient presenting with an acute asthma attack. This should be in line with current best practice and national guidance.
- Publish audit results in the clinical times to highlight areas of poor compliance and offer guidance on how to comply with guidelines.
- Produce audit on a page section on the intranet and sign post staff to this via the clinical bulletin.
- Carry out re-audit in 6 months' time but change the sample size to 100% of the previous 6 months data.

## Clinical Performance Indicators

The Trust takes part in the National Clinical Performance Indicators which look at the following conditions:

### Asthma

Over 5 million people in the UK have asthma and there are almost 4 million consultations and 74,000 hospital admissions for asthma each year in the UK. On average, 4 people per day or 1 person every 6 hours dies from asthma. It is estimated that approximately 90% of asthma deaths could have been prevented if the patient, carer or health care professional had acted differently.

### Trauma Care – Single limb fracture

Extremity fractures are commonly seen in pre-hospital care. They demonstrate a wide variety of injury patterns which depend on the patient's age, mechanism of injury, and pre-morbid pathology.

### Febrile Convulsion

A febrile convulsion is a seizure associated with fever occurring in a young child. Most occur between 6 months and 5 years of age, and onset is rare after 6 years of age. Febrile seizures arise most commonly from infection or inflammation outside the central nervous system in a child who is otherwise neurologically normal. Seizures arising from fever due to infection in the central nervous system (e.g. meningitis and encephalitis) are *not* included in the definition of febrile seizure. Fever is usually defined as having a temperature of more than 37.5°C.

### Elderly Falls (Pilot)

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year.

Falls are associated with increased morbidity, mortality, and nursing home placement. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carer's of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year.

Therefore falling has an impact on quality of life, health and healthcare costs.

These patients are at potential risk of major trauma as there is evidence of the impact of falls <2m on traumatic head injuries and undiagnosed subdural haemorrhages. These patients may re-contact the service following a fall, which would indicate that leaving patients safely at home has not been achieved.

## Mental Health (Pilot)

Ambulance staff have an increasingly important role in the assessment and early treatment of self-harm. Self-harm or deliberate self-harm includes self-injury and self-poisoning and is defined as 'the intentional, direct injuring of body tissue most often done without suicidal intentions.'

The National Institute for Clinical Excellence (NICE) in conjunction with the National Collaborating Centre for Mental Health (NCCMH) have developed guidelines with regard the treatment of patients who self harm and have such described self-harm as ***'self-poisoning or self-injury, irrespective of the apparent purpose of the act'***.

People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, healthcare professionals should take full account of the likely distress associated with self-harm. When assessing people who self-harm, healthcare professionals should ask service users to explain their feelings and understanding of their self-harm in their own words. When caring for people who repeatedly self-harm, healthcare professionals should be aware that the individual's reasons for self-harming may be different on each occasion; therefore each episode needs to be treated as such.

## Care Bundle Performance

| | 13-14 | 14-15 | 15-16 |
|---|---|---|---|
| **Asthma** | 81.50% | 86.00% | 86.75% |
| **Single Limb** | N/A | 26.92% | 17.24% |
| **Febrile Convulsion** | N/A | 83.40% | 71.60% |
| **Elderly Falls (Pilot)** | N/A | 6.08% | 2.33% |
| **Mental Health (Pilot)** | N/A | N/A | 33.00% |

**Note – the care bundle figure is as of March 2016. Due to the CPI submissions being 3 months in arrears the end of year data will not be available until the end of June 2016.*

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# Participation in Research

A key focus for the National Institute for Health Research is the development and delivery of quality, relevant, patient focused research within the NHS. WMASFT continues to be committed to supporting research within pre-hospital care, thus providing evidence to support improved patient care, treatment and outcomes. To achieve this we work with Universities within the West Midlands and further afield as well as acute hospitals, pharmaceutical companies etc. We also work with the Clinical Research Network West Midlands to ensure all research we take part in complies with the Research Governance Framework thus safeguarding participants in research.

During 2015-16 WMAS has supported several portfolio studies[1] the number of patients receiving relevant health services provided or sub-contracted by WMAS in 2015-16 that were recruited during that period to participate in research approved by a research ethics committee was number of recruits to be added when available in May.

## HIGHLIGHTS OF RESEARCH STUDIES DURING 2015-16

### The following studies have continued during 2015-16

**Epidemiology and Outcomes From Out Of Hospital Cardiac Arrest**

Run by Warwick University and funded by the Resuscitation Council (UK) & British Heart Foundation, this project will try to establish the reasons behind such big differences nationally in outcome from Cardiac Arrest. It will develop a standardised approach to collecting information about OHCA and for finding out if a resuscitation attempt was successful. The project will use statistics to explain the reasons why survival rates vary between regions. It will provide feedback to ambulance services to allow ambulance services to learn from one another and promote better outcomes for patients.

**Brain Biomarkers after Trauma**

Traumatic Brain Injury is a major cause of illness, disability and death and disproportionally affects otherwise young and healthy individuals. Biomarkers are any characteristic which may be used to gain insight into the person either when normal or following injury or disease. The study will look at biomarkers taken from blood, from fluid in the brain tissue and from new types of brain scans and investigate whether any biomarkers can give us insight into novel therapeutic strategies. WMAS and Midlands Air Ambulance are working with the University of Birmingham to support this study.

[1] The National Institute for Health Research (NIHR) portfolio comprises clinical research studies of high quality and clear value to the NHS.



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### The following study began during 2015-16

**PARAMEDIC 2**

This trial is looking at whether adrenaline is helpful or harmful in the treatment of a cardiac arrest that occurs outside a hospital. Answering this question will help to improve the treatment of people who have a cardiac arrest.

Adrenaline was introduced as a treatment for cardiac arrest before clinical trials were common. Adrenaline has not been fully tested to find out if it is helpful or harmful for patients who have a cardiac arrest outside of hospital. The International Liaison Committee for Resuscitation (ILCOR) has called for a definitive clinical trial to assess the role of adrenaline.

Many research studies suggest that, while adrenaline may restart the heart initially, it may lower overall survival rates and increase brain damage and there are real concerns in the clinical and research community that current practice may be harming patients. However, the evidence is not strong enough to change current practice.

The International Liaison Committee for Resuscitation (ILCOR) has called for a definitive clinical trial to assess the role of adrenaline.

## Mental Health

**Mental Health Triage Teams within the West Midlands**

The past year has seen the continuation of Mental Health Triage (MHT) teams operating within parts of the West Midlands. The scheme currently provides care for people of all ages across Birmingham, Solihull and the Black Country. It is a successful collaboration between Mental Health Services, Police and the Ambulance Service delivering appropriate mental health crisis care to patients at a time they most need it.

The teams comprise Mental Health Nurses, Paramedics and Police Officers providing cover on a rotating shift from 1000hrs to 0300hrs daily as data analysis has revealed that 85% of demand for all three services falls in this time band. For the Police and Ambulance Services this equates to 16,000 calls per year within Birmingham and Solihull alone.

The team responds together and they conduct a face-to-face assessment looking at patient risks and mental and physical health; this could take place in public places or private residences. The assessment will identify any immediate needs and the team can make referrals into the most appropriate service.

The key aim is to ensure safe, dignified care, identification of people who need detention under the Mental Health Act and appropriate diversion from the Criminal Justice System.

If it is necessary to detain the patient at a place of safety, swift and dignified transportation is provided via the Triage vehicle. If this is not appropriate, due to the behaviour of the individual, an ambulance is requested and the team follow behind providing further assistance at the place of safety as necessary.

Last year saw a reduction of 51% in the detention of patients under s136 of the Mental Health Act, a fantastic example of reducing the potential criminalisation of mental health patients in crisis and providing the appropriate pathway to facilitate enhanced and high quality crisis care.

In order to raise awareness of the services, West Midlands Police and West Midlands Ambulance Service liaise with Community Safety Partnerships, Health and Wellbeing Boards, NHS England, Offender Health Commissioning unit, Local Clinical Commissioning Groups'. Third sector organisations are very supportive of the scheme often giving the team pathways in to their service enabling the team to support people not only with their mental health but with social issues that may be a contributing factor in to why they are feeling unwell.

The team works closely with the 300 Voices (Time to Change) anti-stigma initiative. This enables a unique opportunity for service users to discuss their experience with emergency services and the Mental Health Trust; this enables us to learn from service users experiences. All organisations involved in this scheme have adapted their training as a result in order to improve the service provided to the community. Media links have been made locally to ensure publicity is undertaken to raise awareness of the positive changes West Midlands Police, West Midlands Ambulance Service and the Mental Health Trusts have made when responding to people in the community suffering with mental ill health. BBC Midlands today, the One Show, Sky news and BBC Two have filmed the team/s and produced news articles.

## Service user feedback

*"I would like to say thank you to the mental health car as they have been out to me a few times when I have been very low and down. With WMP/WMAS and a CPN in the car I managed to get the right help needed in my own flat without the need of going to hospital."*

## Family member feedback

*"On this occasion the kindness and professionalism of the triage team was a great support and comfort to my wife, son and I…… We are so grateful that this time the journey from the initial relapse to acute management to the recovery has been a much smoother and well-orchestrated experience. Full credit must be given to the triage team on that first night that set us on the right path."*

## Goals Agreed with Commissioners CQUIN Indicators 2015/16 Reporting (as of Feb 2016)

| Indicator Name | Indicator Weighting (% of CQUIN scheme available) | Expected Financial Value of Indicator | Achieved (Qtr1-3) |
|---|---|---|---|
| 1. Reduction in conveyance to Emergency Departments | 20% | £863,383 | Yes |
| 2. See and Treat Re- contact Rates | 20% | £863,383 | Yes |
| 3. Progress the Electronic Patient Record introduction | 18& | £777,045 | Yes |
| 4. Paramedic Pathfinder and MiDOS technology | 22% | £949,722 | Yes |
| 5. Safeguarding | 10% | £431,692 | Yes |
| 6. Clinical Pathways Referral Hub | 10% | £431,692 | Yes |

## Goals Agreed with Commissioners CQUIN Indicators

| Indicator Name | Indicator Weighting (% of CQUIN scheme available) | Expected Financial Value of Indicator | Achieved |
|---|---|---|---|
| 1. Deliver the Electronic Patient Record | TBC | TBC | |
| 2. TBC | TBC | TBC | |
| 3. TBC | TBC | TBC | |

**Commissioning for Quality and Innovation (CQUIN)** is a payment framework that enables commissioners to agree payments to NHS providers based on agreed quality and innovative work to improve the quality of the Service

## What Others Say About Us

The Trust has been registered with the Care Quality Commission (CQC) without conditions since 2010. This includes compliance with the Health and Social Care Act 2008 and Hygiene code (HC2008). The CQC has not taken enforcement action against West Midlands Ambulance Service during 2015/16.

The Trust was last inspected by the CQC in January 2014. The final report available from www.cqc.org.uk or the Trust website www.w31mas.nhs.uk confirms the Trust remained compliant with all the requirements of registration except for a minor failure in Outcome 4 - 'Care & Welfare of people who use our Service'. The CQC determined the Trust was required to provide a short term plan for improvements in operational performance targets as some patients, whilst receiving excellent treatment from staff, had experienced delays in response times. The Trust agreed a plan to improve response times by July 2014 which was achieved

***Thank you!***

***Whilst walking the short distance home after collecting my two daughters aged 8 and 4 from my parents who only live four doors away, my 4 year old daughter started to fall, I had hold of her hand and in the other had school/lunch bags and fell with her, my right knee smacked onto the kerb and I immediately knew from a popping sound that something was amiss. My eldest daughter summoned her Granddad and an ambulance was called. Stupidly I managed to hop home and only a very short time later two paramedics arrived. One took immediate charge of the situation and managed my level of pain from the outset. The other told me that she was in training, she was extremely caring and attentive. Both involved my daughters in my treatment as obviously they were both very upset as to what had happened to their mummy which I thought was wonderful and my eldest daughter felt like she was my nurse!!***

***I eventually went to A & E where the staff on duty were marvellous and to cut a long story short it turns out that I had fractured my tibia plateau for which I am still receiving treatment.***

***I felt that I had to write this and compliment your crew for their care towards not only myself but that of my two distraught little girls. Both exercised utmost professionalism and my pain which was excruciating was managed so well. Both paramedics are an absolute asset to you and in a very stretched NHS with so many unjust cuts to your services it is only fitting that your staff are acknowledged for the marvellous and caring work they perform every day of their working lives.***

## Data Quality

West Midlands Ambulance Service takes the following actions to assure and improve data quality for the clinical indicators, the Clinical Audit Department completes the data collection and reports. The patient group is identified using standard queries based on both the paper Patient Report Forms and the Electronic Care System. These clinical records are then audited manually by the Clinical Audit Team using set guidance. The data is also clinically validated and then analysed following an office procedure that is available to the Clinical Audit Team and is held on the central Clinical & Quality network drive. The process is summarised as:

- For the clinical indicators, the Clinical Audit Team completes the data collection and reports.
- The Patient Report Forms/Electronic Patient Records are audited manually by the Clinical Audit Team.
- A process for the completion of the indicators is held within the Clinical Audit Department on the central network drive.
- A Clinician then reviews the data collected by the Clinical Audit Team.
- The data is then analysed and reports generated following a standard office procedure. A second person within the Clinical Audit Team checks for any anomalies in the data.
- The results are checked for trends and consistency against the previous month's data.
- The Clinical Indicators are reported through the Trust Clinical Performance Scorecard.

The reports are then shared via the Clinical Steering and Quality Governance Committee to the Trust Board, Commissioners and Service Delivery meetings.

### NHS Number and general Medical Practice Code Validity

The Trust did not submit records during 2015/16 to the Secondary Uses service for inclusion in the Hospital Episode Statistics to be included in the latest published data.

### Information Governance Toolkit Attainment Levels

West Midlands Ambulance Service Information Governance Assessment Report overall score for 2015/2016 was TBC

care.data

### Clinical Coding Error Rate

West Midlands Ambulance Service was not subject to the Audit Commissions Payment by Results Clinical Coding Audit during 2015/2016

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## Performance against key quality indicators

To ensure patients of the West Midlands receive quality care from their Ambulance Service a set of key Performance Indicators and Ambulance Quality Indicators have been set nationally. These help set our policies and guidelines and develop our organisational culture that places quality at the top of the Trust's agenda. The following details the figures for each CPI/AQI and highlights the national mean percentage and the position of WMAS against other Trusts.

### All Ambulance Trusts are required to report the following mandatory Quality Indicators:

#### Red Ambulance Response Times

Percentage of Category A telephone calls (Red 1 and Red 2 calls) resulting in an emergency response by the trust at the scene of the emergency within 8 minutes of receipt of that call during the reporting period.

Percentage of Category A telephone calls resulting in an ambulance response by the trust at the scene of the emergency within 19 minutes of receipt of that call during the reporting period.

#### Care of ST Elevation Myocardial Infarction

Percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction who received an appropriate care bundle from the trust during the reporting period.

#### Care of Stroke Patients

Percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the trust during the reporting period.

#### Care of Patients in Cardiac Arrest

In patients who suffer an out of hospital cardiac arrest the delivery of early access, early CPR, early defibrillation and early advanced cardiac life support is vital to reduce the proportion of patients who die from out of hospital cardiac arrest.

### Ambulance Response Times

| | |
|---|---|
| Red 1 response within 8 minutes | |
| Red 2 response within 8 minutes | |
| Red - 19 Min Performance | |
| Green 2 - 90%-30mins | |
| Green 4 - 90% - triage in 60mins | |

We continue to work with our Commissioners and other Providers such as Acute Hospital colleagues to ensure improvements in the provision of healthcare for the people of the West Midlands. WMAS continues to employ the highest Paramedic skill mix in the country with a Paramedic present in over 95% of crews attending patients every day.

**STEMI** (ST-elevation myocardial infarction)
This is a type of heart attack. It is important that these patients receive:

- Aspirin - this is important as it can help reduce blood clots forming.
- GTN – this is a drug that increases blood flow through the blood vessels within the heart. (Improving the oxygen supply to the heart muscle and also reducing pain).
- Pain scores – so that we can assess whether the pain killers given have reduced the pain.
- Morphine – a strong pain killer which would usually be the drug of choice for heart attack patients.
- Analgesia – Sometimes if morphine cannot be given Entonox, a type of gas often given in childbirth, is used.

The Care Bundle requires each patient to receive each of the above.

In addition the below is monitored for patients that are eligible for Primary Percutaneous Coronary Intervention (PPCI):

- Call to Balloon - 75% of patients that have PPCI should do so within 150 minutes of the initial call. This treatment is provided at a specialist heart attack centre.

**Stroke Care Bundle**
A stroke care bundle includes early recognition of onset of stroke symptoms and application of the care bundle to ensure timely transfer to a Specialist Stroke Centre.

The Stroke Care Bundle requires each patient to receive each of the detailed interventions below:

- FAST assessment - . A FAST test consists of 3 assessments; has the patient got Facial weakness, or Arm weakness or is their Speech slurred.
- Blood glucose - In order to rule out the presence of hypoglycaemia patients suspected of having suffered a stroke should have their blood glucose measured
- Blood pressure measurement documented - Raised blood pressure is associated with increased risk of stroke so patients suspected of having suffered a stroke should have their blood pressure assessed

Where a patient is eligible for thrombolysis, and therefore should be taken to a Hyper-Acute Stroke Unit within 60 minutes.

**Cardiac Arrest**

A cardiac arrest happens when your heart stops pumping blood around your body. If someone has suddenly collapsed, is not breathing normally and is unresponsive, they are in cardiac arrest.

The AQI includes:

- ROSC on arrival at Hospital
- Survival to Hospital Discharge

The above are reported on in two different groups as follows:

- Overall Group
  - Resuscitation has commenced in Cardiac Arrest patients
- Comparator Group
  - Resuscitation has commenced in Cardiac Arrest patients AND
  - The initial rhythm that is recorded is VF / VT ie the rhythm is shockable AND
  - The cardiac arrest has been witnessed by a bystander AND
  - The reason for the cardiac arrest is of cardiac origin ie it is not a drowning or trauma cause.

In this element we would expect a higher performance than the first group. This is due to the criteria indicating that the patient should have a better outcome.

Care bundles have been developed to ensure patients get the best care based on current evidence. Care bundles include a collection of interventions that when applied together can help to improve the outcome for the patient.

### Year-to-date Clinical Performance relating to STEMI and Stoke AQI's

| | Mean (YTD) | | | | | |
|---|---|---|---|---|---|---|
| Ambulance Quality Indicators / Clinical Performance Indicators | WMAS (13-14) | WMAS (14-15) | WMAS (15-16) | National Average | Highest | Lowest |
| STEMI Care Bundle | 75.66% | 72.49% | 77.76% | 77.80% | 88.00% | 72.87% |
| STEMI Call to Balloon within 150 minutes | 89.43% | 88.14% | 87.83% | 85.90% | 92.68% | 82.98% |
| Stroke Care Bundle | 94.28% | 94.00% | 96.09% | 97.70% | 98.84% | 93.88% |
| Stroke FAST + patients transported to Hyper Acute Centre <60 mins | 58.68% | 46.93% | 56.18% | 59.20% | 60.65% | 45.97% |
| Cardiac Arrest - ROSC At Hospital (Overall Group) | 24.48% | 28.71% | 30.90% | 28.30% | 34.26% | 26.07% |
| Cardiac Arrest - ROSC At Hospital (Comparator) | 40.10% | 45.57% | 51.35% | 52.60% | 60.47% | 40.54% |
| Cardiac Arrest - Survival to Hospital Discharge (Overall Group) | 6.55% | 8.29% | 9.41% | 8.90% | 10.79% | 7.74% |
| Cardiac Arrest - Survival to Hospital Discharge (Comparator Group) | 20.29% | 20.62% | 25.23% | 28.20% | 37.14% | 18.60% |

## What our Staff Say

As in previous years, the National Staff Survey was conducted for WMAS by Quality Health. A total of 850 questionnaires were sent to randomly selected staff across the whole of the Trust. There were weekly reminders in the Weekly Briefing, together with reminder letters sent out by Quality Health to individuals to help the return rate. The Survey closed on the 4th December 2015.

218 staff took part in the survey. This is a response rate of 26% and a drop from the response rate of 29% in the 2014 survey.

The average for Ambulance trusts in England was 34%. The overall national response rate for all organisations in England was 42%. Overall, the survey results for WMAS show positive employee satisfaction in many areas in the organisation. The two most prominent areas are:

1. **Organisation Culture(21a, 21b, 21c, 21d)**
   - 72% of staff who took part in the survey said they are enthusiastic about their job and are happy with the standard of care provided by the organisation.
   - 62% agree that the organisation takes positive action on concerns raised by patients or service users
   - 51% would recommend the Trust as a place of work.

2. **Personal development and Career Progression(18b, 18c, 18d, 20g)**
   - 63% of the respondents stated that their manager supported them to receive training, learning and development.
   - 77% agreed that their development has helped them to do their job more effectively and 75% said it helped them deliver better patient experience.
   - 79% agreed that it has helped them stay up to date with professional requirements of their role.

It is encouraging to note that areas which have been prioritised for the last couple of years by the Staff Survey Response Action Group, and the Organisational Development Team, are showing marked progress. Notably areas reporting on the line manager and team member relationship and health and well-being have significantly improved.

**Areas where WMAS could do better:**

**1. Bullying and Harassment at work**

Despite shown improvement in this area, 48% of the respondents said they had personally experienced harassment, bullying or abuse at work at least once from patients, their relatives or other members of the public. 54% said they did not report it.

**2. Discrimination at work**

Whilst 74% of the respondents said the organisation acts fairly with regards to career progression regardless of ethnic background, gender, religion, sexual orientation, disability or age; 12% of them said they are discriminated against by patients or members of the public.

This is a 3% increase compared to the 2014 survey. The highest increase in discrimination was seen for Sexual Orientation (15%) followed by Gender (14%) and Ethnic Background (13%) as compared to the previous survey's results.

**The top 5 Scores for WMAS were**:

- Staff feel their role makes a difference to patients (90%)
- Staff know who senior managers are (87%)
- Staff always know what their responsibilities are (83%)
- Staff are satisfied with the quality of care they provide to patients (83%)
- Staff are able to do their job at a standard they are pleased with (80%)

**The bottom 5 Scores were:**

- Staff feel they are not involved in deciding on changes introduced that affect their work area (57%)
- Staff disagreed that senior managers at WMAS try to involve them in important decisions (57%)
- Staff felt their PDRs did not help them to improve how they do their job (55%)
- Staff felt their PDRs did not leave them feeling their work was valued by the organisation (46%)
- Staff were dissatisfied with the recognition they get for good work (41%)

The full Survey results are published on the NHS Employers website- http://www.nhsstaffsurveys.com/Page/1006/Latest-Results

## Equality and Diversity

Equality and Diversity is built into everything the Trust does including policies, practices and strategies, public engagement and consultation events, where the Trust regularly asks local communities how it can improve services and practices.

Diversity in employment produces a workforce sensitive to the different needs of the community and the Trust has developed a vision for ensuring equality, diversity and inclusion, in both employment and service delivery which reflects `respect, dignity and fairness to all`.

The Trust has endorsed the Equality Delivery System (EDS), which is an NHS Equality and Diversity Framework, to assist in delivering better outcomes for patients and staff.

We have also published our Equality Data Analysis report 2015/2016 and will continue to publish our data with comprehensive analysis annually, in order to meet our Public Sector Equality Duty (Equality Act 2010).

As demonstrated within the report, we will improve the way we make informed decisions about our policies and practices, which are based on evidence, and the impact of our activities on equality and the protected characteristic groups. For Further information please follow the link Equality Data Analysis report 2015/16 http://www.wmas.nhs.uk/Pages/EqualityDataAnalysis.aspx

## Workforce and Organisational Development

**Our People**

**To be completed April (2nd week) 2016**

| 2015/16 | Appraisals | Mandatory Training | |
|---|---|---|---|
| WMAS | | | |
| Staff Development | | | |
| Graduate Paramedic Recruitment | | | |
| Technician to Paramedic Conversion | | | |
| Student Paramedic L1 | | | |
| Student Paramedic L4 | | | |
| ECA to Tech | | | |
| HCRT to Tech | | | |

## Health and Wellbeing

### To be updated April 2016

Working in partnership with Staff side the Trust continues to develop a Health and Wellbeing Strategy and action plan to ensure that health and well-being of staff is supported.

Managers and staff are being supported to update and develop their skills. The Trust are supporting up to 50 Managers to complete an Engaging Leaders Programme of Management Development.

The Trust wants to see a 5% improvement in staff recording that they feel valued and engaged in Staff survey results as well as assurance that there is an Increase in the number of staff with reviewed personal development plans. The Trust also wants evidence that staff are supported to receive the appropriate level of training as per the training plan.

| Measure of Progress | Baseline (2013/14) | Target 2014/15 | Target 2015/16 |
|---|---|---|---|
| Strive to achieve a 4% sickness level by end local target by March 2015 | 5.3% | 4.5% | 4% |
| Reduce long term absence rate of over 28 days from 3.6% to 2.5% by 31 March 2015 | 3.5% | 2.5% | 2.5% |
| Increase our Paramedic skill mix levels towards a 70% target by 2016/17 to enable more patients to be treated at scene | 61.08% | 56.68% | 56.77% |
| Average time from advert to appointment is maintained at 15 weeks | 15 weeks | 15 weeks | 14 weeks |
| Increase by 10% of BME Student paramedics graduating from Coventry, Staffordshire and Worcestershire Universities by 2016 (2011 -5 year target) | **2011/12 Baseline**<br>Coventry 6%<br>UoW: 0%<br>Staffs: NA | Coventry 12%<br>UoW 5%<br>Staffs 5% | **2015/16**<br>Coventry 16%<br>UoW: 10%<br>Staffs: 10% |
| Actively promote and encourage BME development to encourage a higher % of staff appointed at Band 7 and above. (Was 4.39% March 2013) | 6.02% | 7.5% | 8.5% |
| All managers have attended a Leadership Programme or are supported to complete an Engaging Leaders Programme (5 year development plan covering 2013/14 to 2018/19) | 57 people | 42 people | 42 people |
| Increase the number of staff with reviewed PDPs in place | 64% | 85% | 85% |
| Staff are supported to receive necessary mandatory clinical update training in accordance with our training needs analysis | 97.9% | 85% | 85% |
| Annually deliver programmes according to the agreed Training Days Analysis (TDA) Plan | 203083 | 31243 | 56095 |

## Part 3 - Review of Performance against 2015-16 Priorities

| | Priority | Progress | How we did |
|---|---|---|---|
| Patient Experience | Improved engagement with Learning Disabled Service Users | The Trust has introduced a range of easy read documents and has a dedicated Easy Read section on the Trust Website. The Trust used the press and social media to raise awareness of the easy read documents and the leaflets were used at the first National Learning Disabilities & Autism event in Birmingham in which resulting in more requests and sharing of leaflets with other organisations. The Trust also shares leaflets directly with Learning Disability Groups.<br>A specific training package for effective communication with Learning Disability and Autism patients has been developed and launched for staff who receive patient calls. | Achieved |
| | Work with Public Health England to reduce Health Inequalities | During 2015/16 we engaged with TBC | TBC |
| Patient Safety | Reduce the risk of avoidable harm from delays in ambulance attendance. | During 2015/16 the Trust achieved improvements in the reduction of delays as identified by our performance and ability to achieve our operational performance targets for time of arrival. In addition there has been a reduction in complaints and reported incidents relating to delays in attendance of an emergency response. | Achieved |
| | Publicize lessons learnt and good practice from incidents, claims and complaints. | The Trust is fully compliant with the requirements of its statutory Duty of Candour through<br>1. Open communication with patients and their relatives when harm has occurred.<br>2. Quarterly publication of the Trust's Learning Review Report<br>3. Improved website with sharing of serious incident lessons learnt<br>4. Improved Quality Account report (appendix?) End of year report to be included | Achieved |
| Clinical Outcomes | Timely and Effective care delivered on scene - commissioning | This priority identified the delays crews experienced managing the care of patients in their own homes. There have been some areas for improvement identified such as care pathway access however more work is required therefore the Safe on Scene Project will continue into 2016/17. | Partly Achieved |
| | Continue to improve clinical outcomes | Final end of year data required | |

## Patient Safety

Reporting, monitoring, actioning and learning from patient safety incidents is a key responsibility of any NHS provider. At WMAS, we actively encourage all of our staff to report patient safety and non-patient safety incidents so that we are able to learn when things go wrong. This helps us to recognise where improvements are required and make changes.

We encourage staff to report all incidents particularly where there has been no harm.

These present the Trust with the opportunity to learn lessons before an incident occurs resulting in harm. This is important both to resolve the immediate issues that have been raised and to identify the wider themes and trends which need more planning to address.

- **Incidents:** An incident is any unplanned event which has given rise to actual personal injury, patient dissatisfaction, property loss or damage, or damage to the financial standing or reputation of the Trust.
- **Near Miss:** Any occurrence, which does not result in injury, damage or loss, but had the potential to do so
- **Issue/Concern:** If it does not fit into any of the above definitions

Analysis of all incidents takes place and is supported by triangulation with other information such as complaints, claims, coroners' inquiries, clinical audit findings and safeguarding cases.

These are discussed monthly at the Learning Review Group. The meeting is chaired by the Deputy Director of Nursing & Quality and attended by clinicians from across the organisation. Themes and trends are reported quarterly to the Quality Governance Committee and the Trust Board of Directors.

A positive safety culture is indicated by high overall incident reporting with few serious incidents and we continue to achieve.

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## Total Number of Patient Safety Incidents reported by month

| | April 15 | May 15 | June 15 | July 15 | Aug 15 | Sep 15 | Oct 15 | Nov 15 | Dec 15 | Jan 15 | Feb 15 | March 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Birmingham | 8 | 15 | 9 | 10 | 16 | 10 | 7 | | | | | |
| Black Country | 18 | 11 | 6 | 13 | 23 | 20 | 19 | | | | | |
| Coventry & Warwickshire | 8 | 17 | 12 | 10 | 12 | 7 | 7 | | | | | |
| West Mercia | 7 | 17 | 4 | 5 | 12 | 22 | 17 | | | | | |
| Staffordshire | 3 | 8 | 2 | 11 | 10 | 14 | 17 | | | | | |
| PTS | 20 | 17 | 37 | 30 | 23 | 13 | 19 | | | | | |
| EOC | 3 | 3 | 7 | 4 | 9 | 4 | 7 | | | | | |
| Air Ambulance | 0 | 0 | 1 | 0 | 1 | 0 | 0 | | | | | |
| 111 - WMAS | 0 | 0 | 0 | 0 | 3 | 0 | 0 | | | | | |
| Other | 0 | 1 | 0 | 0 | 0 | 0 | 0 | | | | | |
| | | | | | | | | | | | | |
| **Total** | **67** | **89** | **78** | **83** | **109** | **90** | **93** | | | | | |
| **Total Number of Harm Incidents** | **4** | **3** | **9** | **8** | **6** | **6** | **9** | | | | | |
| **Undetermined** | **0** | **0** | **0** | **2** | **0** | **0** | **1** | | | | | |
| **Total Number of No/ Harm Near Misses** | **63** | **86** | **69** | **73** | **103** | **84** | **83** | | | | | |

**To be updated with end of year data April 2016**

## Themes

**Patient Safety/Patient Experience/Clinical Audit**

- Harm Incidents: Continue to be associated with slips, trips and falls and collision/contact with objects with a concern noted about patients in wheelchairs experiencing minor harm such as grazes and bruising. Mainly in our Patient Transport Service (PTS) – the PTS training programme for 2016/17 will include a refresher on assessment of patients and risk of harm from Slip, Trip, Fall and wheelchair use.

- Equipment: Medescan thermometers concerns raised - have resulted in a review and removal of devices with a return to the previous device until a more suitable one can be sourced by the Clinical Equipment Group

- Monitoring patients airway during resuscitation efforts (waveform capnography) – as per SI actions this will be included in Airway Management during 2016/17 training

- Make Ready – an emerging trend of missing equipment is noted and will be monitored to determine if this is due to the Festive REAP effect.

- Delays - PTS delays in attendance continue to be a theme – contractual issues are a main cause due to roll over of under commissioned contract – concerns highlighted to commissioners of services.

**Staff Safety**

- Manual Handling – Incidents relating to failed equipment required for the safe moving and handling of patients. In particular Mangar Elk lifting cushions and Stryker tracked carry chairs– currently under review by the Risk Team and local management

- Straps on Stretchers– Reports are coming through relating to straps being too long on the stretchers and causing a STF risk for staff. They are being cut by staff which then results in a patient safety issue when larger patients require securing. – Vehicle Design group have been asked to review with supplier.

To be completed for year April 2016

## Infection Prevention and Control

Each quarter IPC audits are completed for hand hygiene, cannulation and vehicle and premises cleanliness. The hand Hygiene audits are split between at hospital observations and at the point of care observations undertaken by Clinical Team Mentors with approximately 1,000 observations performed annually. Cannula insertion observations are also done by CTMs) with a minimum of 400 done each year. The results have shown a consistent rise in compliance year on year.

**End of year data required here – April 2016**

## Safeguarding

Safeguarding for Adults and Children is embedded in WMAS throughout Policies, Procedures and literature. All staff within WMAS are educated to report safeguarding concerns to the single point of access Safeguarding Referral Line.

Safeguarding Referral Numbers

**Adult Safeguarding Referrals**

| | Total |
|---|---|
| April 2014 - January 2015 | 12270 |
| April 2015 - January 2016 | 16350 |
| **% variance** | **33%** |

**Child Safeguarding Referrals (Under 18's)**

| | Total |
|---|---|
| April 2014 - January 2015 | 2441 |
| April 2015 - January 2016 | 2928 |
| **% variance** | **20%** |

In April 2015 some aspects of the Care Act 2014 were introduced resulting in a significant change in adult safeguarding. This presented a key challenge to both ensure staff were aware of the changes and the organisation in regards to any implications of such legislation. A bespoke WMAS adult safeguarding pocket book was created and made available to all staff to assist in this transition..

Currently there are 28 Safeguarding Boards across the West Midlands and engagement continues to develop with WMAS.

## Serious Incidents /DoC/ Sign up to Safety

Serious Incidents (SIs) include any event which causes severe harm or death; a scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services; Allegations of abuse; adverse media coverage or public concern about the organisation or the wider NHS.

A total of 27 serious incidents have been reported by WMAS over this reporting period. All serious incidents are investigated using Root Cause Analysis methodology to determine failures in systems and processes. This methodology is used to steer away from blaming operational staff at the sharp end of the error, to ensure the organisation as a whole learns from mistakes and that systems are reinforced to create a robustness that prevents future reoccurrence.

Following investigations into serious incidents, it has been highlighted that the Trust needs to improve;

To be completed for end of year April 2016

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## PATIENT EXPERIENCE

### Complaints and Contacts

Key themes for PALS and formal complaints relate to

- **Timeliness of 999 ambulance and Patient Transport Service Vehicles**–that there is a delay or perceived delay in the arrival of a 999 ambulance or response vehicle or there is a delay in the arrival of a Non-Emergency Ambulance to take a patient to and from their hospital appointment.

- **Clinical Treatment complaints**- that the patient or a family relative feels that the treatment or advice received is not appropriate. Examples being a patient is left at home and not conveyed to hospital, as a GP appointment has been arranged.

#### Complaints

The Trust has received (1 Apr – 29 Feb) 317 complaints compared to 353 in 2014/15, a decrease of 10% (34). The main reason for a complaint being raised relates to the clinical care provided.

Breakdown of Complaints by Service Type YTD:

| | 2014-2015 | 2015-2016 | Variance 14/15 - 15/16 |
|---|---|---|---|
| EOC | 100 | 84 | -16% |
| EU | 163 | 179 | 9.8% |
| PTS | 83 | 49 | -41% |
| OOH | 0 | 0 | 0 |
| Other | 7 | 5 | -28.6% |
| Total | **353** | **317** | **-10%** |

#### Upheld Complaints

The table below indicates that of the 238 closed complaints, 90 were classed as upheld. If a complaint is upheld, learning will be noted and actioned locally and will also be fed into the Learning Review Group for regional learning to be identified and taken forward.

| | Total | Justified | Non Justified | Part Justified |
|---|---|---|---|---|
| Call Management | 9 | 3 | 4 | 2 |
| Attitude and Conduct | 52 | 19 | 20 | 13 |
| Clinical | 74 | 17 | 44 | 13 |
| Driving and Sirens | 6 | 5 | 1 | 0 |
| Response | 69 | 40 | 18 | 11 |
| Other | 18 | 5 | 7 | 6 |
| Total | **238** | **90** | **102** | **46** |

## PALS

Concerns have decreased year on year with 1050 concerns raised in 2015/16 compared to 1118 in 2014/15, a decrease of 6% (68). The main reason for a concern being raised related to 'response' which includes response emergency ambulance delays and issues with non-emergency patient transport arrangements.

## Ombudsman Requests

The majority of complaints were resolved through Local Resolution and therefore did not proceed to an independent review with the Parliamentary and Health Service Ombudsman. During 2015/16 - 8 independent reviews were carried out compared to 10 in 2014/15 of these two were closed with no further action and six remain under investigation by the Ombudsman.

## Patient Feedback/ Surveys

The Trust has received 46 completed surveys through the Trust website relating to Emergency Services and 7 relating to the Patient Transport Service. A targeted survey has also been undertaken of patients that received an emergency response in Q1 & Q2.

The Friends and Family Test (FFT) was official launched on 1 April 2015. The FFT should be offered to patients that dial 999, receive an emergency response but are not conveyed to hospital and patients that use the Non-Emergency Patient Transport Service. Patients are offered a freepost leaflet to return to regional HQ or they can complete the return on online through the Trust website. To date we have received the following responses:

- Patient Transport Service - 36
- Emergency Services – 88

## Compliments

The Trust has received 1155 compliments in 2015/16 compared to 1121 in 2014/15. It is pleasing to note that the Trust has seen an increase of 3% (34) in Compliments received. The Trust has a dedicated compliment email address: compliments@wmas.nhs.uk which is available to members of public via the Trust website and PALS leaflets.

## Annex 1: Statement from the Lead Commissioning Group

**Co-ordinating Commissioner Response**

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## Annex 2: Statement from the Council of Governors

## Chair of Patient Quality Panel on behalf of the Council of Governors

**Requested and awaited for final publication**

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## Annex 3: Local Healthwatch and Overview & Scrutiny Committees

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## Annex 4 - Statement of Directors' Responsibilities

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, Directors have taken steps to satisfy themselves that:

The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14

The content of the Quality Report is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period April 2014 to May 2015;
- Papers relating to Quality reported to the Board over the period April 2014 to May 2015
- Feedback from commissioners dated 14th May 2015
- Feedback from the governors between November 2014 and March 2015
- Feedback from Local Healthwatch organisations dated 2015
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2014 – March 2015 and quarterly reports during the year
- National patient survey 2014
- National staff survey 2014
- The head of internal audit's opinion over the Trust's control environment dated [14/05/015]
- Care Quality Commission intelligent monitoring reports between March 2014 and May 2015

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

## Annex 5: A copy of the External Audit limited assurance report

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# Annex 6: Glossary of Terms

## Glossary of Terms

| Abbreviation | Full Description |
|---|---|
| A&E | Accident and Emergency |
| AED | Automated External Defibrillator |
| AFA | Ambulance Fleet Assistant |
| AMI | Acute Myocardial Infarction |
| AQI | Ambulance Quality Indicators |
| BASICs | British Association of Immediate Care Doctors |
| CCGs | Clinical Commission Groups |
| CFR | Community First Responder |
| CPI | Clinical Performance Indicator |
| CPO | Community Paramedic Officer |
| CPR | Cardio Pulmonary Resuscitation |
| CQC | Care Quality Commission |
| CQUIN | Commissioning for Quality and Innovation |
| CSD | Clinical Support Desk |
| DCA | Double Crewed Ambulance |
| E&U | Emergency & Urgent |
| EMB | Executive Management Board |
| EOC | Emergency Operations Centre |
| FAST | Face, Arm, Speech Test |
| GP | General Practitioner |
| HALO | Hospital Ambulance Liaison Officer |
| HART | Hazardous Area Response Team |
| HCAI | Healthcare Acquired Infections |
| HCRT | Healthcare Referral Team |
| IGT | Information Governance Toolkit |
| IM&T | Information Management and Technology |
| IPC | Infection Prevention and Control |
| JRCALC | Joint Royal Colleges Ambulance Liaison Committee |
| KPIs | Key Performance Indicators |
| MERIT | Medical Emergency Response Incident Team |
| MINAP | Myocardial Infarction Audit Project |
| NED | Non-Executive Director |
| NHSP | National Health Service Pathways |
| NICE | National Institute for Health and Clinical Excellence |
| OOH | Out of Hours |
| PALS | Patient Advice and Liaison Service |
| PDR | Personal Development Review |
| PRF | Patient Report Form |
| PTS | Patient Transport Service |
| QIA | Quality Impact Assessment |
| RIDDOR | Reporting of Injuries, Diseases and Dangerous Occurrences Regulations |
| ROSC | Return of Spontaneous Circulation |
| RRV | Rapid Response Vehicle |
| SI | Serious Incident |
| STEMI | ST Elevation Myocardial Infarction |
| VAS | Voluntary Aid Services |
| WMAS | West Midlands Ambulance Service NHS Foundation Trust |
| YTD | Year to Date |

## Further Information

Further information and action plans on all projects can be obtained by contacting the lead clinician named on the project.

Further information on performance for local areas is available as an Information Request from our Freedom of Information Officer or from the leads for the individual projects.

Progress reports will be available within the Trust Board papers every three months with the end of year progress being given in the Quality Report to be published in June 2014.

If you require a copy in another language, or in a format such as large print, Braille or audio tape, please call West Midlands Ambulance Service on 01384 215 555 or write to:

West Midlands Ambulance Service NHS Foundation Trust
Regional Headquarters
Millennium Point
Waterfront Business Park
Brierley Hill
West Midlands
DY5 1LX

You can also find out more information by visiting our website: **www.wmas.nhs.uk**

If you have any comments, feedback or complaints about the service you have received from the Trust, please contact the **Patient Advice and Liaison Service (PALS)** in the first instance; **01384 246370.**

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historical data, and ensures that the ambulance resources are best positioned to meet daily patient activity.

## Divisional Profiles

## Birmingham Division

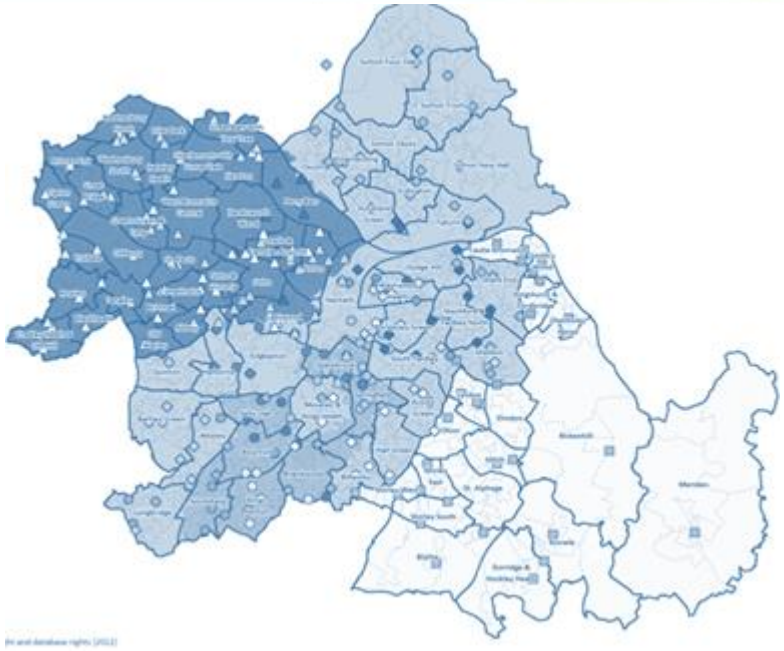
This overview is intended to provide relative information for various bodies, in understanding the composition, operational make up, challenges that face the west midlands ambulance service in Birmingham and Solihull.

The Birmingham/Solihull population is circa 1.3 million residents in the area, and a large transient population that travels into the city centre and returns in evening on a daily basis. The conurbation stretches across 445 sqKM, and is in the main an urban profile.

The Conurbation has 4 Clinical Commissioning Groups, with whom the ambulance service interact on a frequent basis. The CCGs are Birmingham Cross city, Birmingham South and Central, West Birmingham and Sandwell, Solihull.

The ambulance service has strategically located its 2 main ambulance hubs to facilitate both response times ease of supplemental cover, there is also a satellite community Ambulance station at Aston fire station which has a close proximity to the city centre.

An ambulance hub is a centre where staff report to centrally, ambulances are prepared, cleaned and repaired, training and education also takes place. From these ambulance hubs, the ambulances are deployed and strategically placed in line with a dynamic operational plan, the plan changes hourly and depicts the changing activity, this plan is based on emergency activity and



The Trust occupies a varied assortment of properties to support this deployment, ranging from prefabricated building to fixed buildings we also link in with the other emergency services and health care provider colleagues in assisting with accommodation where applicable and that is conducive to adherence to the operational plan.

## Performance

Current Red performance (National Target=75%).

| | Division YTD % | Trust YTD |
|---|---|---|
| Red 1 | | |
| Red 2 | | |
| Red - 19 | | |

## Overview by HUB

**Erdington** – Erdington Hub became operational in September 2013. The busiest postcode area B23 (Erdington) which is the unfortunately not the best performing post code. Most challenged post code B90 (Solihull area).

**Hollymoor** – Hollymoor Hub became operational in July 2013.

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## Black Country Division

This overview is intended to provide relative information for various bodies, in understanding the composition, operational make up, and challenges that face the West Midlands Ambulance Service in the Black Country.

The resident population of the Black Country is approximately 1.1 million people and has seen population increases in recent years; there is also a large transient population that travels through the area on a daily basis due to a busy road and rail network.

The area stretches across approximately 150 sq. miles, and is mainly urbanised with multiple borough. The Black Country operating division has 4 Clinical Commissioning Groups (CCGs), with whom the ambulance service works in partnership with the System Resilience Groups (SRG's) to improve the care provided to our citizens across all Health & Social Care. The CCGs are Dudley, Sandwell and West Birmingham, Walsall and Wolverhampton.

The ambulance service is strategically located in three areas where the main ambulance hubs are sited. An ambulance hub is a unit or building where staff report to centrally, ambulances are prepared, cleaned and repaired, and where training and education takes place. From these ambulance hubs, the ambulances are strategically placed in line with a dynamic operational status plan, based on the emergency activity, and ensure that the ambulance resources are best positioned to meet the daily patient demand.

The Trust occupies a variety of locations across the area as Community Ambulance Stations and standby sites. Many of these sites are based in existing estates owned by other emergency


service providers and this encourages interoperability and good working relationships when attending the same incident.

Black Country is also the site of the Trust Headquarters in Brierley Hill (Dudley area) which accommodates one of the two Emergency Operations Centres, where emergency calls are received and triaged. The regions 111 service provision is under temporary contract to the Trust and is also located in Brierley Hill.

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## Performance

| | Division YTD % | Trust YTD |
|---|---|---|
| Red 1 | | |
| Red 2 | | |
| Red - 19 | | |

**Overview by HUB –**

**Dudley -**

**Sandwell –**

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**Willenhall**.

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ambulance resources are best positioned to meet the daily patient activity.

## Staffordshire Division

This overview is intended to provide relative information for various bodies, in understanding the composition, operational make up, challenges that face the west midlands ambulance service in Staffordshire.

The Staffordshire population is 1.1 million resident in the county, and a large transient population that travels through the county on a daily basis. The county stretches across 1,050 sq miles, and has a mixture of rural and Urban Communities.

The County has six Clinical Commissioning Groups, with whom the ambulance service interact on a frequent basis. The CCGs are North Staffordshire, Stoke on Trent, Stafford and Surrounds, Cannock Chase, East Staffordshire, South East Staffordshire and Seisdon Pennisula. This is further grouped into 2 System Resilience Groups (SRG'S), North Staffordshire and Stafford being one and South East and East Staffordshire being the other. The formation of the University Hospital of North Midlands (the amalgamation of Royal Stoke and County) is part of the current reconfiguration of services taking place in the county which continues to offer challenges to WMAS.

The ambulance service is strategically located in three areas where the main ambulance hubs are sited. An ambulance hub is a centre where staff report to centrally, ambulances are prepared, cleaned and repaired, and where training and education takes place.

From the ambulance hubs, the ambulances are strategically deployed in line with a dynamic operational plan that changes each hour, this plan is based on emergency activity, and ensures that the


The Trust occupy a varied assortment of properties to support this deployment ranging from prefabricated buildings to fixed buildings and do link in with our sister emergency services colleagues in assisting with accommodation where applicable to the operational plan. Staffordshire is also the site of one of the two Emergency Operations Centres, where emergency calls are received and triaged.

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## Performance

### Overview by HUB –

Post code activity is a variable each week and is dependent on the activity in that post code area. A snapshot is provided in this briefing which indicates that instability.

| | Division YTD % | Trust YTD |
|---|---|---|
| Red 1 | | |
| Red 2 | | |
| Red - 19 | | |

**Tollgate (Stafford)** –

**Lichfield -**

**Stoke –**

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## West Mercia Division

This overview is intended to provide relative information for various bodies, in understanding the composition, operational make up, challenges that face the Trust in the West Mercia Division. West Mercia Division covers the counties of:

- Herefordshire
- Worcestershire
- Shropshire (Telford & Wrekin and Shropshire County)


The population of West Mercia is in excess of 1.1 million and stretches across 2,868 square miles with a combination of both rural and urban communities. This area accounts for more than 50% of the geographical size of the Trust.

West Mercia has six Clinical Commissioning Groups (CCG's), with whom the Ambulance Service interact with on a frequent basis. The CCGs are Shropshire, Telford and Wrekin, Herefordshire, South Worcestershire, Redditch and Bromsgrove and the Wyre Forest.

There are 5 ambulance hubs which are supplemented by Community Posts. An ambulance hub is a location where staff report to centrally, ambulances are prepared, cleaned and repaired, and where training and education takes place.

From these ambulance hubs, the ambulances are strategically placed in line with a dynamic operational plan that changes each hour. This plan is based on emergency activity and ensures that the ambulance resources are best positioned to meet the daily patient activity. The Trust occupy a varied assortment of properties to support this deployment ranging from prefabricated building to fixed buildings, and we do link in with our sister emergency services colleagues in assisting with accommodation where applicable to the operational plan. Many of these premises are occupied by Community Paramedics in Rapid Response Vehicles.

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## Performance

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| | Hub YTD % | Trust YTD |
|---|---|---|
| Red 1 | | |
| Red 2 | | |
| Red - 19 | | |

**Shropshire**

**Worcestershire**

**Herefordshire**

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# Arden Division

**Introduction**

This overview is intended to provide information to support the understanding of the composition and operational challenges that face the West Midlands Ambulance Service in Arden.

Arden consists of a population of 845,000 residents in the county with a large transient population that travels through the county on a daily basis. The county has a mixture of both rural and urban communities. The population is continuing to expand in Rugby, Nuneaton and Warwick as examples with new housing estates being built.

The County has three Clinical Commissioning Groups (CCGs), with whom the ambulance service interact on a frequent basis. These are:

1. Coventry & Rugby CCG
2. South Warwickshire CCG
3. Warwickshire North CCG

The Arden Division Emergency & Urgent ambulance provision is located at two hubs/buildings, one in Coventry and the second in Warwick. An ambulance hub is a centre where staff report to at the start of their shift, where ambulances are prepared, cleaned and repaired (fleet on site) by the make ready team and where training and education takes place. Ambulances are mobilised from these hubs to response posts situated at strategic points throughout the Arden County. The 'Make Ready' team ensure that all operational vehicles are fully equipped and cleaned, ready for the start of each shift to provide the correct environment for patient care.


Ambulances are moved on a dynamic basis and in line with our System Status Management operational plan that changes each hour. This plan is based on emergency activity, and ensures that the ambulance resources are best positioned to meet the daily patient activity.

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## Performance

| | Division YTD % | Trust YTD |
|---|---|---|
| Red 1 | | |
| Red 2 | | |
| Red - 19 | | |

**Coventry Hub Area**

**Warwick Hub Area**

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