NHS
Dudley
Clinical Commissioning Group

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Dudley Clinical Commissioning Group

Long-term Strategic Plan 2014-2019

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

Our Vision

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

What we will Do

Our overarching objective is to improve the healthy life expectancy of the population we serve. To achieve this:

- We must promote good health and wellbeing; reduce inequalities in health; and commission services and interventions that help us all achieve those goals.
- We must therefore privilege services which operate on a population basis and which are designed to support health and wellbeing - particularly primary prevention services.
- And we must recognise the key role of the individual person, in contributing to their personal health and wellbeing - and the collective engagement of the local population in contributing to their collective health and well-being; so promoting recognition of autonomy for the individual alongside mutual roles and responsibilities.

Overall our key aims are to improve: healthy life expectancy; health outcomes; quality and safety; and system effectiveness.

We must also allow variations in the delivery of services to reflect different needs and inequalities in health in our local communities. However we must remove variations in performance and clinical practice which adversely affect the delivery of health outcomes.

Achieving sustainable care in a reductionist economy

Our NHS is at a tipping point. The NHS cannot continue to deliver healthcare using the same organising principles as it has done in the past. Rising demands through the growing elderly population, patients with increased co-morbidities, an increased range of therapies, rising costs of all treatment modalities, and limited economic resources create big challenges we must address. However, these challenges are not insurmountable. The greater challenge is whether we can re-imagine how we work and adapt to delivering healthcare in a networked society.

Our NHS organisations have been established within a modernist paradigm, working with imposed reductionist efficiency, performance targets and operating in organisational and professional silos which are insufficient to respond to these big challenges. This undermines the ability to deliver better outcomes for our population and contributes to risk averse practices, creating dependency and over-

medicalisation of care. Our structures, business models, service provision and organisational cultures need to be radically re-assessed in light of the social, technological, environmental and economic challenges we face.

In current thinking, hospitals are conceptualized and invested in as the central delivery point of healthcare; healthcare is delivered as a supply-led process: patients fit into the system - it is not demand-led, i.e. designed around their individual contexts and needs. Healthcare economics attempt to measure and cost episodes of care, thereby turning patients into diagnostic categories and numbers. This is false accounting as it doesn't account for externalities, i.e. the unseen costs of the holistic social and health care required by a patient who increasingly presents with complex healthcare needs. In addition, there is a dependency and conformist mindset which risks diminishing human compassion, creativity and innovation.

Instead we conceptualize Community Hubs of healthcare as the central delivery point of healthcare and well-being; GPs as generalists are highly regarded within the healthcare system, and hold commissioning power; registered members of GPs (their patients) are members of the mutualist healthcare community and as members contribute fully to healthcare decisions within their locality. Autonomy is a principle that ensures registered members have maximum control over their lives; and healthcare economics are holistic and systemic, accounting for real costs of care, including external costs and taking longer-term perspectives. Finally our workforce is encouraged to be collaborative, transparent and develop an adaptive culture, that is more human in its response, and always thinks about patients in their context.

So our strategy endeavours to reassess these factors, proposing a new vision for health and wellbeing services. This strategy starts with the patient perspective, in the context of a networked community. It will recognise the importance of clinical leadership and the pivotal role of general practice. Reimagining the organisation and culture of services to enable sustained health and wellbeing for everyone is our challenge.

Our Underlying Principles

Our CCG operates to six key principles:

1. **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 an 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.

2. **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.

3. Primary Care at our heart

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

4. 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.

5. 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.

6. 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.

Our Key Outcome Objectives

Our key outcome objectives are derived from the findings in our Joint Strategic Needs Assessment and designed to meet the needs of our population. These objectives include parameters that we can currently measure; however we will also be designing new measures which will more accurately in the future reflect the new structure and design of services that we are trying to create.

1. Effective and Efficient Care

Our health and social care system must be as efficient, effective and adaptive as possible in order to meet the rising needs of our population within our more challenging economic constraints. Therefore

our emphasis will be to maximise the benefit and potential of front-line interactions by our clinicians with our patients; and to avoid unnecessary interventions wherever possible.

Existing measures in place include:

- Reducing time spent avoidably in hospital:- 2,419 avoidable admissions by 2018/19
- Increasing proportion of older people living at home: People still at home 91 days after discharge 230 as at 2018/19

Future measures will evaluate:

- Ensuring clinicians have more time to spend with those who need it most
- Pathways of care (both urgent and planned care services) are as efficient as possible with minimal variations in performance between clinicians

2. Healthy Life Expectancy

Our overarching objective is to improve the healthy life expectancy of the population we serve.

Existing measures that we use to evaluate this include:

- Securing a 3.5% reduction per annum in avoidable years of life lost for people with treatable conditions to 1685/100,000 in 2018/19
- Improving Quality of Life for People With Long-term conditions: 74% of people report their health status has improved in 2018/19

Future measures will include:

- Delivering improvement to reduce the inequalities in health between different groups – thus ensuring parity of esteem for all vulnerable groups
- Ensuring Health and wellbeing services are at the heart of healthcare delivery

3. Mutual approach to achieving best possible outcomes

Improvements needs to be measured and understood both from a clinical outcome perspective but also from the value that is derived and perceived by the patients receiving care. Also outcome objectives need to be shared in advance between the individual and the service. Existing measures in place include a variety of patient related outcome measures for certain treatments and somewhat limited patient experience measures:

- Increasing people's positive experience of hospital care: average number of negative responses per 100 patients reduced to 145 by 2018/19
- Increasing number of people with positive experience of care in general practice and the community: Average number of negative responses reduced to 5/100 patients by 2018/19

However in the future we will develop measures which place the emphasis on patient-led outcome objectives:

- Enable patients to quantify the real value of the services that they receive
- Demonstrate how individuals achieve greater autonomy from healthcare
- Demonstrate how all service providers network better around the needs of patients

4. High Quality Care for all

The public expect the NHS to deliver safe and effective services. We already have a wide range of quality improvement measures and CQUIN arrangements which cover mortality indices, reducing rates of infection, safeguarding children and adults from harm, and evaluating and learning from serious incidents.

As we progress with the delivery of this strategy we will develop measures to ensure that:

- Services are safe and unwarranted variations are minimal
- Patients are treated with care and dignity and not over-treated
- Our system is transparent and learns and improves with the public

Re-imagining healthcare – a Mutualist Culture

(citizen participation and empowerment)

The NHS constitution sets out rights for the individual in respect of healthcare which Dudley CCG supports and we will ensure these are delivered for our population. However, rights alone are insufficient: they promote a consumerist attitude to healthcare and also a top-down culture whereby those in power give rights to the recipients of care. This is unsustainable and undesirable in an economically constrained system. It fails to recognise the importance of Mutual engagement which balances rights alongside responsibilities. Individuals are then expected to use resources responsibly and to recognise that they are part of a community, and the community is part of them.

Individuals must take responsibility, as much as is possible, for managing their own health and wellbeing. Our philosophy is to support individuals to do this and so reduce their demands on healthcare. We will therefore invest in activities that encourage adoption to this way of thinking and which provide proactive intervention and advice to the population. We will also foster 'health as a community responsibility' by supporting integration with the voluntary sector; facilitating active community engagement between NHS services, Public Health and VCSE services.

In addition, we will change the basis of future engagement from the representative mechanism of the willing, to a participative mechanism for all. This will involve the development of information tools that enable every person receiving healthcare to articulate the benefits (or otherwise) of the care that they receive and the personal impact that it has had for them (One such tool currently being piloted through our Building Healthy Partnerships programme is the PSIAMS tool). We will then be able to use actual patient feedback to evaluate the effectiveness of services as determined by the patients themselves.

Ensuring that every person is an engaged and registered member of our CCG is also an important way in which we will address inequalities in health and parity of esteem for all vulnerable groups – including the homeless, ethnic groups, disabled people, new migrants and arrivals to the borough - and is central to our approach to equality, diversity and inclusion. Priority of action will be given to ensuring reliable data in primary care to identify groups with worse outcomes; and we will design new services to ensure improved access (so for example our new urgent care centre will include mechanisms for registering anyone who attends, who is not already registered with a GP).

Our CCG is a membership organisation and is ultimately funded to support those people who register with our GPs. We have started our membership engagement through the development of our patient participation groups linked to each of our practices; and we will continue to strengthen this as a key means of engagement. However in five years we will have developed an active membership programme for all those people registered with our GPs. This will incorporate a patient portal providing health and wellbeing advice; enabling access to their records; and clear mechanisms for support and access to healthcare through their GP. Opportunities for giving feedback and participating in shaping and informing the development of their local healthcare services will be integral.

We currently have a way of working where increasingly components of our healthcare service work on a protocol driven model of care. This is positive in creating minimum and consistent standards but

it also leads to reduced individual clinical judgement and a risk averse approach which ultimately results in too many people being referred on to more intensive services and contributes to rising patient dependency. Instead we will actively promote to establish a new way of working which encourages mutual responsibility between patient and professional; and supports increased personalised care which also enables individuals to have a greater say in managing risk and therefore managing the outcomes that they want to achieve. This approach will reduce dependency and reduce over-medicalisation of patients.

This mutualist approach will create a more engaged relationship with our registered population where they have a clear share in how services are shaped and developed; as well as a more personalised service which encourages more autonomous self-management. Most importantly our members will know, value and understand the benefits of being a member of our CCG.

Re-imagining healthcare – the Structure of the System

(access to highest quality urgent and emergency care)
(a step change in productivity of elective care)

The traditional organisational structures of healthcare are inadequate to meet the conflicting challenge of rising demand versus reducing resources. The existing separation of services into primary care, community services, mental health services and acute services is artificial, contributes to silo working and doesn't reflect the needs of the modern population.

We have already started to rethink the organisation of care into four different groupings:

- planned care: value-added treatment interventions with defined outcomes;
- urgent care: short-term interventions to help and treat you in a crisis;
- reablement care: services designed to help reduce your dependency;
- and proactive care: population-based care to help you manage your health needs.

Commissioning healthcare on this basis enables us to set common performance improvement requirements for each of these groups of services and brings consistency for mental health patients as well as other vulnerable groups. Parity of esteem for all groups is a theme throughout our organisation and our providers.

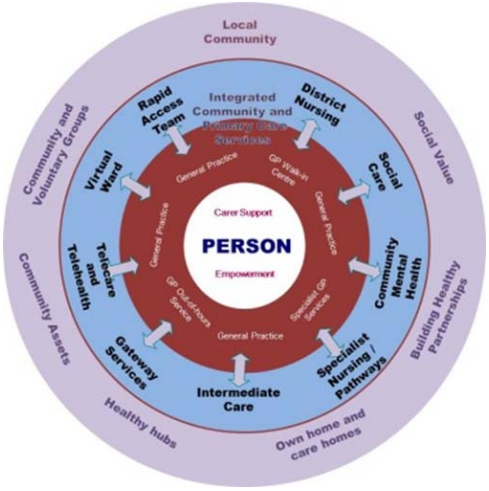
In planned care we will be commissioning based on measureable value-based outcomes of the services provided. We will have systems in place to monitor and report on variations in individual clinical performance – with the aim of improving both the whole pathway efficiency of services (left-shifting the distribution curve), as well as the outcomes of treatment. Ultimately, we will set prices for planned care on the basis of best practice performance (on effectiveness of outcomes and total pathway efficiency) and will expect providers to adhere to those performance standards.
We will expect our service providers to have dedicated facilities and capacity for planned care, without risk of significant interruption from urgent care, so that both clinicians and patients can provide and experience a high quality, efficient and effective service.

With urgent care we will have established our new urgent care centre at Russell's Hall Hospital and we will implement new pathways of care for both our frail elderly population and also for mental health care, so that A&E is not part of the pathway, but instead enables patients to go direct to the most appropriate service. We will commission emergency medical care as an extension and integral

part of population-based health and wellbeing services. This will then create a paradigm-shift in the organisation of care for our frail elderly population: instead of urgent treatment being managed within the confines of the hospital; services will instead be managed between the home and the hospital. This will both enable more patients to stay at home as well as enable clinicians to better co-ordinate capacity between community and hospital care. Similarly A&E will therefore be available solely to provide genuine accident and emergency care – particularly trauma and emergency surgery.

Our reablement services will form part of our extended partnership with social services and the voluntary sector. We will be commissioning services specifically to reduce dependency and enable individuals to return or stay at home wherever possible. This directly correlates to the national Better Care Fund objectives of reducing the future need for residential and nursing care. Also, we will engage with the public about expectations on healthcare to ensure that patients, carers and families support the need for people to move quickly to as low a dependency setting as possible, recognising that hospitals should only be used for short-term treatment interventions that make a difference.

Our integration model works on five local communities and is designed to deliver our approach to proactive care. This organises services based around the needs of the person and integrates community services, mental health services and social services around our general practices – so that all services are working with the same groups of patients. This enables both personalised care, as well as firmly basing the team that supports them within the local community of healthcare. This emphasises a network approach to health and social care delivery. Our partnership with Dudley MBC and with the local VCSE through our Building Healthy Partnerships programme is essential to securing a sustainable and integrated service.



Over the next five years we will develop our integration model into comprehensive, population based, health and well-being services. This will include the management of all long-term conditions and emergency medical care for the frail elderly.

Re-imagining healthcare – Population Health and Wellbeing Services

(a modern model of integrated care)

Within the next five years will re-commission pro-active population-based healthcare services via a different model.

We need a step change in how primary care systematically manages long term conditions to deliver healthy life expectancy: so we will bring together all population-based care into one set of integrated services based upon the registered populations with general practice. GPs are at the heart of this model, as the key co-ordinators of care; and this recognises the dual roles of providing: on-going health and wellbeing care support which can be planned over time; as well as the need for more urgent access in times of illness or crisis. We will therefore commission these two types of activity separately:

- For health and wellbeing care patients prefer continuity of clinician/professional.
- For urgent care, speed and ease of access is important.

In addition we will differentiate between different levels of intensity of service. For example:

- Proactive care is about supporting people to remain healthy and is linked to the Dudley Office of Public Health and Dudley MBC programmes for prevention
- Long-term care support to those living with long-term conditions would include a mix of longer, pre-bookable appointments with GPs and/or specialists
- Enhanced and End of Life care (including community care in the home, or nursing / residential care) will be improved through the use of risk stratification, partnership with social care and the voluntary sector.
- We will engage in a broader discussion with the public about how best to support people at home near the end of their lives. Should so many treatments that over-medicalise care be carried out? We will be having discussions with our population, our patients and their families to ensure they have the support they need to manage their circumstances, whatever they may be, with dignity and compassion.

		Population Health and Wellbeing Services			
		Health and Wellbeing Care		Urgent Care	
level of intensity of support	low	Proactive Care	Starts with universal services for children. Includes wellbeing advice and support	Self-management	Advice on how to manage minor ailments (NHS 111)
		Long-term Care	Helping individuals to manage living with their long-term condition(s)	Pharmaceutical support	Medication and advice from your pharmacist
		Enhanced Care	Significant support for those living with the most complex needs and co morbidities	GP-led Access	Urgent appointments at your local, or near-by, practice
	high	End of Life Care	Care and support when you need it most.	Community Rapid Response to the home	For the frail elderly and those with complex conditions

Note: there is an assumption in this table that end of life demands high support- whereas our aim is to return the care to the community- diminishing professional support

Health and Wellbeing Care will be personalised to the individual. For many individuals they are the main co-ordinator of their care for 99% of the time so the level of intervention and NHS support will be minimal; will be designed to enhance the individual's self-management; and can be provided on a planned basis – particularly proactive care and long-term care. Enhanced Care will include some enhanced support that would be provided on an on-going 7-day basis depending on the needs of the individual (eg: community nursing support into the home; or 7-day nursing or residential care). Similarly End of Life Care will include access to significant support on a 7-day basis if and when it is necessary.

Urgent Care within this model will be provided on a 7-day basis. In these circumstances, expediency of access to an appropriately qualified individual, based on an assessment of your need, is more important than continuity of care. Therefore GP services in particular can only be provided once primary care is organised at scale across localities. However the lack of continuity of individual clinician can be mitigated through continuity of information by our establishment of a single GP IT system which allows access to complete medical records.

These plans can be achieved through commissioning the services at scale; and by improved integrated commissioning with NHS England (as the organisation that procures GP services) - so we will pilot this approach with NHS England for co-commissioning this model of service. This will bring together their contracting of primary care with our contracting of community care. This will enable an integrated model of delivery, supporting the national Better Care Fund initiative; will remove traditional boundaries between services by bringing together all population-based care into one set of integrated services based upon the general practice registered patients; and will establish shared outcome measures for improved population health and wellbeing.

Our shared intention with NHS England will be to achieve a stepped change in how primary care systematically manages long-term conditions to deliver healthy life expectancy. This will enable us to significantly refocus large proportions of care and support into the community, based around general practice; and will enable us to establish more comprehensive and fully integrated outcome objectives to understand the needs of those living with long-term conditions and reflect them in our priorities.

Re-imagining healthcare – Health and Wellbeing centres for the 21st Century

(wider primary care, provided at scale)

In Dudley we are fortunate to have modern hospital facilities that can provide excellent care for our population when they need it. However, the quality of primary and community care facilities is much more variable and much of it does not meet the needs of our population. High quality facilities are key to allow us to make the quantum leap in terms of care for our communities.

In addition we have a workforce that is often under pressure and there are increasingly shortages (nationally) of staff in key groups. For example, a significant proportion of our GPs are expected to retire in the next 5 years so we need to recruit new GPs in to work in Dudley.

During the next five years we will put in place an innovative development programme for the healthcare estate in Dudley. We will encourage existing practices to come together to both make full use of the existing high quality facilities as well as develop new larger centres. These new centres will provide the focal point for our approach to delivering health and wellbeing services and so will have the capacity to provided specialist clinics (eg: for long-term conditions) as well as extended general practice. This will bring longer-term population-based healthcare out into the community as part of our locally integrated services.

We will be actively encouraging independent developers to work with us to access the capital required for this development programme; and we will be working with NHS England to put in place the necessary agreements on pooling CCG and NHS England resources in order to develop the financial arrangements to provide the revenue support needed.

We want Dudley to be the place where people want to come and work because they will get the best possible training, support and satisfaction from a job well done; by extension, our population will get the best possible care. So investing in our workforce is mission critical. We will therefore expand our current education and training programme to put in place comprehensive training and support for all the staff groups that are part of these new health and wellbeing services.

We have inherited a system from our predecessor organisations which has allowed significant variation (over 100% variation) in the levels of investment in primary care between practices; and in the organisation of community services across the borough. We will implement a new quality performance framework that correlates financial investment with outcome performance in order to incentivise high performance - but paid for at the right price.

In addition, we intend to free-up our front-line staff across primary and community services, to both maximise their opportunities for work with patients and achieve better outcomes. To achieve this we will invest in systems design and integrated services at scale, to both centralise support functions and improve technological support to maximise front-line capacity and efficiency.

Re-imagining healthcare – Innovation and Learning

We are a learning organisation and as such we highly value, and are investing in, research and organisational development. We have established links with the HSMC at Birmingham University to develop our evaluation and review of services; and we have developed a substantial organisational development programme for both the CCG and our healthcare system. We will also use research to explore and evaluate some of the key concepts and ideas in our strategic plan to ensure that we accelerate our progress - so developing the best possible services for our population.

In our first year we will make significant steps to improved working with technology – as all our GPs will be using the same clinical IT system. This will not only enable integrated working between practices but will also enable access to other services (such as A&E) and so significantly improve the quality and safety of care to all of our population.

Subsequently, we will commission for a comprehensive information system, which incorporates GP IT, to provide the infrastructure and system support for all services that are part of our integration model. We will then require all providers that contribute to the integrated model, to use this information system – thus establishing a comprehensive population-based information database which underpins our population-based health and wellbeing services. We will only commission from service providers who commit to using this system and database – and this system will very clearly incorporate rules on data sharing so that only the right people have the right access at the right time.

This approach to commissioning-led information will also significantly improve provider efficiency and effectiveness; reduce barriers to market entry; and improve contractual efficiency with our CCG. So for example: all the required performance reporting, invoicing and validation processes will be co-ordinated centrally and derived from the directly inputted patient/clinician activity. Payments will be automatically made by the CCG to providers in accordance with the agreed contract – so all associated back-office functions for both primary and community providers will no longer be necessary. Smaller organisations, including new social enterprises and VCSE organisations will more easily be able to participate in our health and social care economy because they will not need to invest in these costs, which can often be prohibitively expensive for smaller organisations.

A key strategic objective is to improve system effectiveness. This means making it our business to focus on achieving efficiency and best practice in front-line care:

- Firstly, enabling providers to improve back-office efficiency and reduce overheads in order to focus on front-line care. The development of commissioning-led information systems is a key component of this approach.
- Secondly, ensuring that we maximise the efficiency and opportunity of our front-line staff. We will invest in IT designed for a specific purpose: to develop systems to benefit clinical effectiveness efficiency and safety. We will also invest in mobile technology for all primary and community services
- Secondly, reducing variations in practice in order to eradicate inefficiencies. We will benchmark variation by individual clinician and clinical team. We will use centralised risk stratification and population utilisation analytics to identify vulnerable patients and at risk groups who aren't receiving the care they need and would benefit from targeted support.
- Thirdly, supporting patients in maximising their autonomy. We will empower our population by investing in publicity and advice; recognise that the individual's identification with community is manifest through a multitude of different networks; we will invest in voluntary sector support and learn from their connections and identity with communities; and we will embrace new technologies which enable remote or self-monitoring of health conditions.

Our population-based design to future healthcare delivery will make it easier for other GPs to join our CCG in the future. We will develop an induction process to support new practices to join our CCG which will include GP IT integration: a practice development and mentorship programme: our approach to mutualist healthcare and registered membership; and the integration of community and social care services around the practice.

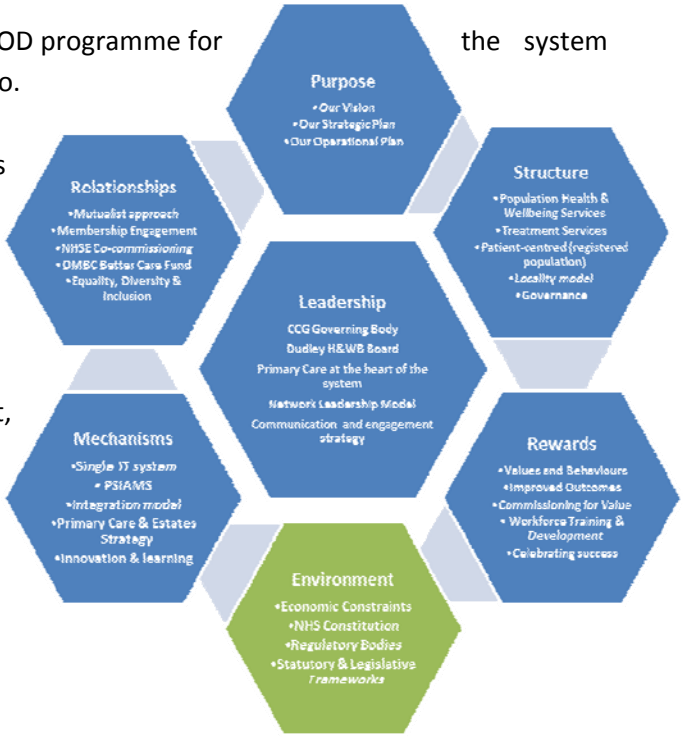
We also believe that we have a responsibility with the wider NHS to share our good practice and also learn from others. So we will work with other CCGs to establish an Organisational Development and Learning network to exchange ideas and learning. We will also develop a franchise approach to our population health and wellbeing model of delivery, linked to registered membership. This will enable other CCGs, with endorsement from NHS England to utilise and apply our new model of care with their groups of practices. This will therefore enable a rapid roll-out of our model to other areas of the NHS, should they want our help and support.

Next Steps – Implementing this Vision

As the local leaders of the healthcare system, our OD programme for the system is one of the most important aspects of what we do.

So our organisational development plan realises our strategic vision by setting out the development programme and operational objectives for all of the components of this strategy over the first two years.

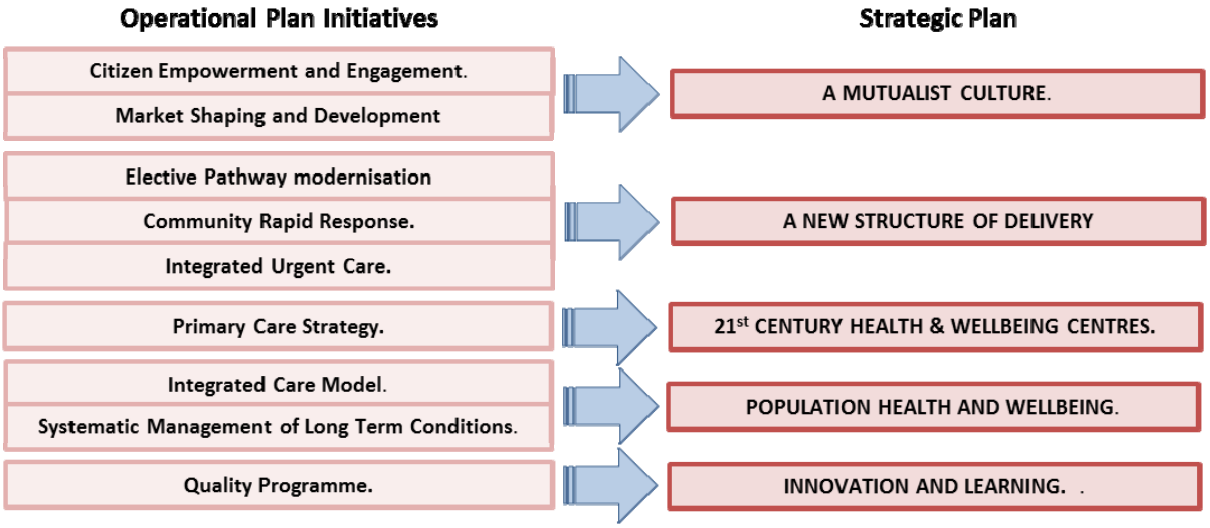
This takes account of the external environment, constraints and challenges within which we are working and maps out our programme for development against the six components of our



OD model:

- Purpose
- Structure
- Rewards
- Mechanisms
- Relationships
- Leadership

Then the first operational stages of this five-year strategy are set out in our two-year operating plan. The following diagram provides an illustration of how the main operational plan initiatives provide the start point to subsequently enable our re-imagined health and social care system as set out in this strategy. This is then fully realised with the addition of the key enablers that are explained in both the operational plan and this strategy.



These plans together therefore lay the foundations for all of the key components for achieving this longer-term vision.

Thinking Differently

NHS Dudley Clinical Commissioning Group

Five-year Strategy 2014-1019 Plan on a Page

APPENDIX 2

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

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

Objectives	Reimagining	Enablers
Objective: Effective and Efficient Care • Clinicians have more time to spend with those who need it most • Pathways of care (both urgent and planned) are as efficient as possible	**Reimagining: A MUTUALIST CULTURE.** Creating opportunities for active citizenship in vibrant communities and a participative mechanism of engagement for all registered members. Changing the way we evaluate healthcare so that the patient can articulate the value of the services they are receiving. Promoting mutual responsibility between patient and professional to manage risk and personalise healthcare planning.	Enabler: A mutualist based relationship with member practices and responsible local citizens – developing PPGs and an autonomous registered membership.
Objective: Healthy Life Expectancy • Premature mortality is reduced • Inequalities in Health between all population groups are reduced • Health and wellbeing services are at the heart of healthcare delivery	**Reimagining: A NEW STRUCTURE OF DELIVERY** Changing the definitions of services from primary, community, mental health, social care and acute to: planned care, urgent care, reablement care and proactive care. Removing the boundaries between different professions to privilege population-based healthcare in the community with a networked primary care and registered population at the centre.	Enabler: Development of person-centred information: PSIAMS – personalised patient-driven reporting on the value of care ; Risk stratification to target resources based upon individual patient risk profiling. Enabler: Commissioning for value: removing unwarranted variation in care and evaluating individual clinical performance to inform patient choice
Objective: Mutual approach to achieving best possible outcomes • Patients can quantify the real value of the services that they receive • Individuals achieve greater autonomy from healthcare • All service providers network better around the needs of patients	**Reimagining: POPULATION HEALTH AND WELLBEING.** Enabling a step change in how our GPs coordinate the systematic management of long term conditions to achieve healthy life expectancy. Differentiating between: population health and wellbeing services - where continuity is key; from urgent care - where responsive access is the priority.	Enabler: Commissioning-led population-based information systems and integrated IT that enable health and wellbeing services; mobilise front-line staff; support market shaping and market entry; and reduced cost to providers
Objective: High Quality Care for all • Services are safe and unwarranted variations are minimal • Patients are treated with care and dignity and not over-treated • Our system is transparent and learns and improves with the public	**Reimagining: HEALTH & WELLBEING CENTRES FOR THE 21st CENTURY.** Supporting the development of new centres of care across the borough to provide modern facilities in our communities. Investing in front-line staff so they have the best possible training, support and satisfaction from a job well done – and by extension providing best possible care to our population.	Enabler: Our Primary Care Strategy and Estates Strategy – with Co-Commissioning of Primary Care with NHS England.
	Reimagining: INNOVATION AND LEARNING. Using research to test and evaluate the key components of this strategy. Making it our business to focus on achieving efficiency and best practice in front-line care. Working better with technology: both within the health and social care eco-system as well as with individual patients.	Enabler: Joint governance, performance and commissioning frameworks with all partners. Better Care Fund with Dudley MBC. Memorandum of Understanding with the Office of Public Health. Enabler: Network leadership, training, evaluation and research programmes

Supported by: Our 2-year **2014- 2016 Organisational Development Plan** and our 2-Year **2014-2016 Operating Plan**