Appendix 1

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.

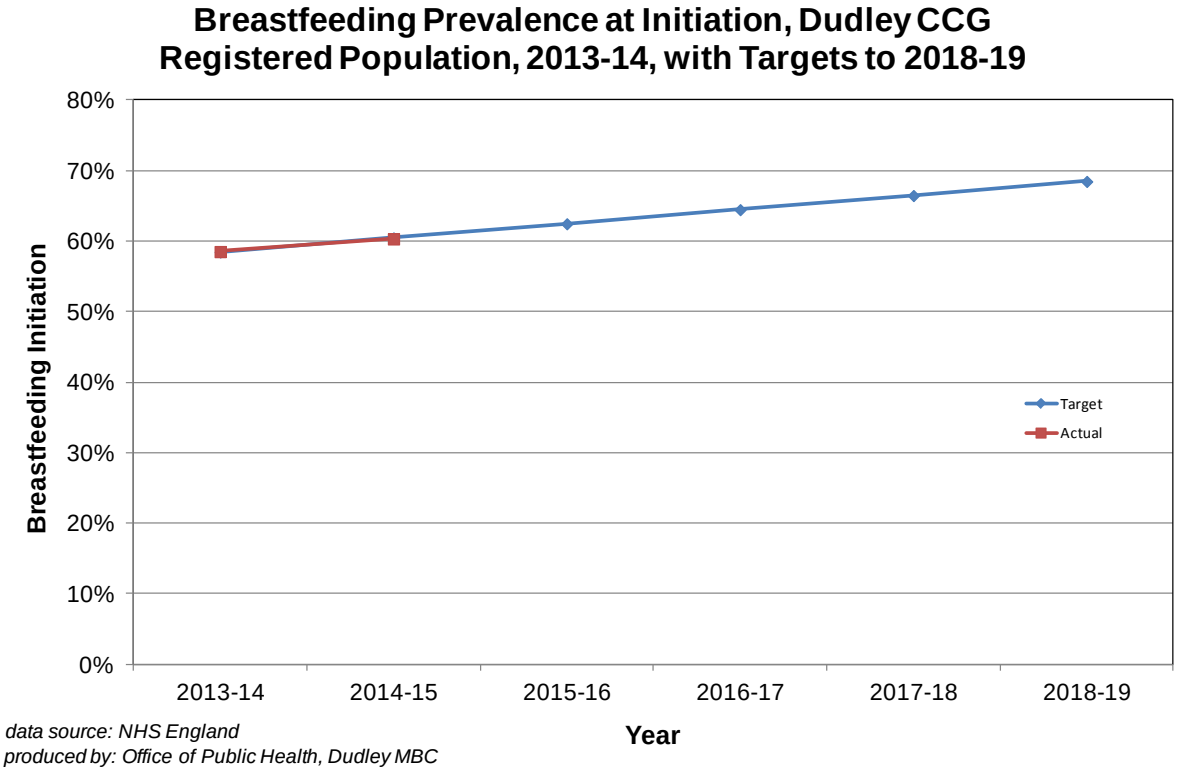
Promote healthy aging:-

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

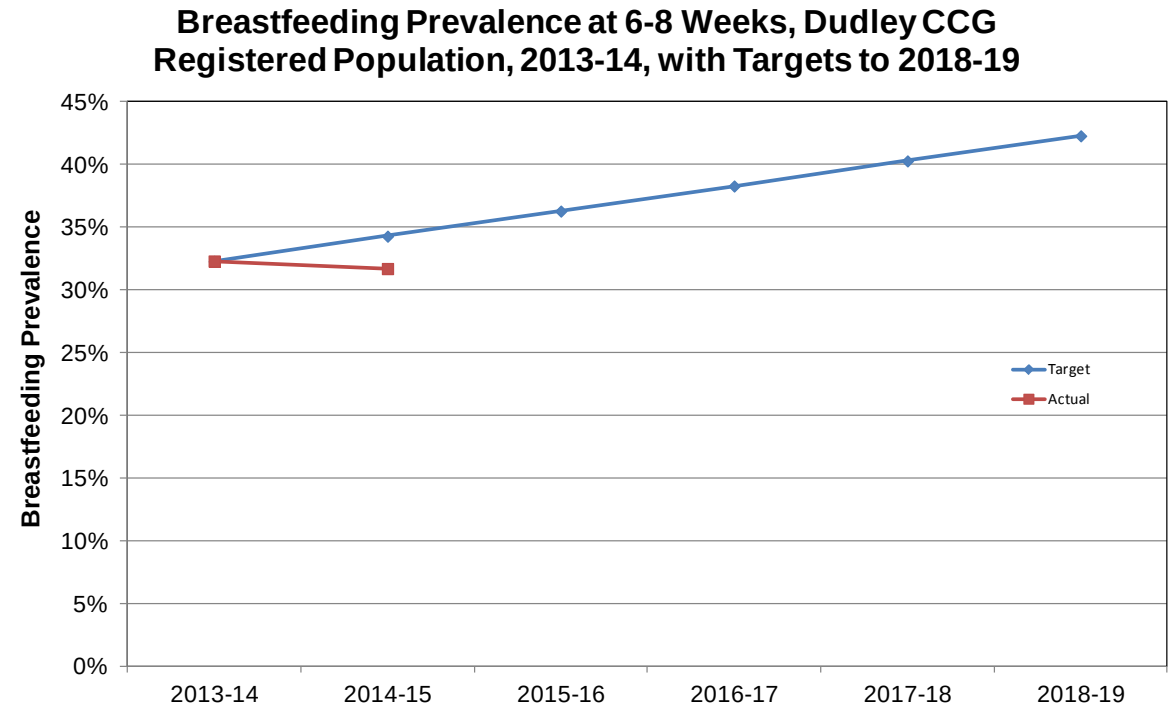
We have agreed specific targets with the Office of Public Health, broken down by locality and practice for obesity, tobacco control and alcohol. These are shown below:

a) Obesity

i) Shared breastfeeding targets (baseline 2013-14)

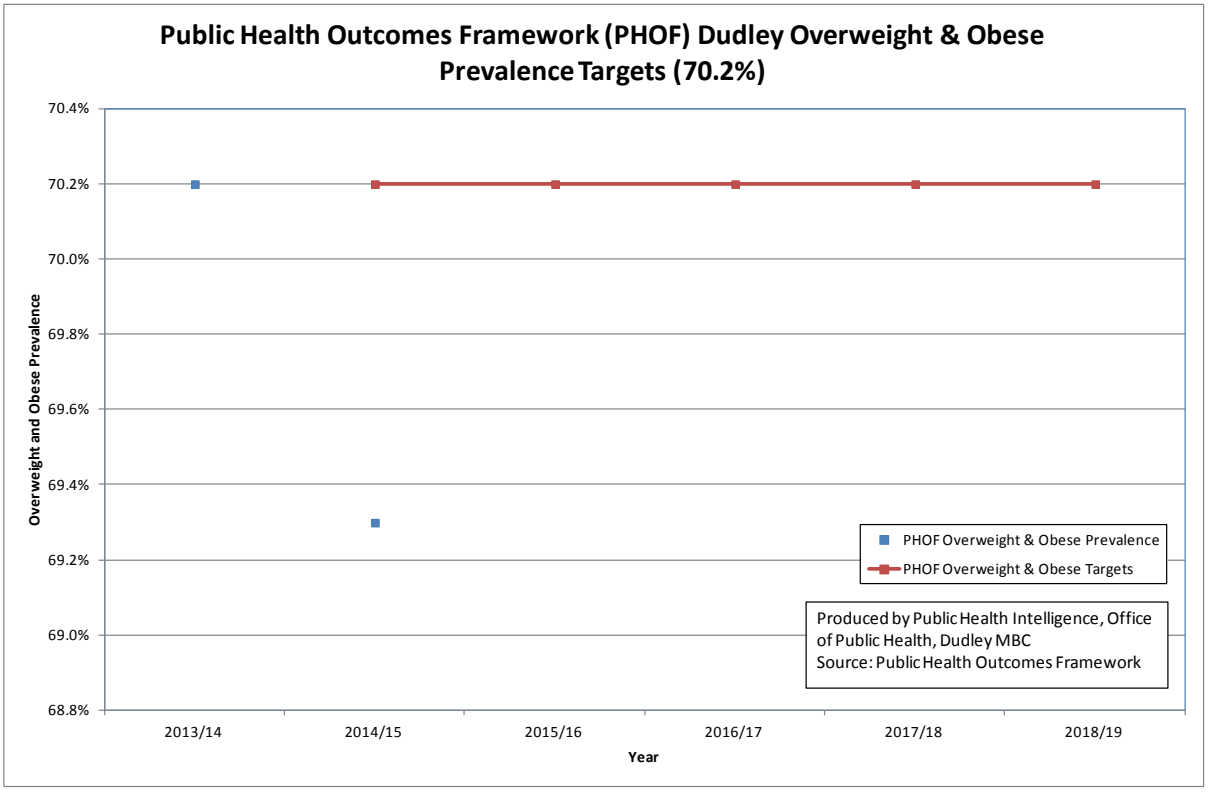


data source: NHS England
produced by: Office of Public Health, Dudley MBC

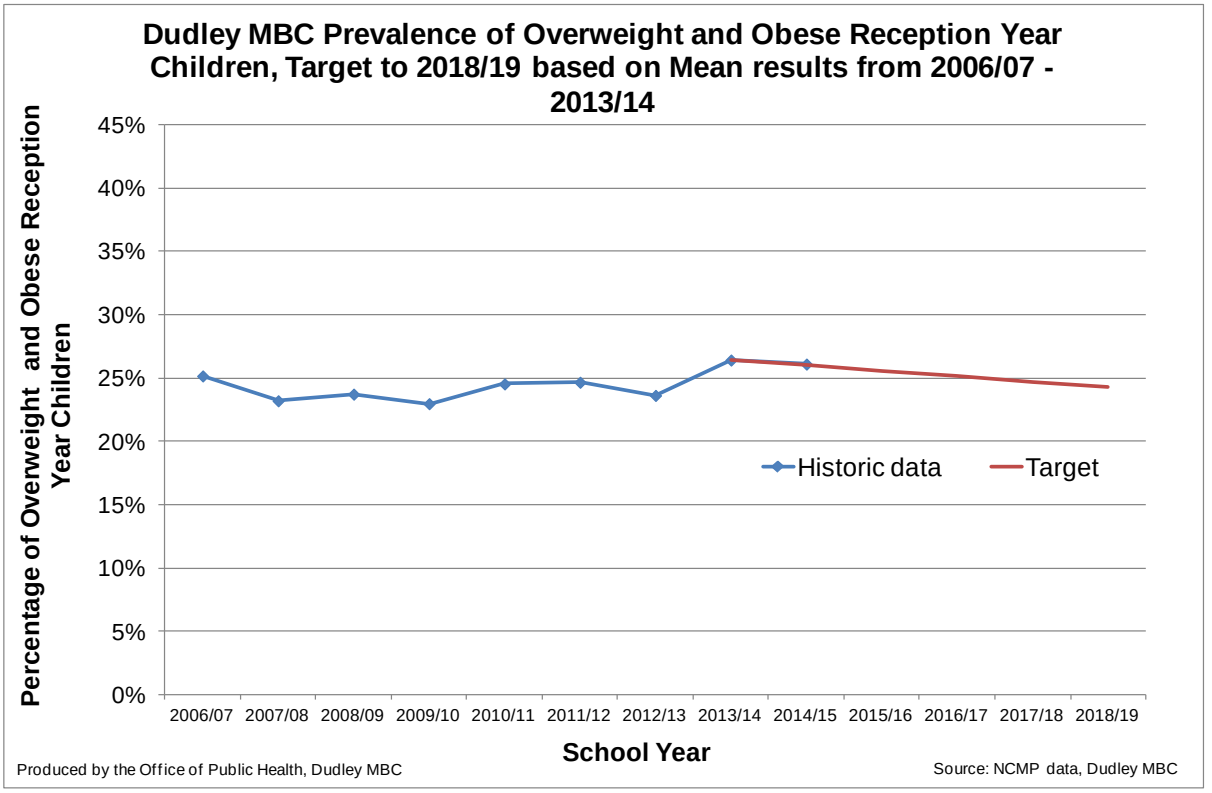


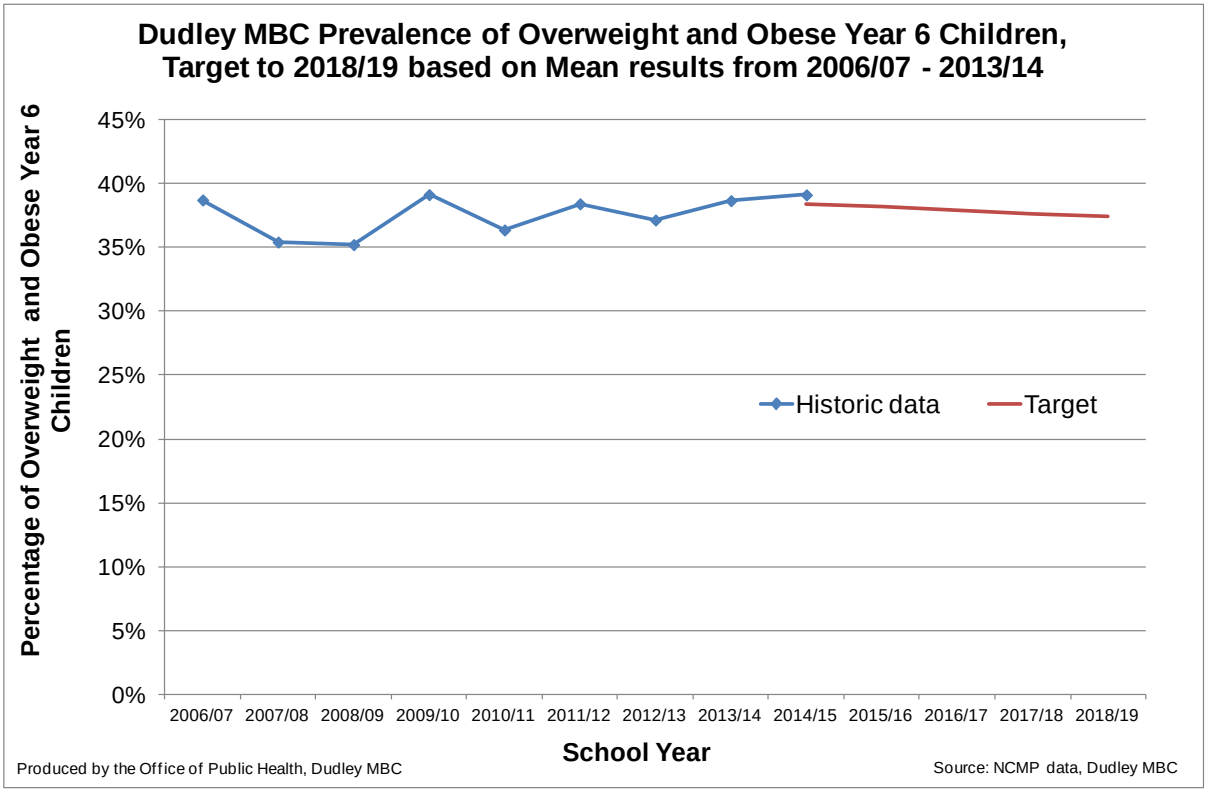
data source: NHS England
produced by: Office of Public Health, Dudley MBC

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



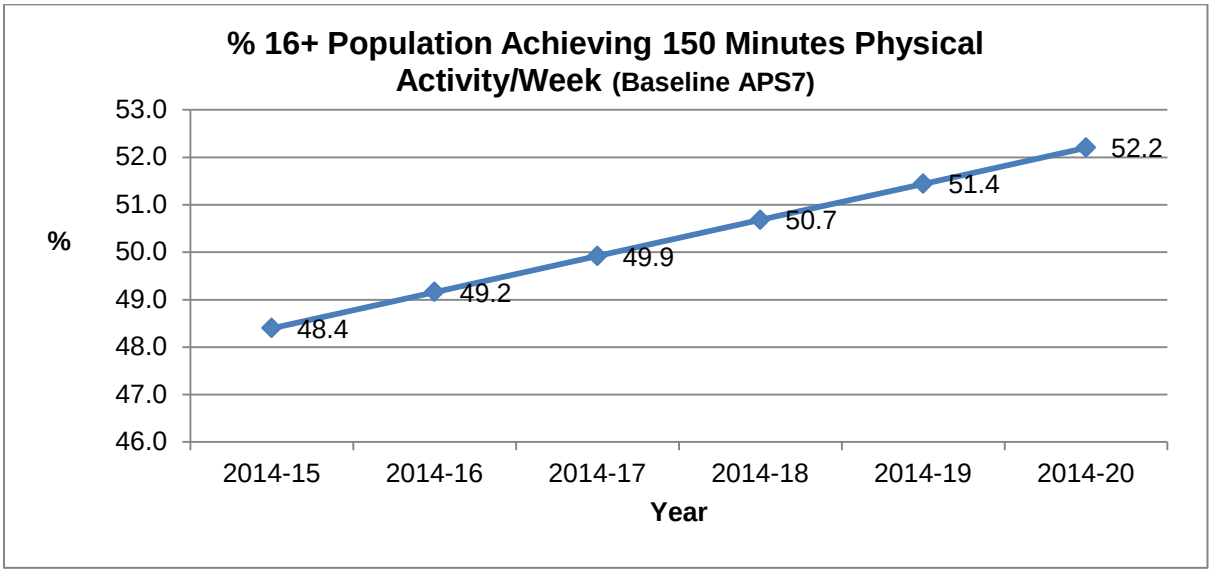
iii) Shared child excess weight targets (baseline 2013-14)





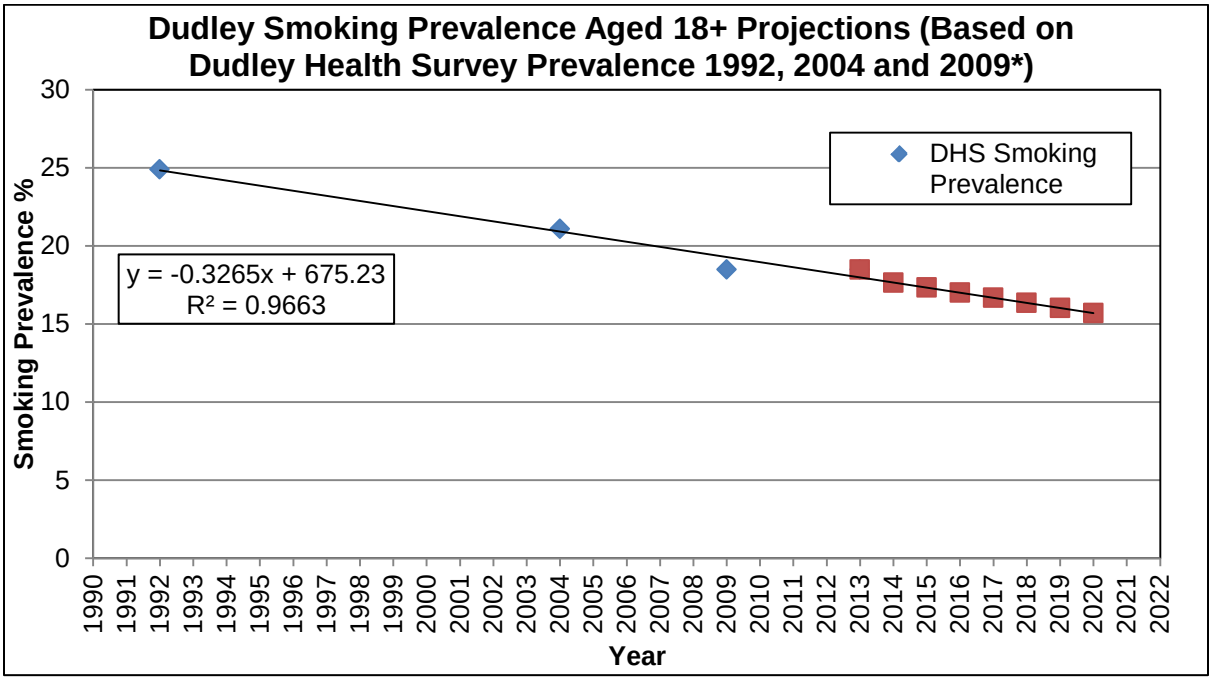
iv) Physical Activity

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



b) Tobacco control

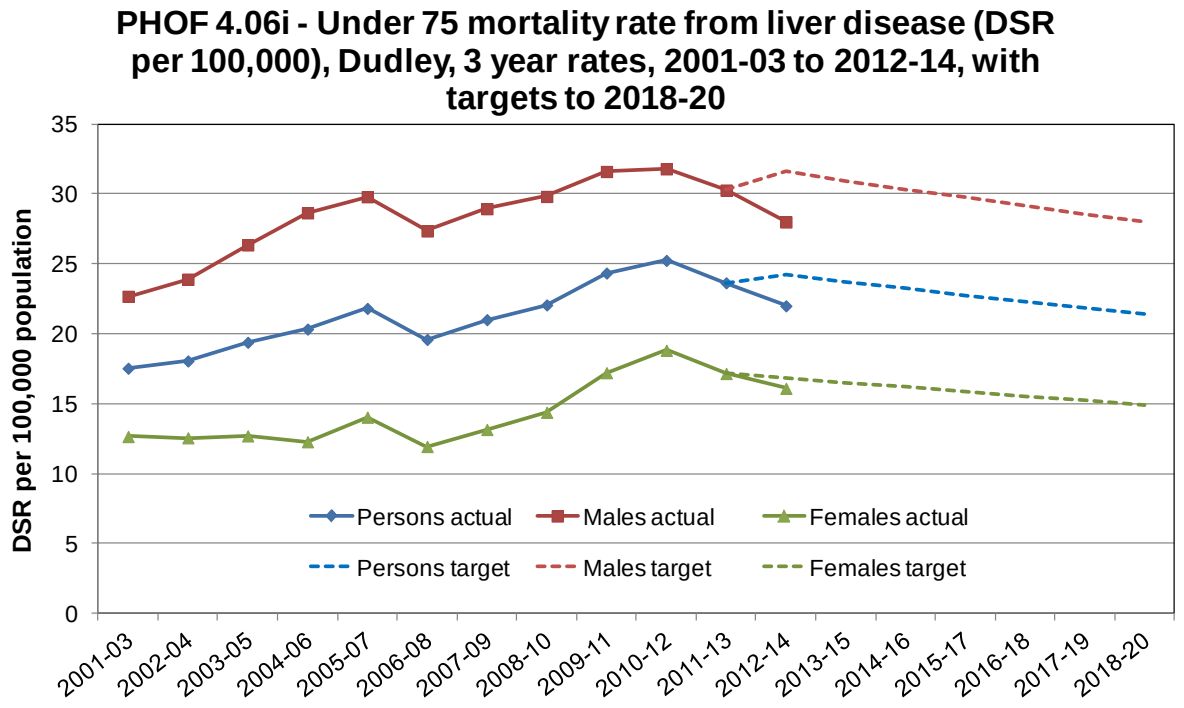
i) Smoking prevalence



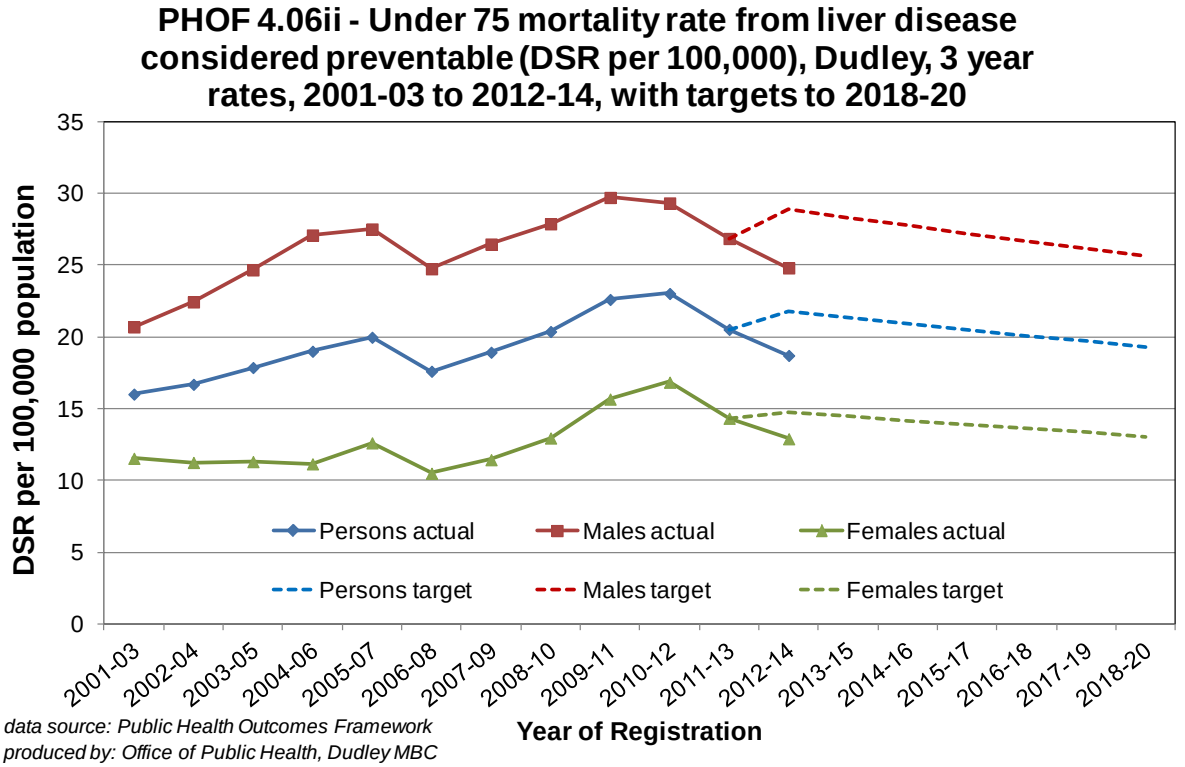
* Prevalence was assumed to have remained constant between 2009 and 2013. Based on ONS Integrated Household Survey data

c) Alcohol

i) Alcohol mortality targets

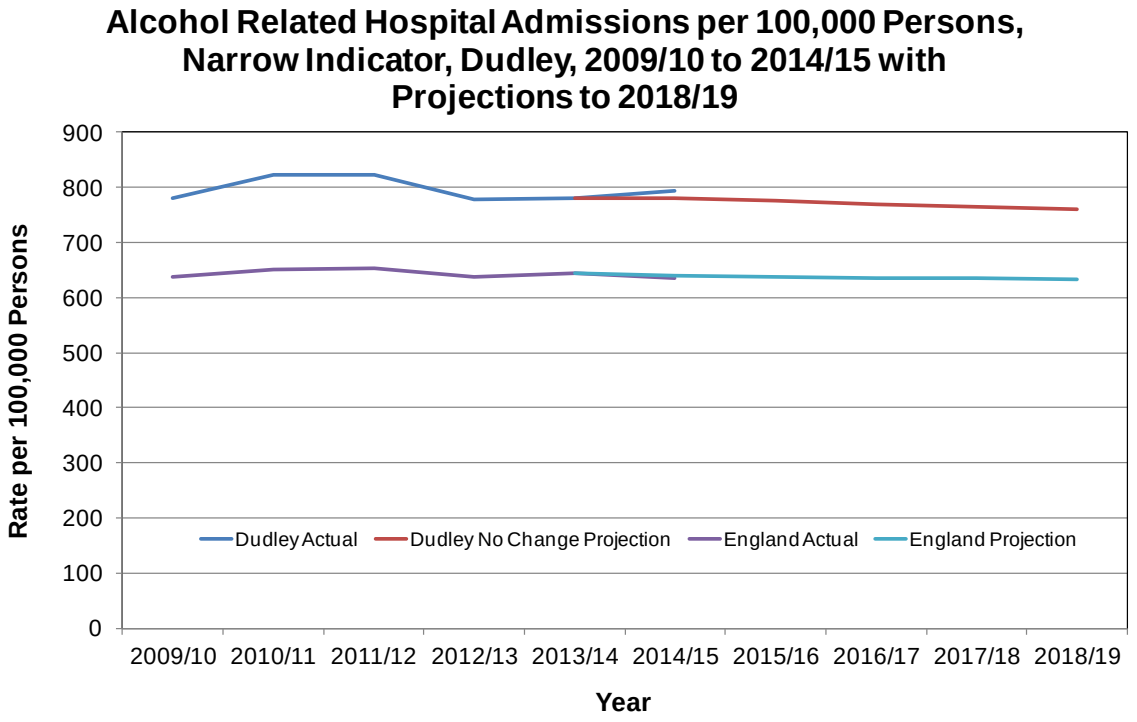


data source: Public Health Outcomes Framework
produced by: Office of Public Health, Dudley MBC



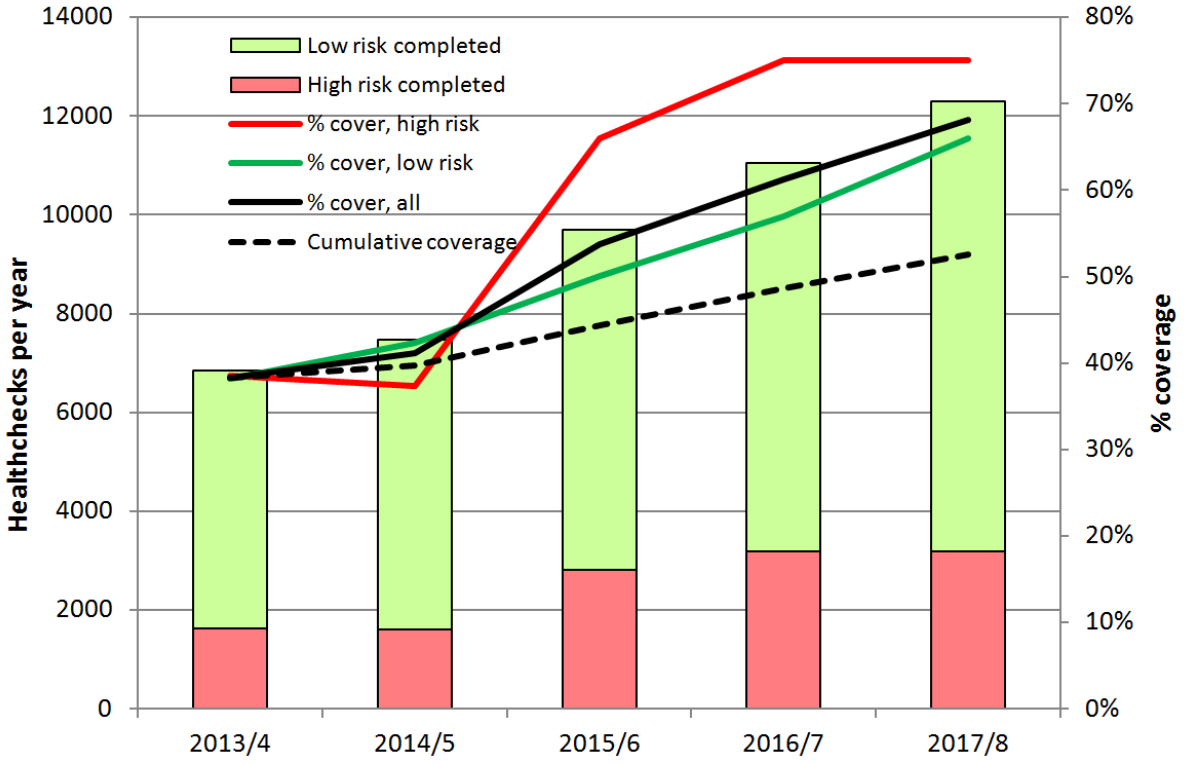
data source: Public Health Outcomes Framework
produced by: Office of Public Health, Dudley MBC

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.

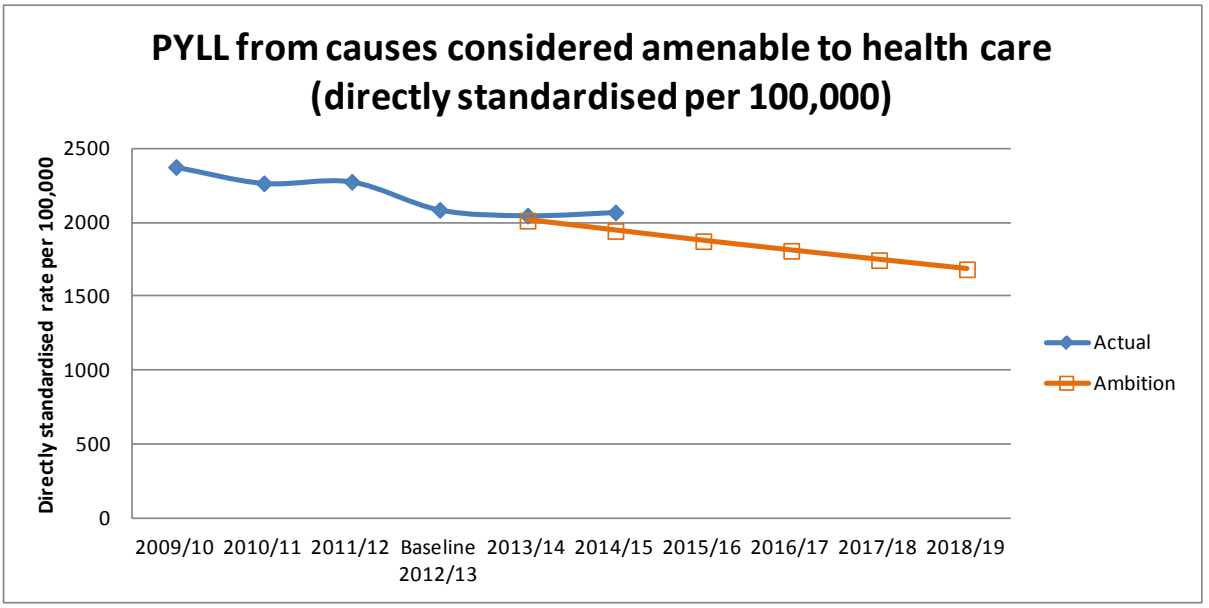
5. Our Outcome Ambitions – Reducing the Care and Quality Gap

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:-

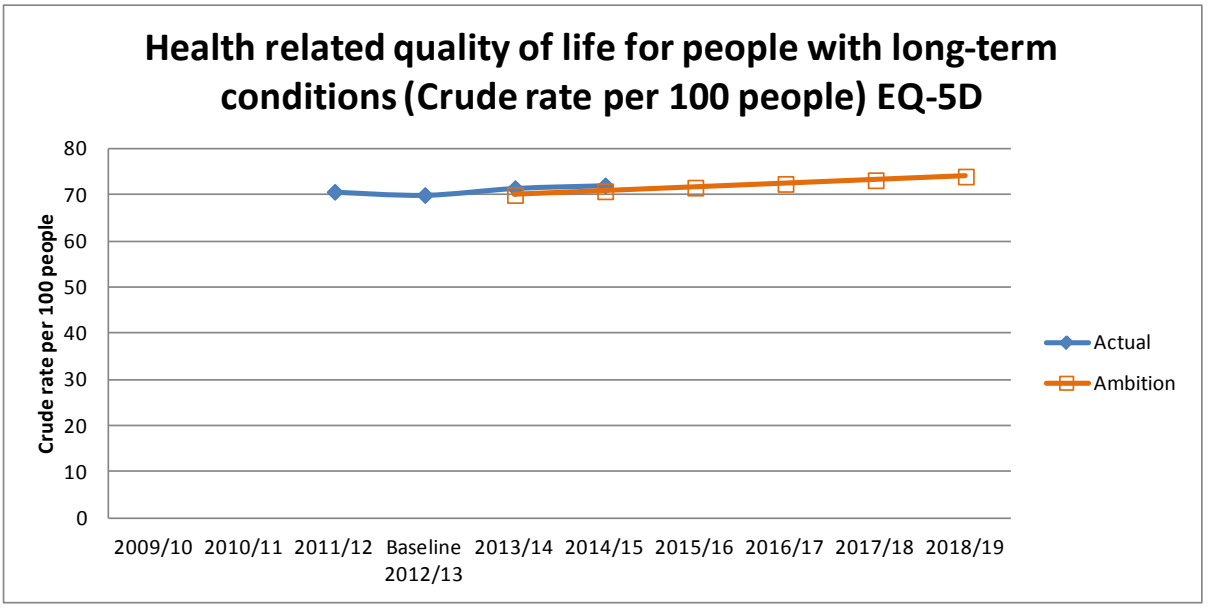
- 3.5% reduction in potential years of life lost (PYLL) per annum from 2087 per 100,000 in 2012/13 to 1943.5 per 100,000 in 2014/15 and 1685 per 100,000 in 2018/19; work with the Office of Public Health to improve the uptake of smoking cessation services in primary care;

- 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.



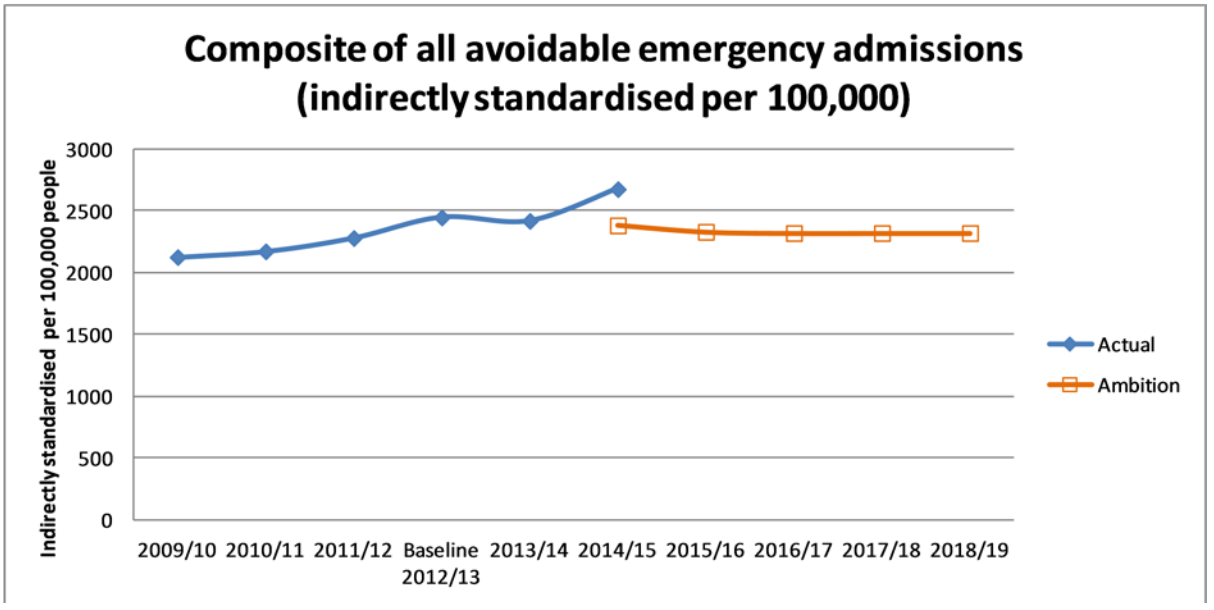
b) **Improving quality of life for 15m plus people nationally with one or more long term conditions:-**

- 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.



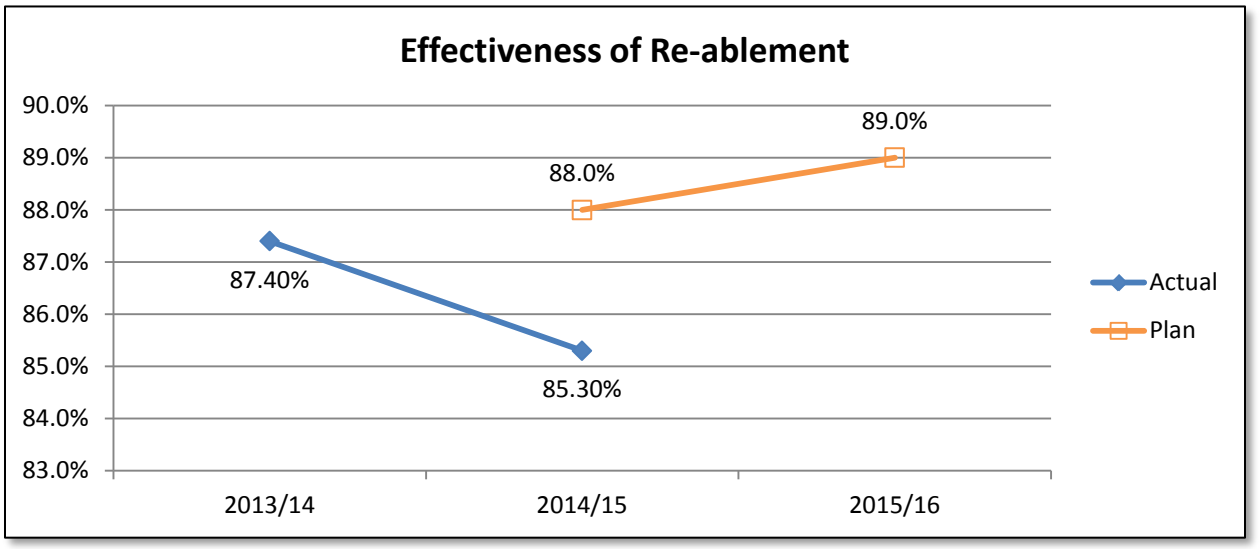
c) **Reducing time spent avoidably in hospital through more integrated community care:-**

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



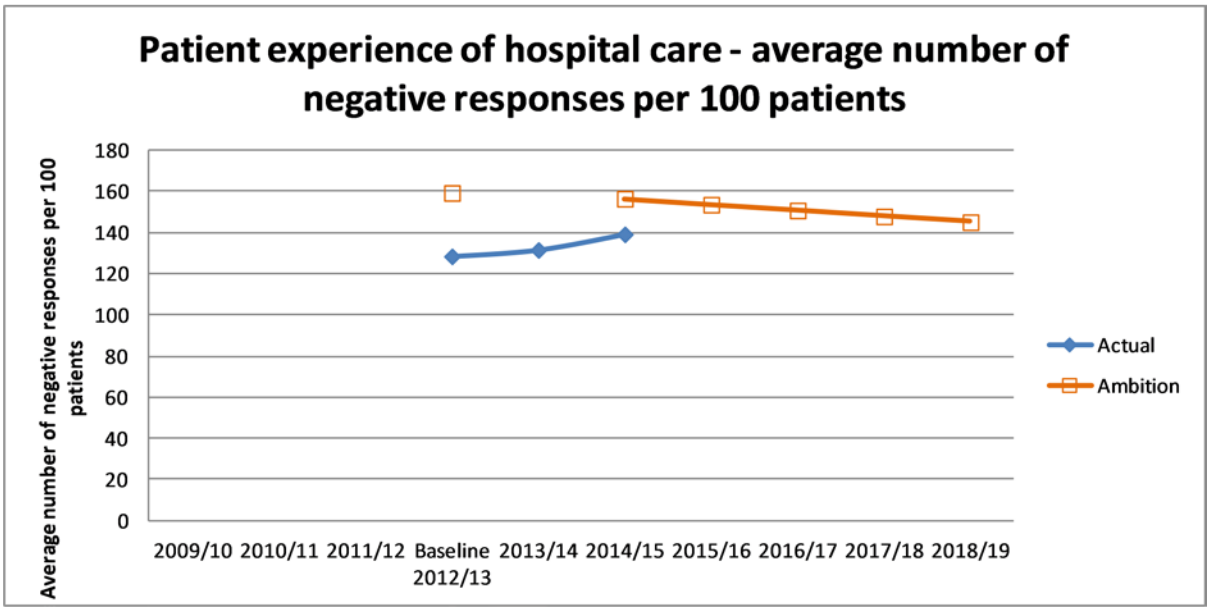
d) Increasing proportion of older people living independently at home after discharge:-

- 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).



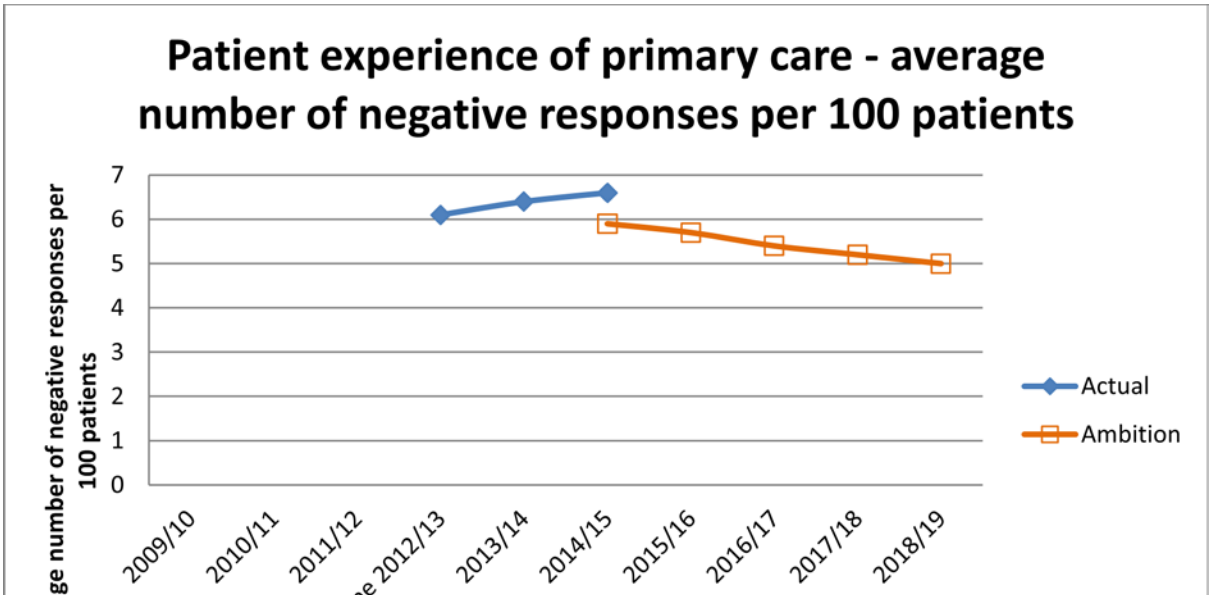
e) Increasing people's positive experience of hospital care:-

- 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

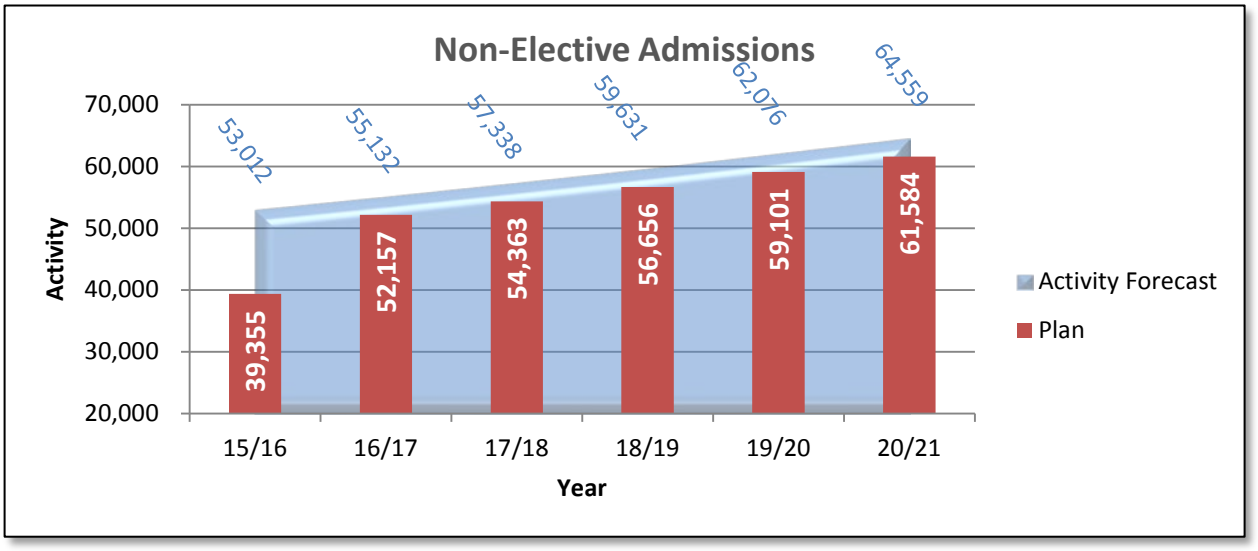
We have made significant progress in primary care: all practices are on the same IT system (EMIS); our 46 practices come together into five localities (each with ~60,000 population) to exchange information / best practice; we have developed, piloted and evaluated a General Practice Development Programme (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.

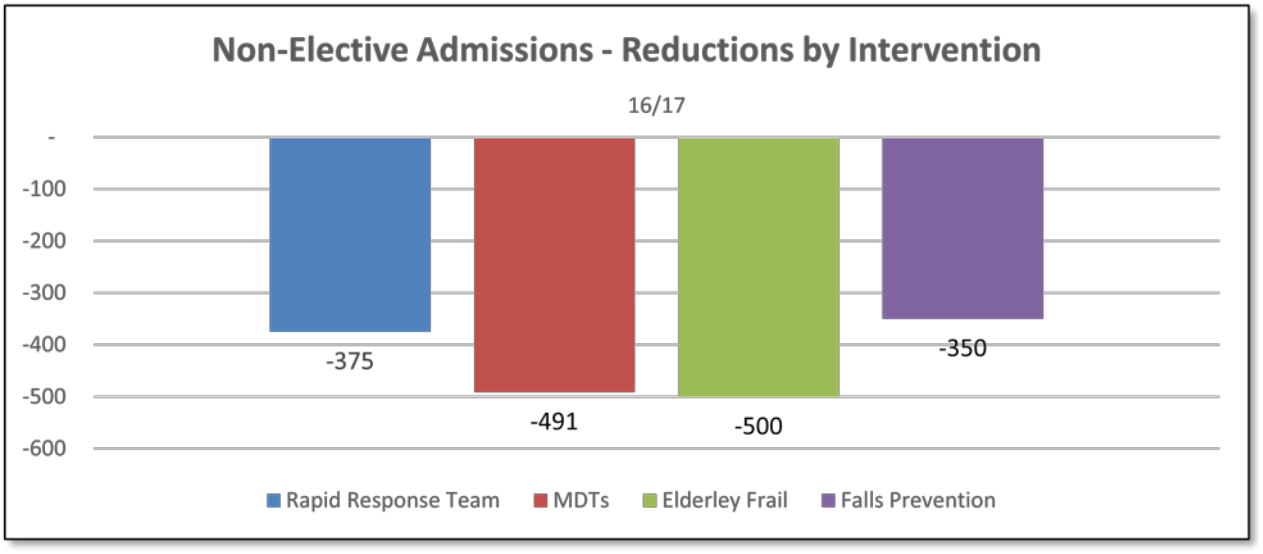
Fundamentally, this will aid the formation of larger-scale operations that will provide resilience, sustainability and quality across General Practice.

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.

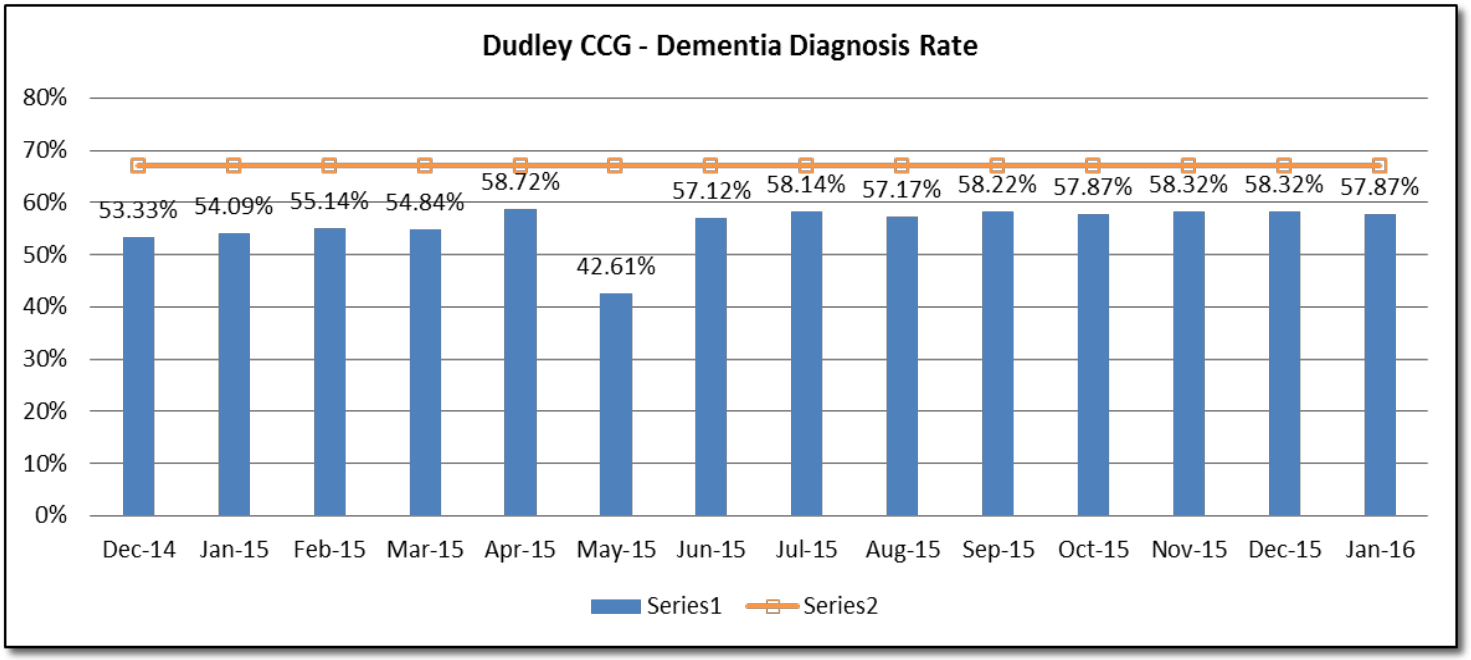
v) GP locality leadership – 5 GPs have been appointed. They lead the implementation of our integrated model in each locality.

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.

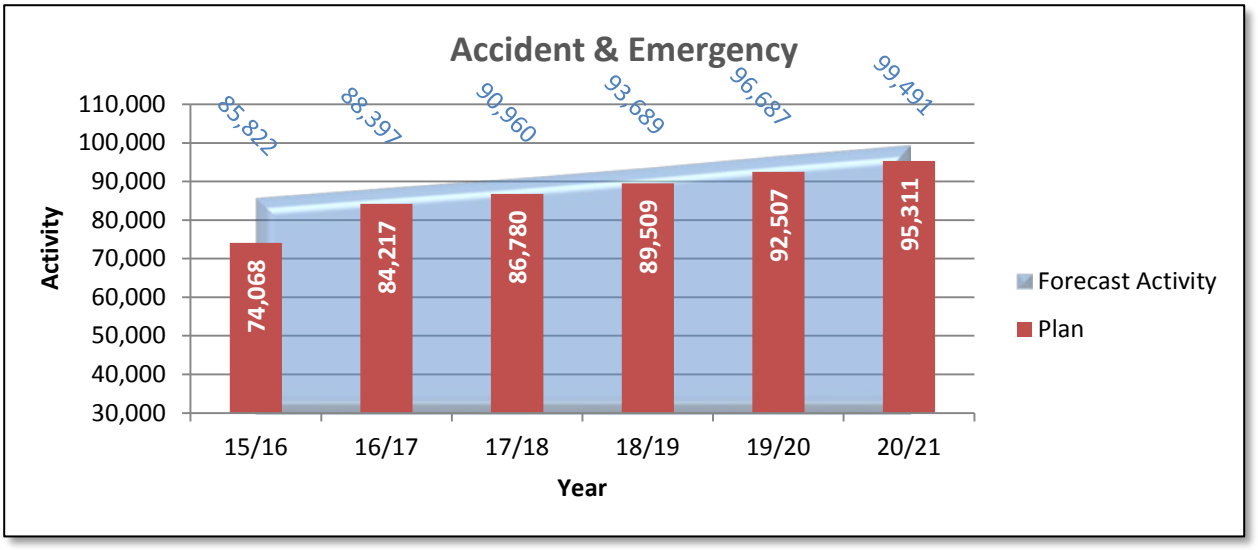
In terms of the key performance metrics:-

- 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.

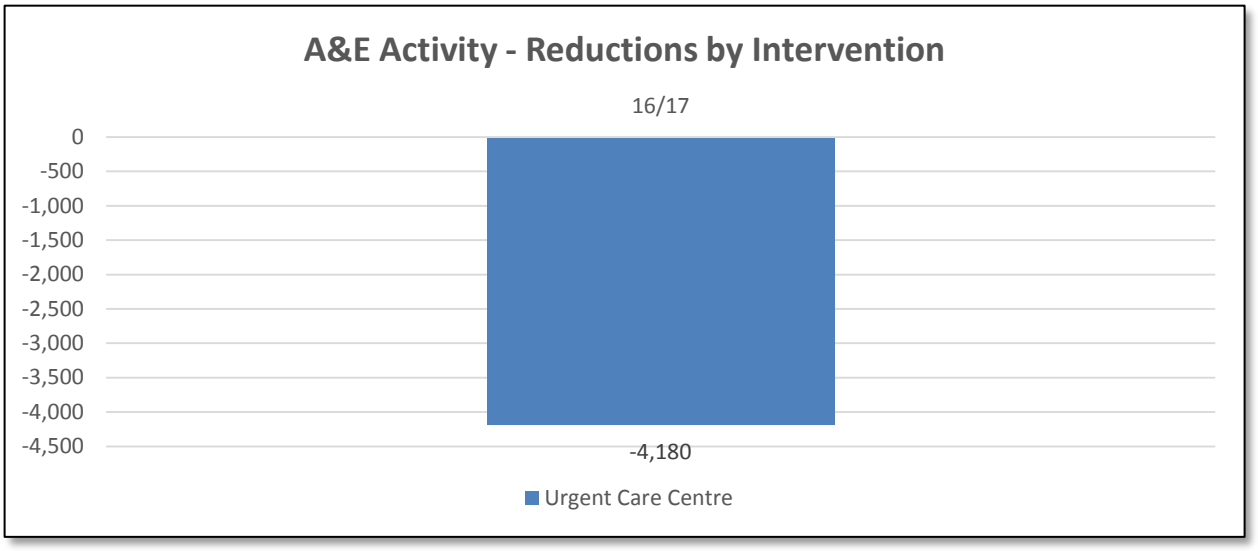
Our agreed contract with Dudley Group NHS Foundation Trust for 2016/17 is constructed on the basis of the required reduction in emergency activity from the BCF.

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.

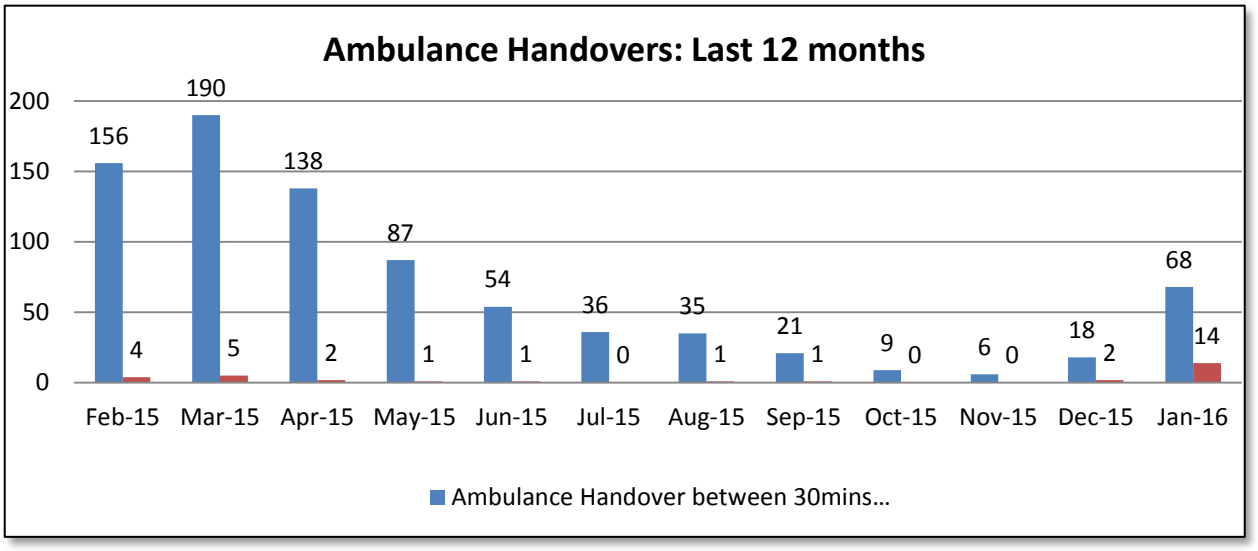


The graph above demonstrates the interventions and the respective impact required to achieve the planned reductions in ED Activity.

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:-

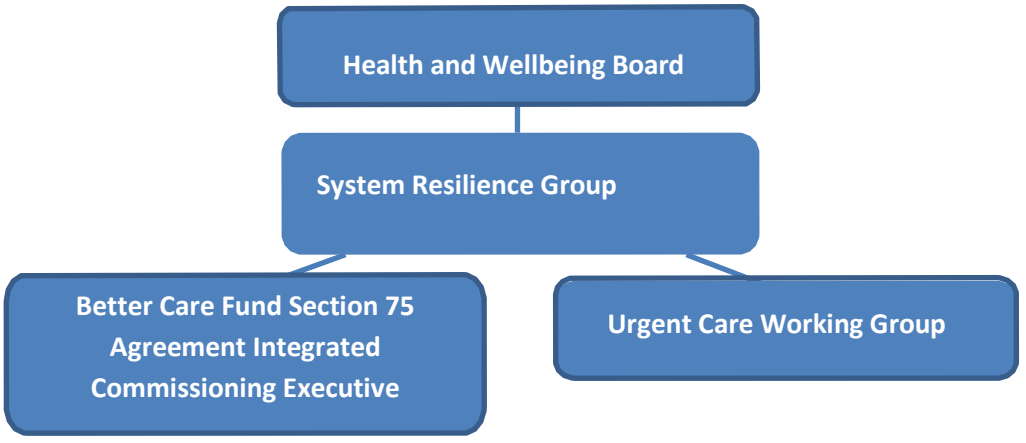
- addressing issues in relation to delayed transfers of care;
- ensuring "see and treat" and " hear and treat" are reflected in our ambulance service specifications;
- remodeling the UCC and ED estate to facilitate the more effective management of patients as they present, including those with mental 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**

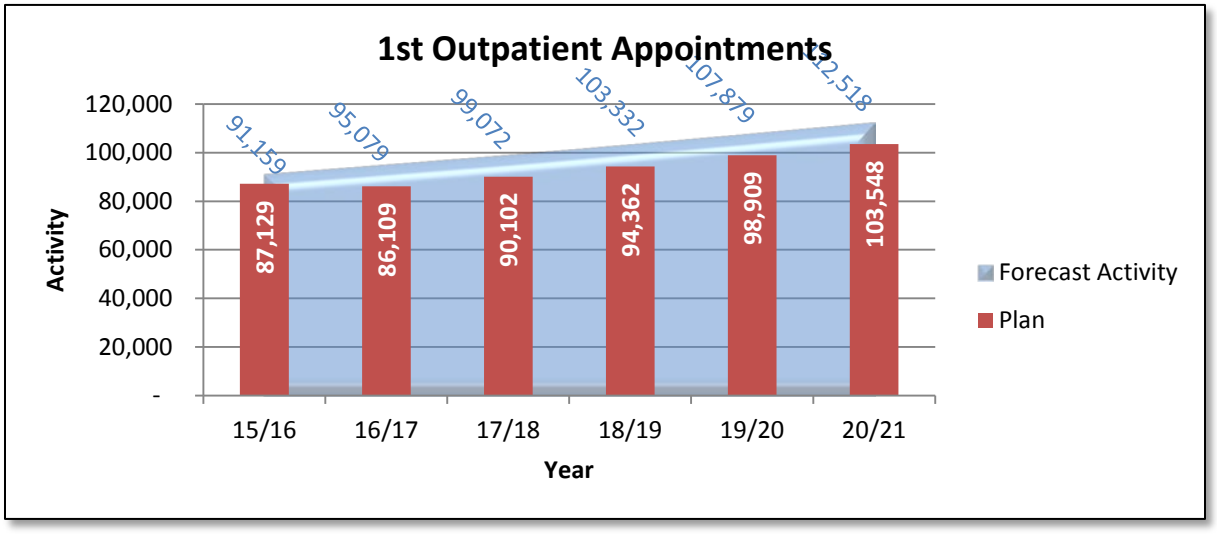
Our expectation is that by continuing to implement the schemes which pass the 2015/16 year-end confirm and challenge process, the current emergency four hour wait performance target will continue to be met.

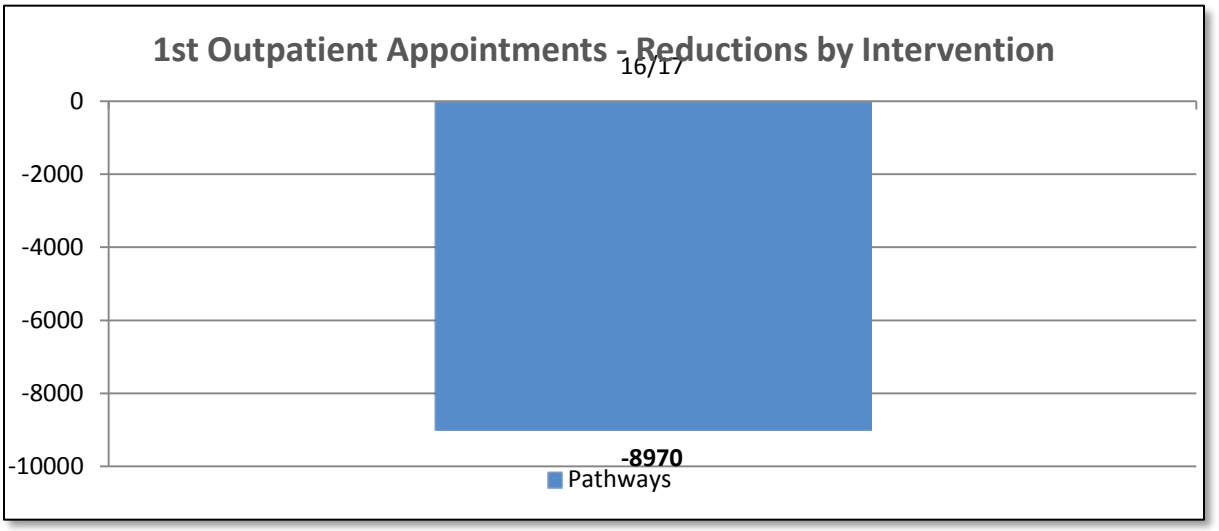
In addition in 2016/17 we will:-

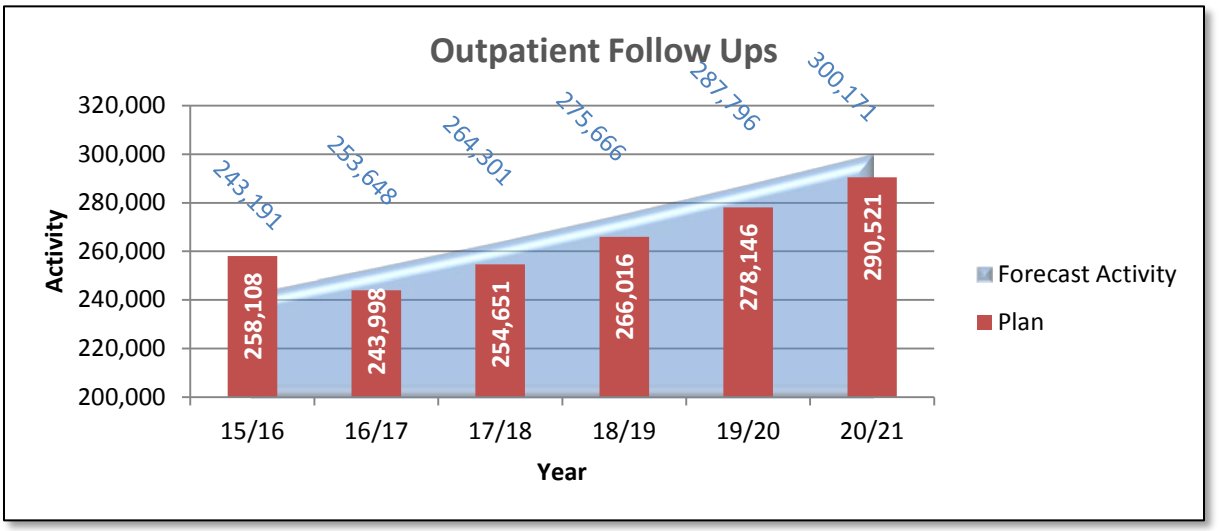
- review the pathways and charging arrangements for the various admission avoidance and assessment units currently linked to the Acute Trust unplanned care pathway;
- re-commission the NHS 111 service by July 2016.

h) A Step Change in Productivity of Elective Care

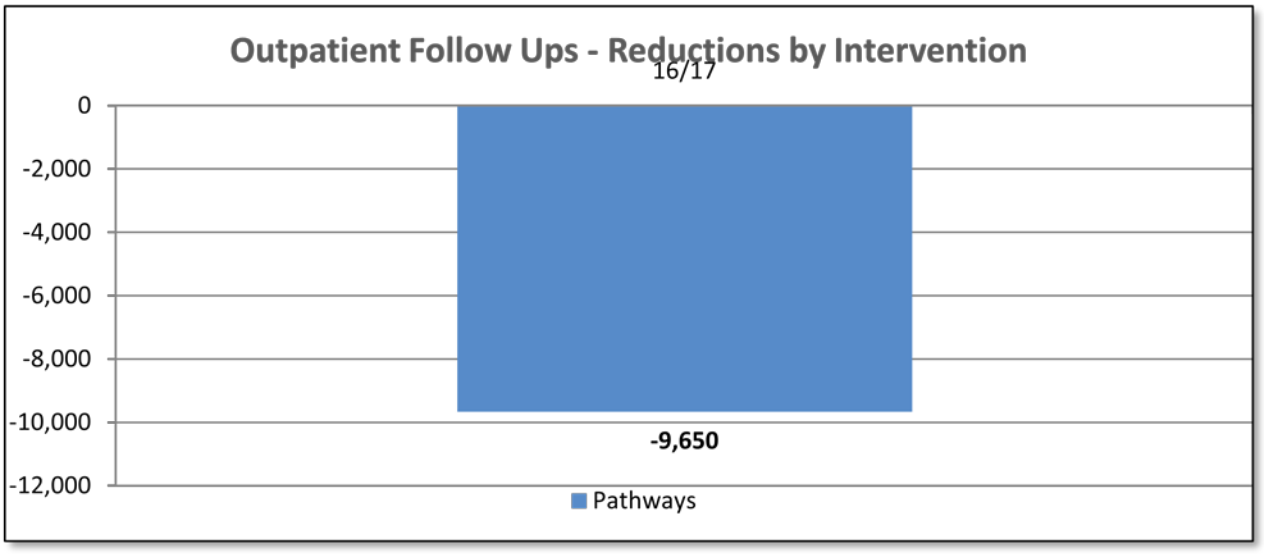
- To be met by a 20% reduction over 5 years, whilst countering a potential £100,000 cost increase, due to demographic change, per year.
- Outpatient follow up attendances to reduce by 8929 by 2017/18.
- Advice and Guidance and Triage to be introduced across all appropriate specialties at the point of 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.



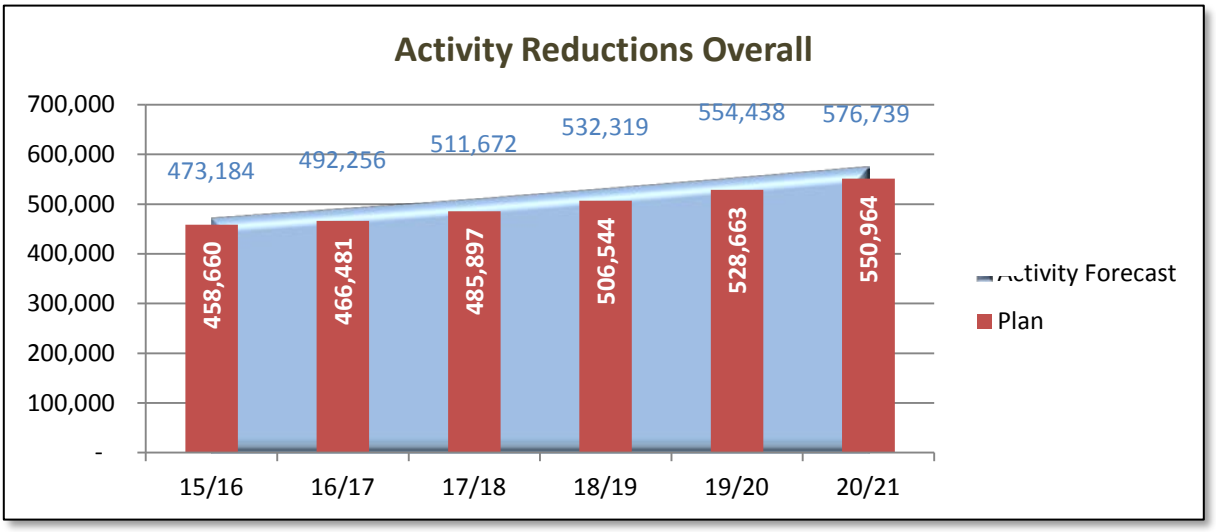


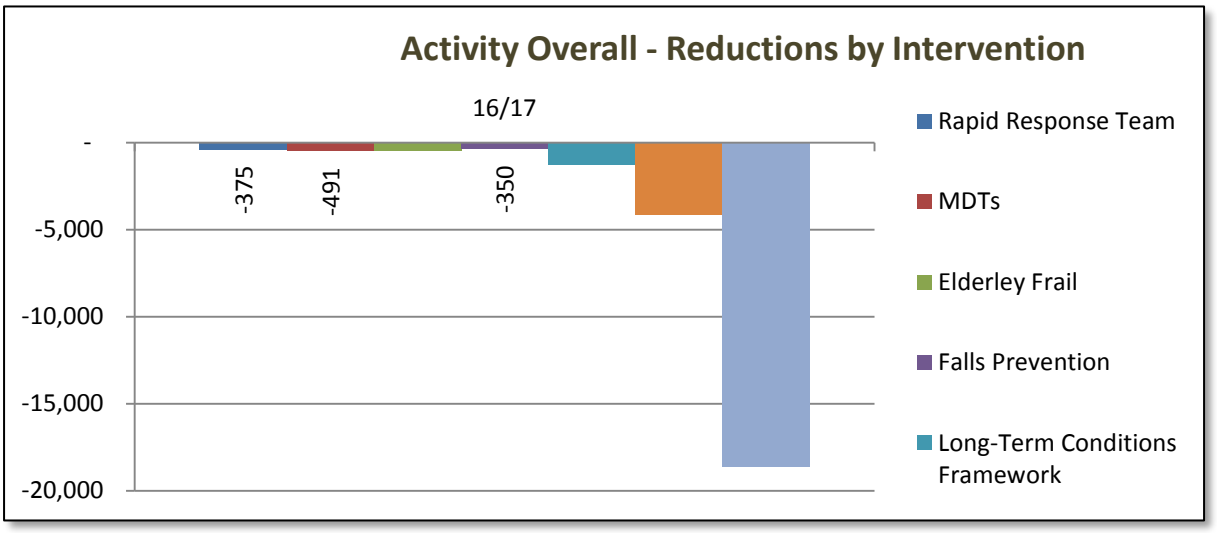


The graph above shows the planned reduction of Elective Activity against the backdrop of predicted activity growth due to changes in demography.



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

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

GLOSSARY

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

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

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