Directorate of Corporate Resources

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Your ref:	Our ref:	Please ask for:	Telephone No.
	JJ/jj	Mr J Jablonski	815243

9th June, 2014

Dear Member

Dudley Health and Wellbeing Board

You are requested to attend a meeting of the Dudley Health and Wellbeing Board to be held on Tuesday, 17th June, 2014 at 5.00 pm at Wrens Nest Community Centre(Main Hall),Summer Road, Wrens Nest,Dudley,DY1 3PD to consider the business set out in the Agenda below.

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

Yours sincerely

Director of Corporate Resources

A G E N D A

1. ELECTION OF CHAIR

   The Elected Members of the Board to elect a Chair

2. APPOINTMENT OF VICE-CHAIR

   The Elected Members of the Board to appoint a Vice-Chair

3 APOLOGIES FOR ABSENCE

To receive apologies for absence from the meeting

4. APPOINTMENT OF SUBSTITUTE MEMBERS (IF ANY)

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

5. DECLARATIONS OF INTEREST

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

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

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

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

6. MINUTES

To approved as a correct record and sign the minutes of the meeting of the Board held on 26th March, 2014 (copy herewith)

<u>INFORMATION ITEMS</u>

7. Healthwatch Dudley Activity Report (Pages 1 – 5)

8. Health and Wellbeing Board Annual Account – The First Chapter 2013/14 and Overview of the Health and Wellbeing Board's Annual Conference 2014/15 (Pages 6 -15)

9. Dudley Health Protection Cooperation Agreement (Pages 16 – 44)

10. Better Care Fund Update – Oral report

DISCUSSION ITEMS

11. Special Educational Needs Reforms - Presention (Pages 45 – 66)

12. Dudley Clinical Commissioning Group Strategic Plan 2014-2019 (Pages 67 – 86)

STRATEGIC ISSUES

13. Maximising the role of healthwatch on the Health and Wellbeing Board – Oral report

14 Membership of the Board – To consider the inclusion of a representative from the Fire Service as a Board Member. Neil Griffiths is being recommended to serve as the Fire Service representative.

15 ITEMS TO NOTE

(a) Dudley Group NHS Foundation Trust – Quality Report. This has been received and commented on by the Health and Wellbeing Board

(b) Pharmaceutical Needs Assessment : Briefing on process for completion by April 1st,2015. Received and noted by Board Members.

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

MEMBERSHIP OF THE
BOARD

Councillors Branwood, Crumpton, Harris and Neale

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

Director of Public Health

Roger Clayton – Chair of Safeguarding Boards

Dudley GP Clinical Commissioning Group

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

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

Andy Gray – Dudley CVS CEO

Pam Bradbury – Chair of Healthwatch Dudley

Chief Superintendent Johnson – West Midlands Police

OFFICER SUPPORT

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

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

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

Ms K.Jackson, Deputy Director of Public Health (Office of Public Health)

DUDLEY HEALTH AND WELLBEING BOARD

Wednesday, 26th March, 2014 at 3.00 pm
in Committee Room 2, The Council House, Dudley

PRESENT:-

Councillor Crumpton (Vice-Chair) (In the Chair)
Councillors Branwood and Miller
Director of Adult, Community and Housing Services, Assistant Director of Planning and Environmental Health, Director of Public Health, Dr S Cartwright – Dudley Clinical Commissioning Group; Alison Taylor, Local Area Team, NHS Commissioning Board, Andy Gray, CEO Dudley CVS; and Pam Bradbury, Chair of Healthwatch Dudley.

In attendance

Assistant Director, Adult Social Care (Directorate of Adult, Community and Housing Services), Assistant Director (Quality and Partnership) (Directorate of Children's Services), Mr N Bucktin, Head of Commissioning, Clinical Commissioning Group and Mr J Jablonski (Directorate of Corporate Resources)

Also in attendance

Jayne Emery, Chief Officer of Healthwatch Dudley (for Agenda Item No. 10) and 4 members of the public.

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36. COMMENTS MADE BY THE CHAIR

The Chair welcomed everyone to the meeting in particular Dr Jennifer Deveraux an FY2 – Trainee Doctor – currently on secondment to the Office of Public Health.

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37. APOLOGIES FOR ABSENCE

Apologies for absence from the meeting were submitted on behalf of Councillor S Turner, Pauline Sharratt, Paul Maubach, Chief Superintendant Johnson and Karen Jackson.

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38. DECLARATION OF INTEREST

Dr S Cartwright declared a non-pecuniary interest in Agenda Item 7 – Urgent Care Centre (UCC) Procurement and draft UCC Service Specification (Version 0.6) in that the present walk in centre was on the same site as his practice – Keelinge House Surgery.

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39. MINUTES

RESOLVED

That the minutes of the meeting of the Board held on 28th January, 2014, be approved as a correct record and signed.

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40. NEXT STEPS FOR THE HEALTH AND WELLBEING BOARD INCLUDING WORK PROGRAMME FOR 2014/15

A joint report of Officers was submitted on next steps and the work programme for the Board for 2014/15.

A number of issues were considered in relation to:-

- Joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment
- Community Engagement and Communications
- Quality assurance
- Governance
- Draft work programme 2014/15

Arising from the presentation given of the content of the report and its Appendices, the Chair expressed concerns regarding the publicity that needed to be given to future Board meetings being held in the community and to the timing of Board meetings, which were currently shown as commencing at 5.00pm. He indicated that he would raise these concerns with Councillor S Turner.

RESOLVED

That the information contained in the report, and Appendices to the report, submitted on the issues indicated above be noted and endorsed with particular reference to updated Governance arrangements set out in Appendix 1 to the report, the adoption of a user friendly Board reporting style draft guidelines set out in Appendix 2 to the report, the dates for future meetings of the Board to be held in the community on

Tuesday, 17th June, 2014
Tuesday, 30th September, 2014
Tuesday, 16th December, 2014; and
Wednesday, 25th March, 2015

currently shown as commencing at 5.00pm together with the other activities contained in the Work Programme set out at paragraph 19 of the report submitted.

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41. DUDLEY CCG OPERATIONAL PLAN 2014/2015 – 2016/2017 AND STRATEGIC PLAN 2014/2015 – 2018/2019

A report of the Chief Accountable Officer, Dudley Clinical Commissioning Group (CCG) was submitted reviewing the CCG's draft Operational Plan for 2014/15 – 2016/17 and the development of the Strategic Plan for 2014/15 – 2018/19. A copy of the draft Operational Plan was attached as Appendix 1 to the report submitted.

As part of the presentation of the report given by Mr Bucktin particular reference was made to the issues that the Board were asked to consider as set out in paragraphs 17 to 24 of the report submitted.

Mr Bucktin also asked that authority be given to the Chief Accountable Officer of the CCG and the Director of Public Health to agree a target in relation to the reporting of medication errors.

Arising from the presentation given of the report and Appendix 1 to the report submitted, a number of particular comments were made, as follows:-

- That there were inconsistencies between figures shown in the draft Operational Plan and the Joint Strategic Needs Assessment/Health and Wellbeing Strategy in relation to emergency admissions and it was agreed that the Director of Public Health and Officers from the CCG be authorised to clarify the position.

- Regarding the content of the paragraph in the draft Operational Plan, page 7, entitled "The Challenge" it was considered that further wording should be included regarding community assets identified in the Joint Strategic Needs Assessment.

- That whilst it was agreed that hypertension was an appropriate local quality premium target, reference was made to performance in GP Practices falling below the level expected in relation to vascular checks. It was requested that arrangements be made by the CCG to ensure that vascular checks were back on track to meet the required target. In response it was reported that hypertension was recognised as being appropriate as it also had an impact on dementia and that the CCG were aware of the reduction in vascular checking and were investigating the matter. It was further reported that once all practices moved to a single IT system in the next calendar year there would be significant opportunities to deliver this service.

- In response to a query regarding the use of NHS 111 it was noted that the CCG were going out to tender in respect of the Urgent Care Centre proposals with the expectation that patients would phone NHS 111. Any issues relating to the performance of 111 would be dealt with separately.

- That whilst it was appreciated that the Operational Plan needed to be written in a prescribed manner, for non-medical persons it made difficult reading particularly with the use of a number of acronyms making it difficult to fully understand what was being reported on. The CCG therefore needed to be aware that the report would be viewed by different audiences who would not be fully aware of all the terminology used.

Following comments made consideration was then given to the issues set out in the report submitted at paragraphs 17-24 that the Board were asked to consider.

RESOLVED

(1) That the information contained in the report, and Appendix 1 to the report, in respect of the draft Dudley CCG Operational Plan 2014/15 – 2016/17 and the development of the Strategic Plan for 2014/15 – 2018/19, be noted and that the CCG be requested to take on board the particular points as recorded above

(2) That the issues identified in paragraphs 17-24 of the report submitted be responded to as follows

(i) That the Board was satisfied that the areas of focus shown on pages 9 and 10 of the Plan were appropriate.

(ii) That the Board was satisfied that the levels of “outcome ambitions” in relation to those areas identified in paragraph 10b of the report submitted and at pages 11-12 of the Plan were appropriate.

(iii) That the local quality premium target indicator for 2014/15 – hypertension – was appropriate.

(iv) That the dementia diagnosis rate be used as a local performance measure for the Better Care Fund.

(v) That the actions described in relation to commissioning for quality and safety were appropriate.

(vi) That in relation to parity of esteem for people with mental health problems the actions set out in pages 14 and 15 of the Plan be supported.

(vii) That the proposed priorities of urgent care, planned care, integrated care and primary care development were relevant.

(viii) That the actions in respect of the six system characteristics for transformation as set out in pages 16 to 24 of the Plan were regarded as sufficient.

(3) That the Board confirm that the Plan was consistent with the Joint Health and Wellbeing Strategy.

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42. CHANGE IN ORDER OF BUSINESS

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

RESOLVED

That the remaining items of business be dealt with in the following order:-

Agenda Items numbers 8, 9, 10, 7 and 11.

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43. GP ACCESS AND URGENT CARE

Neill Bucktin of the Clinical Commissioning Group(CCG) introduced a short animated film that had been produced in order to raise the awareness of the public in relation to GP access and urgent care. It was noted that these issues had been raised at the last meeting of the Board. The animated film known as a doodle ad was currently on You Tube and showed how work was taking place to improve access to GP Practices.

A particular aspect of this was the development of Patient Participation Groups by the CCG the intention being to have such a group in each practice in the Borough. Over 40 of the 49 practices in the Borough had a Patient Participation Group.

Arising from meetings of each group it was hoped to report on how access could be improved based on the ideas and suggestions coming from the groups.

A press release would shortly be issued by the CCG on the development of the doodle ad with the intention of spreading good practice around the GP Practices in the Borough. It was also commented that the Patient Participation Groups were a good way of getting the message out to the public about the Health and Wellbeing Board and for inspiring local people to the fact that they could make a difference.

RESOLVED

That the content of the film shown on improving GP access and Urgent Care and the comments made at the meeting on this be noted.

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44. BETTER CARE FUND

A joint report of Officers was submitted updating the Board on Dudley's Better Care Fund proposals and to confirm direction and next steps.

As part of the consideration of this matter a visual presentation was also made and commented upon by the Director of Adult, Community and Housing Services and Neill Bucktin of the CCG. A copy of the presentation would be uploaded to the Council's Committee Management Information System.

The presentation covered a number of points and referred to progress since January, 2014 when the matter had been considered at the last meeting of the Board. A first draft had been submitted to NHS England on 14th February, 2014. The next submission to NHS England would be on 4th April, 2014 together with the CCG's Strategic Plan. Following the submission all Members of the Board would receive a copy of the full and final submission.

Other aspects of the presentation included the Modern Model of Integrated Care, a copy of the model which involved multi disciplinary teams as indicated at the last meeting of the Board, Taking the Prevention Model Forward, the Rapid Response Service, Performance Measures – Minimum Requirements, National Minimum Funding Level and Dudley Health and Social Care approach.

Regarding Next Steps, in addition to the timetable already indicated it was noted that the details to be agreed included confirmation of the governance arrangements under this Board including establishing shadow arrangements from 14th April, 2014 to be reflected in a Section 75 Agreement.

In conclusion the presentation also gave an indication of what success would look like.

Particular comments made on the presentation were as follows:-

- That Healthwatch should be asked to consider a different name to replace the one currently used i.e. Better Care Fund Dudley.

- That the Rapid Response Service was a real alternative to Hospital admission and would have benefits for the health system as a whole. It was indicated that there was a wish to provide care on a par with hospitals for example assessments could often be done at home rather than involving trips to a hospital by ambulance. Therefore, there would be developments in the assessment and treatment of people in their home.

- There was the need for assessment on a regular basis to ensure that the Rapid Response Service was of a high standard and work would be undertaken with colleagues in Healthwatch, other health colleagues, pharmacists and the Local Authority in relation to the Better Care Fund. There was national interest in the work being done in relation to this service and work was being done with other CCG's in the Black Country.

- That performance measures would be developed with Healthwatch and performance reported to the Board. The performance measures would be an aggregate of information at the Practice, Local and Borough levels.

- That the efficiencies to be delivered from within the fund of £4 million were to be reinvested into Rapid Response and GP leadership. A meeting will be held next week to finalise the submission.

- In response to a query about the increasing number of elderly in the population a response was given to the effect that forecast modelling was in place to assist with meeting increased demands and meeting needs with positive alternatives and the Better Care Fund would be able to expand the opportunities available.

- In response to queries regarding staff profiles and whether there were sufficient staff it was noted that there had been investment of £1 million in a significant organisational development programme leading to serious investment in staffing. It was recognised that there would be significant changes to how, where and the hours worked by staff with a coming together of different disciplines. However, this would enhance capacity and the approach would be reviewed so that the capacity required would be available. It was also noted that some staff were already working the hours and days required with some services to be available on a 24 hour basis. There would therefore be significant changes in ways of working which differed from those in the past the aim being to put the client first.

- That in response to a query about the opportunities for improving the end of life care it was noted that this was not always dealt with in a dignified manner and was not of a high quality. This issue was something that still needed to be addressed but discussions would be held as to the best way forward so that it could be planned with patients. The role of residential and nursing care homes was crucial in this and discussions needed to be held with providers.

- That if more people were going to be looked after in their own homes there was a need to understand the implications of this which could include loneliness and isolation and therefore there needed to be reassurance as to how people were going to be looked after.

- Success would largely depend on the use of the language of co-production so that individuals came together to provide the service experience required for patients and users. The Client would be the focus of the work undertaken.

RESOLVED

That the information contained in the report, presentation and comments made arising from the presentation, as indicated above, be noted on the further update of Dudley's Better Care Fund proposals to confirm direction and next steps.

45. UPDATE ON HEALTHWATCH DUDLEY PROGRESS

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

Jayne Emery, Chief Officer, Healthwatch Dudley, was in attendance at the meeting and commented on the content of the report submitted.

Particular comments were made in respect of the Information Points referred to at paragraph 7 of the report submitted and the fact that there were now 72 settings registered as Community Information Points. The training indicated had been a good opportunity for those involved to network.

Arising from the presentation given she commented that for the next meeting of the Board it was suggested that there be an opportunity for a discussion session about Healthwatch Dudley for example how its role could be maximised and with a possible focus on a specific topic such as the Information Points.

Arising from this a comment was made that it was important that the Board listened to what actual people had to say so that the voice of the people could be bought to the Board. This would necessarily include people's experiences whether they were good or bad.

A request was made for an FAQ about Healthwatch Dudley to be produced for circulation to all Councillors so that their awareness could be raised. It was indicated that Healthwatch Dudley were already considering this matter and how they could get people involved.

RESOLVED

That the information contained in the report submitted, as reported at the meeting, updating the Board on Healthwatch Dudley progress be noted and that the comments raised above be progressed, as appropriate.

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46. URGENT CARE CENTRE (UCC) PROCUREMENT AND DRAFT UCC SERVICE SPECIFICATION (VERSION 0.6)

A report of the Chief Accountable Officer, Dudley Clinical Commissioning Group was submitted providing an update on the design and procurement of the new Urgent Care Centre (UCC) proposed and agreed at the Board meeting of the CCG on 9th January, 2014.

The submission of the report was in response to comments made at the last meeting of this Board.

Attached as Appendix 1 to the report submitted was the latest draft version of the Service Specification. The specification would be considered by the CCG Board on 4th April, 2014 to report progress, then finally to the Board on 8th May. It was noted that this matter was also being considered by the Council's Health Scrutiny Committee.

Comments on the draft UCC Service Specification were invited as it was considered that such comments would be invaluable to developing a UCC that reflected the needs of local people, was safe, affordable and fit for purpose.

Arising from the presentation given on the content of the report, and Appendix 1 to the report, submitted a number of comments were made, as follows:-

- The Chair of Dudley Healthwatch indicated that comments had already been sent to the CCG on the draft, however, there were still concerns about where people would go if their needs could not be met as it was considered that they would try to find another route into the system and the issue of unregistered patients. It was noted that currently people who used the walk in centre did not have to be registered.

  Regarding the issue of registration this was seen as a fundamental issue given that this was the whole basis of the GP Service and the services being developed. Therefore, whenever possible people seen should be registered with a GP and if they were not registered attempts would be made to facilitate registration. Once the EMIS IT system was in place this would facilitate this and the UCC would be using the system as well.

  As regards the service not meeting needs it was considered that the quality of the triage provided was an important factor in meeting this concern. This Board at its last meeting had raised concerns about GP provision and what clinical triage meant. There was a need to be careful therefore and work out what the quality of the triage was.

- There was a need to task the provider with seeking continuous feedback and it was important that the CCG facilitated this.

- It was considered that in order for people to envisage the system to be provided that a flow chart be developed to show what the service would look like.

- In respect of pathways it was noted that substance misuse was subsumed under mental health and that as regards the provision of substance misuse this was commissioned by the Office of Public Health. CRI was the service provider and had been awarded a new contract with effect from 1st April. There needed to be liaison with that new provider as to how they fitted into the system.

- It was considered that a wet room be provided so that those in need of such a room could be accommodated prior to being treated.

- There was a need for the Service Specification to fully recognise the particular needs of people requiring the psychiatric liaison service and to meet the needs of children.

- Concerns were raised at the low staffing ratio proposed which should be looked at in the light of experience.

Arising from the points raised it was indicated that they would be considered with particular reference to psychiatric services as mental health and those for children were already the subject of further work. The issue of triage would also receive further consideration.

RESOLVED

1. That the information contained in the report, and Appendix 1 to the report, submitted on the design and procurement of the new Urgent Care Centre involving the draft Urgent Care Centre Service Specification (Version 0.6) be received and noted relating to assurance on the planning and commissioning process of the new Urgent Care Centre.

2. That arising from consideration of the draft Service Specification the comments made, as indicated above be considered as the responses of this Board to the CCG for consideration and inclusion in the final draft version of the Service Specification.

The meeting ended at 4.50 pm

CHAIR

DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item No.7**

REPORT SUMMARY SHEET

DATE	**17 June 2014**
TITLE OF REPORT	**Healthwatch Dudley Activity Report**
Organisation and Author	**Jayne Emery, Chief Officer, Healthwatch Dudley**
Purpose of the report	**To give the Health and Wellbeing Board an update on Healthwatch Dudley activities**
Key points to note	**The wide and varied range of activities and opportunities for local people to be heard and influence as a result of Healthwatch Dudley**
Recommendations for the Board	**That the Board note the activities being undertaken by Healthwatch Dudley**
Item type	*Information*
H&WB strategy priority area	*Services, children, mental wellbeing, lifestyles, neighbourhoods, integration, health inequalities, quality assurance, community engagement,*

DUDLEY HEALTH AND WELLBEING BOARD

DATE **17 June 2014**

REPORT OF: **Chief Officer, Healthwatch Dudley**

TITLE OF REPORT **Update on Healthwatch Dudley Activities**

HEALTH AND WELLBEING STRATEGY PRIORITIES

1. The voice, views and experiences of local people are integral to all Dudley Health and Wellbeing priorities. Healthwatch Dudley (HWD) is the link to ensure that these voices are heard and taken into account.

PURPOSE OF REPORT

2. To provide an update to the Board on HWD activities and key areas of work.

BACKGROUND

3. This report has been requested by the Board and follows the report submitted to the meeting on 26 March 2014.

OUTLINE OF ACTIVITIES

4.1 Organisational Development

HWD are currently recruiting for two new officers to support the team – Information and Administration Officer and Community and Volunteer Engagement Officer.

Pam Bradbury, Chair of HWD has recently been appointed one of six new Healthwatch England Committee members. Pam will help to represent the views of patients and the public at a national level.

4.2 Urgent Care

HWD has continued to be involved in the development of the service specification through the Urgent Care Centre Reference Group. HWD identified some gaps in the Group's engagement with patient representatives and health economy partners including dentists and pharmacists. This has been addressed by Dudley CCG who are now involving patient and health economy representatives.

4.3 Information Points

Training delivered jointly by HWD and CAB staff is underway for Information Champions who will support Community Information Points across Dudley borough. The training involves understanding the important difference between giving information and advice, walks through key websites including Dudley

Community Information Directory (DCID); it also covers indepth case studies and the range of support available to prevent people from getting into crisis situations. Feedback has been incredibly positive with comments including 'I feel loads more confident knowing that I can access lots of information in one place' (through links on members area on HWD website) and 'exciting opportunity to bring information to the public'.

Many more partners are now keen to join the Information Point network from local charities to the recent addition of dentists following HWD recent attendance at NHS England 'Improving Dental Care and Oral Health – A Call to Action'. The network and how DCID could be developed to enable its use as a social prescribing tool is currently being discussed at Dudley CCG Locality Meetings.

A volunteer who has been supporting HWD with communications and marketing has been further developing relationships with local community pharmacies to promote the role of HWD and encourage further sign up to the network.

4.4 The Dudley Group NHS Foundation Trust

HWD is now a member of the newly formed patient experience group. The group will ensure that the Trust has appropriate and effective systems in place that cover all aspects of patient experience, promoting effective shared learning and a culture of excellent patient care.

HWD provided a variety of patient experiences to the CQC along with attending the two listening events prior to their inspection of the Trust. HWD has been invited to the Quality Summit on 6 June, ahead of the release of the CQC quality report.

4.5 Mental Health Services

Following the recent CQC inspection of Dudley and Walsall Mental Health Partnership NHS Trust, HWD attended the Quality Summit to provide input from a patient/public perspective, in accordance with our statutory role. Our involvement will support in developing and taking forward their action plan.

HWD challenged commissioners about their engagement with people who access Dove House regarding re-configuration of services. This has resulted in plans being put on hold and a number of meetings taking place between DMBC, Dudley CCG, Dudley Mind and people who access the service to address the issues.

HWD has participated in a multi-agency event to look at a single point of access and development of a more effective pathway for mental health services. Further meetings have been planned and HWD will continue to support this work.

Similar support has been given to a multi-agency steering group through HWD staff team and a key volunteer with extensive work experience in mental health. The group has been established to review mental health services provided from Woodside Day Centre. The role of HWD is to ensure that the people who access services and those that don't are involved throughout the process.

4.6 Children and Young People

HWD presented at the recent 'Working Together for Change' Dudley Parent Carer Forum event. This forum represents parents and carers of children with disabilities and additional needs. HWD will continue to work with this forum to ensure that their voices are heard in a way that influences change and service design.

The views and experiences of children and young people about their health and wellbeing are extremely important to HWD. Staff are working with a DMBC Youth Empowerment Officer to develop a health project that will involve a wide range of activities for 12-18 year olds. The project will involve workshops, questionnaire design (linking to HWD Enter and View Function) and lots of opportunities to hear the voices of a diverse range of young people. It is hoped that outcomes will influence commissioning and local service delivery.

4.7 Social Networking

HWD now has 799 followers on Twitter, an increase of 104 from the last report.

Website Hits: 1,121 in March, 935 in April and so far 1,068 in May.

HWD mailing list has 405 subscribers

FINANCE

5. Local Healthwatch is funded by the Government and primarily through Department of Health. The contract runs for a 3 year period subject to the Governments on-going funding of the Healthwatch programme.

LAW

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

EQUALITY IMPACT

7. A main function for HWD is to listen to lesser heard voices in Dudley borough. This includes older people, children, hidden carers, people with mental ill health, and people living in disadvantaged neighbourhoods.

RECOMMENDATIONS

8. It is recommended that the Board note the activities being undertaken by Healthwatch Dudley.

Jayne Emery
Chief Officer
Healthwatch Dudley
Tel: 03000 111 001
Email: jayne@healthwatchdudley.co.uk

DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item No 8**

REPORT SUMMARY SHEET

DATE	**17th June**
TITLE OF REPORT	**Health and Wellbeing Board's Annual Account- The First Chapter 2013/14** **Overview of the Health and Wellbeing Board's annual conference 2014/15**
Organisation and Author	**Valerie. A. Little** — **Director of Public Health Dudley Council** **Andrea Pope-Smith** — **Director of Adult Community and Housing Services Dudley Council** **Pauline Sharratt** — **Interim Director of Children's Services Dudley Council** **John Millar** — **Director of Urban Environment** **Paul Maubach** — **Chief Officer Clinical Commissioning Group Dudley Council**
Purpose of the report	• **Introduces the H&WB Boards annual account for 2013/14** • **Provides an overview of the key objectives and themes for the 2014/15 annual accountability conference**
Key points to note	• **The audience for the annual account is the Board's stakeholders** • **It gives an overview of the activity overseen by the Board during 2013/14 and next steps for 2014/15** • **It will be disseminated via the annual accountability conference on 4th July 2014, and via communications lead in the Board's respective organisations** • **The overall aim of this year conference is to inspire, engage and stimulate collaboration. It will provide:** o **An overview of what the H&WBB has taken forward during 20134/14** o **An opportunity for people to meet H&WBB members and ask questions** o **An opportunity for people to understand and take forward in their roles coproduction, asset-based working, approaches to increase community** • **The report details the programme, and objectives of the workshops.**
Recommendations for the Board	• **That the Board notes the content of the annual account** • **That the Board approves the dissemination method for the document**
Item type	*Information*
H&WB priority	*all areas*

Dudley Health & Wellbeing Board

The first chapter

Annual Account 2013-2014

health &wellbeing
looking after our borough

DUDLEY HEALTH AND WELLBEING BOARD

The First Chapter

Introduction

Our Health and Wellbeing Board brings together Dudley Council, Dudley Clinical Commissioning Group, West Midlands Police, Healthwatch Dudley, NHS England and partners from the voluntary and community sector to identify key priorities for **improving health and wellbeing** and **reducing health inequalities** in Dudley borough**.** We have undertaken an ambitious programme of activities to ensure an integrated approach in making progress towards meeting these priority objectives.

This report summarises some of our activities over the last year which reflect our intention to ensure people within the Dudley borough **will live longer, healthier, more fulfilling lives**.

Health and Wellbeing Boards are leaders for the health and care system with the role of overseeing production of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing strategy. These activities have enabled us to establish five priority areas for action. Also through engagement with stakeholders and the public we have agreed commissioning plans with key partners to improve health and wellbeing outcomes as well as driving the reconfiguration and integration of health and social care provision locally.

Building the Foundations for Our Vision

Our Health and Wellbeing Board was established in shadow form on 9th February 2011, becoming a statutory board on 1st April 2013. Our first **Joint Health and Wellbeing Strategy *'Wellbeing for Life'*** was ratified on 21st January 2013 and

made steps to share the board's vision for health and wellbeing locally, including the identification of priority areas for action.

These priority areas were identified from the Joint Strategic Needs Assessment and the views of local people through a series of engagement and consultation activities involving key partner agencies.

Consultation activities included a feet on the street approach. We carried out surveys with local people across the borough to hear their ideas about what really matters in relation to their health and wellbeing. We were also able to engage with people through a variety of community health forums and focus groups to capture the views of children and young people, adult social care service users and carers, ensuring representation of the diverse communities existing here in Dudley.

The responses we received sent a clear message from local people for the need to empower them to have the capacity and capability to make healthy, informed decisions around their own wellbeing. They were also clear they wanted to be involved in the production of easily accessible, fit for purpose services ensuring they are able to feel good and function well from day to day.

The '***Wellbeing for Life'*** strategy was officially launched at our inaugural health and wellbeing conference on 26th June 2013. As well as launching the strategy, the conference focused on giving an overview of the role of the Health and Wellbeing Board, the Joint Strategic Needs Assessment and providing an opportunity for attendees to meet board members and ask questions around their visions for the health and wellbeing of local residents.

'Meet the board' sessions enabled conference delegates to discover more about the board members aspirations and visions for the health of people locally

Conference delegates also had a key role to play in enabling the board to better understand the role they can play in making a real improvement in the priorities identified locally.

More than 150 people attended the conference including a range of stakeholders from healthcare providers, the council, colleges, statutory and voluntary organisations community groups and service users and carer's forums. Break-out sessions centred on the identified priority areas within the strategy. They gave stakeholders the opportunity to share their views on many of the key issues related to the priorities and shape the context of future spotlight events to address these. Overall the conference evaluated well playing a pivotal role in bringing people together to join in the conversation of how we make the Health and Wellbeing Board's strategy a reality.

Shining a spotlight on priority areas

We made further progress against the five priority areas through a series of spotlight events with key stakeholders. Each spotlight event focused on specific challenging issues identified from the Joint Strategic Needs Assessment associated with the priority area. They each followed a process of diagnosing the issue, providing information on the key challenges and then stimulating the generation of ideas and action planning across partners.

Our five priority areas:

a. **Making our neighbourhoods healthy** – by planning sustainable, healthy and safe environments and supporting the development of health enhancing assets in local communities.

Spotlight Outcomes:

As a Board we need to guide service providers and commissioners to better understand the local population's skills, strengths and passions and enhance these health promoting factors. We need to invest in and develop the social networks through which information is shared between people, supporting resilience and enhancing the skills available within communities to shape the level and range of services accessible to them. This will be the key theme for our 2014 annual conference event.

b. **Making our lifestyles healthy** – by supporting people to have healthy lifestyles and working on areas which influence health inequalities such as obesity, alcohol, smoking and the early detection of ill health

Spotlight Outcomes:

Areas of priority presented to us and key stakeholders addressed the need to achieve reductions in rates of Alcohol Misuse and Improvements in rates of Breast Feeding as determined by the Joint Strategic Needs Assessment.

Where Alcohol Misuse is concerned there should be a concentration on education from an early age, campaigns which bring about a cultural change to achieve responsible alcohol use, improved restrictions on availability, effective detoxification

treatments and support to ensure greater levels of resilience and coping skills within the population.

Breast feeding workshops helped to establish the role the Board can play by improving cultural acceptance of Breast Feeding amongst the general population and health professionals. This may be facilitated through developing local Breast Feeding campaigns, development of the volunteer buddy scheme, increased awareness in primary care and integration of support services following discharge.

c. **Making our children healthy** – by supporting children and their families at all stages bur especially the early years; keeping them safe from harm and neglect, supporting the development of effective parenting skills and educating young people to avoid taking risks that might affect their health in the future

Spotlight Outcomes:

The role of parents and extended families was formally recognised in improving wellbeing outcomes for young people. Targeted interventions such as parenting programmes and the role children's centres play is key, particularly where parents themselves are vulnerable. Early interventions should be in place to address identified needs across an integrated range of agencies for parents and children. As a Board we need to support initiatives to improve the resilience and coping skills of young people around the transition age and ensure that we are nurturing children through the early developmental years.

d. **Making our minds healthy** – This spotlight is focused on the twin aims of promoting mental wellbeing and reducing rates of depression, as well as how to reduce risk factors for, effectively diagnose and support people to live well with Dementia.

Spotlight Outcomes:

Promoting mental wellbeing through an evidenced based series of actions (5 ways to wellbeing) across the whole population can enable people to function well and flourish. Good mental health is a key factor in making headway to reduce a range of health risk behaviours as well as reducing the risk of mental illness and supporting

people's journey to recovery. As a board we have a role to play in changing the local landscape so that the stigma associated with mental illness no longer deters people from seeking the help and support they need at an early stage and creating a mental health friendly borough.

A range of positive steps have been taken locally to reduce risk factors associated with Dementia and these need to continue to be developed through opportunistic and targeted brief interventions around healthy lifestyle programmes and health checks.

More work needs to be done to promote awareness of the Dementia Gateways and improve professional awareness of and sign posting to the range of dementia services available locally.

We must strive to develop Dementia friendly communities with opportunities to support people with Dementia, their family and carers in a way that enhances their strengths, skills, passions and recognises the valuable contribution people can make to shape the support available to them.

e. **Making our services healthy** – by integrating health and care services to meet the changing Dudley borough demography, starting with urgent care

Spotlight Outcomes:

The urgent care system in Dudley needs to be simplified, easy to access and navigate and available 24hours a day, seven days a week. It should be patient centred, and linked into mental health and alcohol treatment services. As a board we need to develop and consult on a new urgent care model for the borough.

A key theme from all of the above events is the capacity, skills and knowledge individuals and communities have- their "assets". Also how through strong inclusive networks levels of wellbeing for people across the borough can be enhanced.

Spotlight issues- A call for action

Through the spotlight events seven issues were identified for action to improve delivery and outcomes:

- **Improve the effectiveness of urgent care services**
- **Increase breast feeding levels**
- **Reduce alcohol misuse**
- **Improve mental wellbeing, reduce rates of depression and support recovery**
- **Reduce risk factors for dementia**
- **Increase resilience of young people in the early and transition years (16-18)**
- **Develop empowered and self reliant communities**

Outcomes and recommendations from the spotlight sessions are currently being presented to the appropriate lead commissioning group or board to agree key actions and performance indicators to take forward during 2014/15. As part of our wider engagement plan a series of interviews with board members have taken place to bring together perspectives in relation to engaging and involving individuals and communities to collaborate in shaping these actions. This activity has also contributed to the ongoing development of the boards communication and engagement strategy.

Workshops engaging young people on their views around risk taking behaviour

Next Steps

The actions described collectively within this report frame the implementation plan for the Health and Wellbeing Strategy for 2014-2015 and the board will have responsibility for reporting outcomes on progress to achieve these objectives through the Health and Wellbeing Priorities Outcomes Frameworks.

A series of public facing meetings in locations across the borough will enable members of the public to gain a greater understanding of the activities undertaken.

Making a difference

We have:

- **Shaped the Better-Care Fund plans for integrating health and social care for the frail and elderly**
- **Shaped the 'Urgent Care' delivery model for Dudley borough**
- **Challenged commissioners and providers to deliver on priority areas for health and wellbeing through the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.**
- **Championed seven issues with a call for action to the responsible partnership boards in Dudley borough**

During 2014/15 we will refresh the Joint Strategic Needs Assessment in line with local progress and engage further on any emerging issues from the assessment, ensuring these shape the health and wellbeing strategic priorities. We will oversee the implementation of the urgent care model and continue to drive improved quality and safety through integrated health and social care, as well as continuing to challenge commissioners and providers to deliver on priority areas for health and wellbeing.

In conclusion the Dudley Health and Wellbeing Board has made positive headway in its first chapter to develop strategies and action plans to contribute towards its twin aims of reducing health inequalities and improving the health and wellbeing of people locally.

DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item No.9**

REPORT SUMMARY SHEET

Date	17th June 2014
Title of Report	Dudley Health Protection Cooperation Agreement
Organisation and Author	Pauline MacDonald, Nurse Consultant Communicable Disease Valerie Little, Director of Public Health
Purpose of the report	To inform/assure the board on the arrangements in place if there is a Health Protection incident or outbreak in Dudley
Key points to note	The cooperation agreement gathers assurances from all the involved parties on their roles in the event of a health protection incident. It supports existing Emergency Planning strategies, and has been endorsed by members of Dudley Health Resilience Partnership Group. The agreement details processes, roles, funding, and the mobilisation of NHS resources in Dudley to support a health protection incident.
Recommendations for the Board	That the board accept the report and endorse the Cooperation Agreement for use in Dudley.
Item type	Information
H&WB strategy priority area	Quality Assurance

health & wellbeing
looking after our borough

DUDLEY HEALTH AND WELLBEING BOARD

DATE: 17th June 2014

REPORT OF: Valerie Little, Director of Public Health

TITLE OF REPORT: Dudley Health Protection Cooperation Agreement

HEALTH AND WELLBEING STRATEGY PRIORITY

Making our neighbourhoods healthy - by planning sustainable, healthy and safe environments and supporting the development of health-enhancing assets in local communities

PURPOSE OF REPORT

1. Health Protection seeks to prevent or reduce the harm caused by communicable diseases and minimise the health impact from environmental hazards such as chemicals and radiation exposure. The report details Dudley Health Resilience Partnership's agreement on the local response if there was a Health Protection Incident in Dudley.

BACKGROUND

2. The changes to structure of healthcare detailed in the Local Authorities Regulations (2013) and NHS Act 2006, created the need for clarification on the roles of new and existing agencies in the event of a health protection incident.

   Following guidance from The Association of Directors of Public Health (ADsPH), Department of Health, Faculty of Public Health, Local Government Association, NHS England and Public Health England; this document summarises the Health Protection arrangements for Dudley which have been updated in light of these new regulations.

THE MAIN ITEM/S OF THE REPORT

3. The report details the agreement between Dudley Metropolitan Borough Council (Office of Public Health), West Midlands Public Health England Centre, Dudley Clinical Commissioning Group, NHS England Birmingham, Solihull and Black Country Area Team and Dudley Group Foundation Trust.

   The report summarises the national legislative, commissioning and provision guidelines. More detailed is given on the formal identification of incident/outbreaks, roles and responsibilities of all involved parties, the activation processes to mobilise a response and the management structures involved, if there were an incident in Dudley.

FINANCE

4. In Dudley, the funding at local level of clinical interventions whether investigative or curative, is a responsibility of the NHS. It has been agreed that NHS England - Birmingham Solihull and Black Country Area Team will commit resources, in accordance with the principle of respond first, clarify invoicing later and the decisions on funding must not delay responses.

   The Director of Public Health would be responsible for the mobilisation of any local authority resources necessary to support the response agreed by the Incident Management Team.

LAW

5. The responsibility for coordinating a Health Protection incident response falls to the West Midlands Centre of Public Health England and NHS England's Birmingham, Solihull and the Black Country Area Team. The Director of Public Health has overall responsibility for strategic oversight of a Health Protection incident, and will ensure an appropriate response is put in place by NHS England and Public Health England, however they have no authority to direct, command or take decisions relating to mobilisation of NHS resources.

EQUALITY IMPACT

6. Communicable Diseases, chemical releases and other health protection incidents are neither discriminatory nor respective of existing classifications and boundaries.

   The impact of a Health Protection incident will not affect a specific demographic group more than others, and responses detailed in this report will focus on clinical responses giving the best treatment to each patient, regardless of which demographic they identify with.

RECOMMENDATIONS

7. Accept the report, thank the Communicable Disease and Emergency Planning Team, Office of Public Health for their work to create and coordinate this work.

Signature of author/s

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Dudley Health Protection Co-operation Agreement 2013-15

29th May 2014

CONTENTS

1. Preface

On 1st April 2013 large changes took place in the health and social care landscape through implementation of the new Health and Social Care Act (2012). This established NHS England, Public Health England (PHE), Clinical Commissioning Groups (CCGs) and transferred the majority of former NHS Public Health responsibilities into local authorities, including Director of Public Health responsibilities. However NHS England also retains some public health functions as well as the overall lead for NHS emergency and incident planning and response.

2. Background

Health Protection seeks to prevent or reduce the harm caused by communicable diseases and minimise the health impact from environmental hazards such as chemical and radiation.

Under regulation 8 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, made under section 6c of the NHS Act 2006, there is a requirement for cooperation agreements, memoranda of understanding and protocols around Health Protection to be revised and updated.

The Association of Directors of Public Health (ADsPH), Department of Health, Faculty of Public Health, Local Government Association, NHS England and Public Health England agreed that it would be helpful to set out some national principles about the roles and responsibilities of different agencies in relation to local health protection responses (Professional Letter, 2012). These principles agreed by partners build on previous guidance and seek to provide a framework to support the local analysis and review of health protection arrangements.

This document summarises the Health Protection arrangements for Dudley which have been updated in light of the ADsPH principles and these new regulations.

3. Introduction to Dudley

The metropolitan borough of Dudley covers an area of 38 square miles with a population of 313,000 people. In such a densely populated urban environment there are a range of potential risks to the health and wellbeing of local communities.

Dudley Metropolitan Borough Council (A Unitary Authority) works with partners and local communities to maintain various plans to facilitate resilience in the event of anything from minor outbreaks to full scale emergencies.

The Dudley Borough has a strong industrial heritage from foundries, brickworks and glass manufactures. This has largely been replaced with high technology industries and a strong and diverse service sector, including financial services, distribution and retail.

One of those developments is the Merry Hill Centre at Brierley Hill which is one of the largest retail developments in Europe attracting approximately 26 million visitors to the Borough every year.

Dudley

The nature of the Dudley borough leads to its own set of diverse challenges for health protection.

4. Principles of Local Response

4.1 General

Local agencies are the building blocks of planning, response and recovery. Proportionate and evidence-based decisions should be taken at the most appropriate level as close to the frontline as possible with co-ordination at the highest necessary level; consistent with national health protection policies and guidelines.

Local health protection roles and responsibilities need to be clearly articulated and there needs to be agreement about the working arrangements and responsibilities for committing resources in a response.

4.2 Legislative framework

- Under section 2A of the NHS 2006 Act (as inserted by section 11 of the Health and Social Care Act 2012) the Secretary of State for Health has a duty to "take such steps as the Secretary of State considers appropriate for the purpose of protecting the public in England from disease or other dangers to health". In practice PHE will carry out much of this health protection duty on behalf of the Secretary of State.

- Under the Local Authorities (Public Health Functions and Entry to Premises by Local HealthWatch Representatives) Regulations 2013 unitary and upper tier local authorities have a new statutory duty to carry out certain aspects of the Secretary of State's duty to take steps to protect the health of the people of England from all hazards, ranging from relatively minor outbreaks and contaminations, to full-scale emergencies, and to prevent as far as possible those threats emerging in the first place. In particular, regulation 8 requires that they promote the preparation of health protection arrangements by "relevant bodies" and "responsible persons", as defined in the regulations. In addition, regulation 7 requires local authorities to provide a public health advice to clinical commissioning groups (CCGs), which includes advice on health protection. Local authorities will continue to use existing legislation to respond to health protection incidents and outbreaks.

- Directors of Public Health (DsPH) are employed by local authorities and responsible for the exercise of local authorities' new public health functions. Directors will also have a responsibility for the "exercise by the authority of any of its functions that relate to planning for, and responding to, emergencies involving a risk to public health".

- Under new section 252A of the NHS Act 2006, NHS England is responsible for
    - ensuring that clinical commissioning groups and providers of NHS funded services are prepared for emergencies,
    - monitoring their compliance with their duties in relation to emergency preparedness and
    - facilitating coordinated responses to such emergencies by clinical commissioning groups and providers.

- The Health and Social Care Act 2012 also amends section 253 of the NHS Act 2006 (see section 47 of the 2012 Act), so as to extend the Secretary of State's powers of direction in an emergency to cover an NHS body other than a local health board (this will include NHS England and clinical commissioning groups); the National Institute for health and Care Excellence (NICE); the Health and Social Care Information Centre; anybody or person, and any provider of NHS or public health services under the Act.

- Under the Civil Contingencies Act 2004 (CCA) Local Authorities are category 1 responders, and have a duty to cooperate and work together to plan for and respond to emergencies, and DsPH as officers of the Local Authority share in this responsibility.

- Under the consequential amendments made by the Health and Social Care Act 2012, NHS England and Public Health England (as part of the Department of Health exercising the Secretary of State's responsibilities in relation to responding to public health emergencies) are also Category 1 responders under the CCA. CCGs are Category 2 responders under the Act giving them a duty to provide information and cooperate with civil contingency planning as needed.

4.3 Commissioning the Incident Response

Clinical Commissioning Groups are responsible for ensuring that their contracted NHS providers (acute hospital, community health, mental health, out-of-hours etc) will provide the clinical response to incidents that threaten the health of local people and communities.

NHS England's Direct Commissioning functions (Section 7A public health services, primary care services, specialised commissioning services, health & justice services and armed forces and veterans' health services) are responsible for ensuring that their contracted providers will deliver an appropriate clinical response to any incident that threatens the public's health.

Local Authorities are responsible for ensuring that the NHS and other providers with whom they have contracts (including providers of sexual health services, drug and alcohol services and school health services etc) will provide an appropriate response to any incident that threatens the public's health.

All commissioners need to ensure that they have agreed roles with providers and that detailed contract provisions exist with providers, including primary care contractors. This should include 'dormant' arrangements such as local enhanced services, which identify specific services and any surge capacity required to enable timely local health protection responses. Commissioners need to be assured that providers have the appropriate capacity and capability to deliver an effective response.

4.4 Providing the Incident Response

Public Health England will provide the specialist health protection and public health microbiology services that were part of the Health Protection Agency and will ensure that there is co-ordinated management of incidents and outbreaks.

PHE will agree with partners the establishment and leadership of an Incident Management Teams (IMT) and when requested by Strategic Co-ordinating Groups (SCG), will establish Scientific and Technical Advice Cells (STAC). PHE will normally lead the response for infectious disease and will advise on the requirement for and sourcing of prophylactic treatment and immunisation for all health protection incidents.

PHE will co-ordinate the management of the response to biological, chemical, radiological and environmental incidents. The response, led by the appropriate PHE Centre and escalated to regional and national levels as needed using PHE's agreed escalation policies, will include interaction with PHE's national microbiology, chemical, radiological and other specialist services which provide management advice and/or

direct support to incident responses (e.g. interpreting air quality results, coordinating UK radiation monitoring).

NHS providers are required to deliver the response to incidents and outbreaks under the guidance of the Incident Management Team. The need to respond appropriately and in a timely manner is part of the NHS Contract. Providers need to ensure that they have suitably qualified and skilled staff to deliver their contribution to the response.

Local Authorities will provide some services and facilities to support the management of the incident or outbreak, including the environmental and public health team, where relevant.

4.5 Funding

The key funding streams are as follows:

a) NHS commissioned services: the funding stream is through the NHS Mandate and the allocations to direct commissioning functions and CCGs, and through the Section 7A. These allocations fund contracts with NHS providers to deliver their element of the incident response.

b) LA commissioned services: the funding streams form part of the core local authority budget for the environmental health and other teams, and the Public Health Grant that is allocated to each upper tier local authority, which is ring-fenced at least until 2015-16. This allocation funds the local authority's public health team and contracts with providers to deliver their element of the incident response.

c) Public Health England: the local specialist health protection and public health microbiology services are funded through the "grant in aid" funding provided to the Agency.

In practice the funding at local level of clinical interventions whether investigative or curative, is a responsibility of the NHS. NHS England and CCG finance officers will agree an appropriate methodology for sharing costs on a case by case basis from within budget allocations, to support the locally agreed clinical responses. The sharing of more significant costs will be agreed as appropriate, with NHS England Regional and National Finance Directors.

The Department of Health will continue to keep guidance around the funding of health protection responses under review, in order to enable effective delivery and best value for public money.

5. Dudley Health Protection Co-operation Agreement

5.1 Purpose

This agreement aims to ensure that for Dudley:

i) Respective roles and responsibilities of NHS England Birmingham Solihull and Black Country Area Team (NHS England – BSBC AT), West Midlands Public Health England Centre, the Dudley Director of Public Health, Dudley CCG and providers of NHS services, in the event that a response to a public health incident is required, are clear and understood.

ii) There are arrangements for the provision and timely release of sufficient resources by the above organisations to support the investigation and management of a health protection incident in line with the duty of NHS provider organisations to respond accordingly.

iii) All partners in the Dudley Health Protection arrangements, as signatories of this document, agree their respective responsibilities. (Appendix 1)

Dudley Health Resilience Partnership (DHRP)

Dudley Health Resilience Partnership is a sub group of the Dudley Resilience Forum and aims to ensure that robust planning takes place so that the borough is resilient in response to and recovery from health related incidents and emergencies.

A function of Dudley Health Resilience Partnership will be the production, agreement, and review of this cooperation agreement.

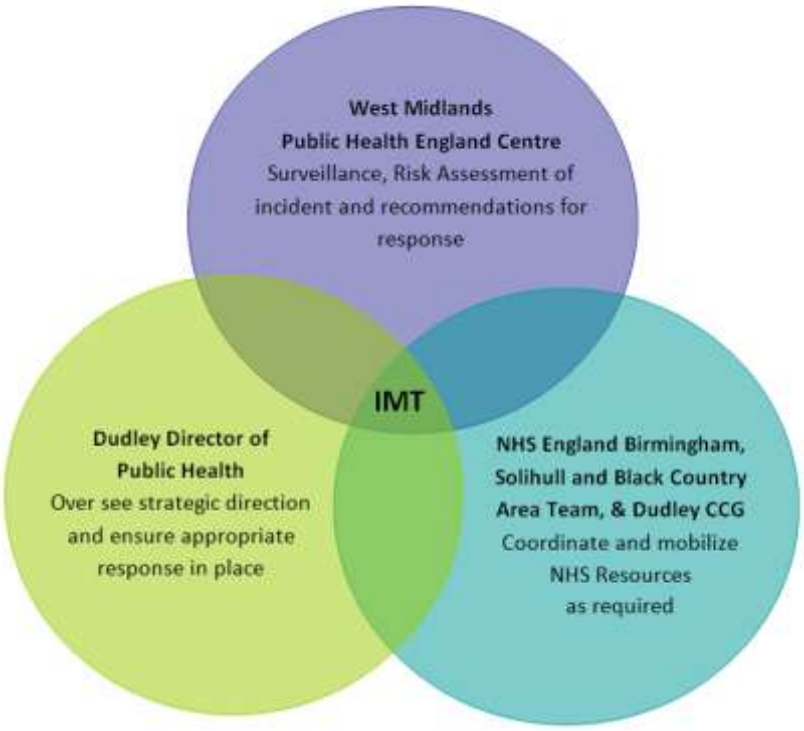
DHRP Membership includes:

- Dudley Metropolitan Borough Council (MBC) - Office of Public Health
- Dudley Clinical Commissioning Group
- Dudley Group Foundation Trust
- West Midlands Public Health England Centre
- NHS England - Birmingham Solihull and Black Country Area Team
- Other invited providers as required
    - Dudley and Walsall Mental Health Trust
    - Black Country Partnership Foundation Trust
    - Police
    - Ambulance
    - Fire

5.2 Management of Health Protection incidents

The successful management of Health Protection incidents will be in facilitating mutually supportive three-way working between the NHS (NHS England - Birmingham Solihull and Black Country Area Team, Dudley CCG and Dudley providers), West Midlands Public Health England Centre and Dudley Director of Public Health in Dudley MBC. This working would normally be facilitated by the formation of an Incident Management Team (IMT). (Fig 1)

Fig 1: Management Roles



5.3 Roles & Responsibilities in Dudley

The Emergency Preparedness Framework (NHS England 2013), PHE Concept of Operations (Public Health England 2013) articulates the roles and responsibilities of NHS England, Directors of Public Health and Public Health England in response to a significant/major incident as follows:

West Midlands Public Health England Centre

PHE will lead the epidemiological investigation and the specialist health protection response to public health incidents and has responsibility to declare a health protection incident, major or otherwise. PHE would normally Chair the Incident Management Team (IMT) meetings/teleconferences and keep the health protection risks under review during the incident, providing expert health protection advice to the IMT (drawing on specialist advice from regional and national PHE and other experts as required). PHE will normally coordinate the public communications/ media response as required in collaboration and agreement with other local organisations represented in the IMT.

NHS England Birmingham, Solihull & Black Country Area Team

Has responsibility for managing/overseeing the NHS response to the incident, ensuring that relevant NHS resources are mobilised to support the incident and commanding/directing NHS resources as necessary. NHS England are key players within the IMT and may, on occasions, take the lead role instead of PHE in responding to an incident. Transfer of the lead response role from PHE to NHS England would be dependent on :

- The size and spread of the incident requiring the deployment of significant NHS resources with significant cost implications
- Where the incident requires complex coordination and/or communications in order to mobilise the NHS response
- Where provider organisations and PHE are not co-operating with each other.

The decision to transfer the lead response role from PHE to NHS England will be undertaken with the agreement of all parties in the IMT.

The NHS England – BSBC AT will co-ordinate the primary care response to the incident.

The NHS England - BSBC AT will also co-ordinate any significant or complex response required by Community Trusts and/or Acute Trusts.

Dudley CCG

The CCG role is to support NHS England in discharging its EPRR functions and duties locally.

They must ensure contracts with provider organisations contain relevant emergency preparedness, resilience (including business continuity) and response elements, and provide a route of escalation should a CCG commissioned provider fail to maintain and deliver the necessary EPRR capacity and capability

The CCGs will be Category 2 responders under the Act giving them a duty to provide information and cooperate with civil contingency planning as needed, and to maintain business continuity plans for their own organisation.

Dudley CCG should form part of the IMT as necessary and help inform the IMT's decisions about the appropriate level of NHS response from providers and any CCG resources needed to be released for an integrated approach in response to an incident.

Dudley CCG may be requested by the NHS England BSBC Area Team to provide clinical support for the prescribing and administration of medication and specialist infection control advice where required, depending on the nature of the incident, and as determined by the IMT.

Community Pharmacy Services

Under the direction of Dudley CCG (with support from Dudley OPH Pharmacy Advisor), local community pharmacy services will support the incident response by obtaining the necessary medication as determined by PHE, dispensing and supplying in a flexible way to meet the needs of the incident.

Commissioned Providers

The NHS England Standard Contract outlines what NHS organisations are expected to deliver in terms of health protection generally, as well as incident and emergency planning management and any cooperation requirements necessary to achieve those objectives. Appendix 2 contains the EPRR Extract of the NHS Standard Contract.

Dudley MBC Director of Public Health

The DPH has overall responsibility for strategic oversight of an incident. They should ensure an appropriate response is put in place by NHS England and Public Health England, however they have no authority to direct, command or take decisions relating to mobilisation of NHS resources. The DPH should brief Local Authority colleagues and local politicians and mobilise any local authority resources necessary to support.

NHS acute, community and mental health provider(s)

Local acute, community and mental health services providers will deploy and coordinate relevant and available resources as negotiated and agreed with the IMT to support an NHS response including as necessary clinical and administrative staff to enable clinical advice and investigations, and prescribing and administration of medications.

5.4 Funding

NHS England and CCG finance officers will agree an appropriate methodology for sharing costs on a case by case basis from within budget allocations, to support the locally agreed clinical responses. The sharing of more significant costs will be agreed as appropriate, with NHS England Regional and National Finance Directors.

In Dudley the funding at local level of clinical interventions whether investigative or curative, is a responsibility of the NHS. It has been agreed that NHS England - Birmingham Solihull and Black Country Area Team will in the first instance commit resources at risk (Williams, L (2014), in accordance with the principle of respond first, clarify invoicing later and the decisions on funding must not delay responses.

Upon agreement of the required response to an incident by the IMT, should the response (in terms of staff/ resource commitment) exceed that detailed in relevant surge plans, providers will quantify the cost of extra pay and non pay resources utilised as a result of the enhanced response. Costs will need to be reasonable, locally agreed and presented with full supporting evidence.

Payments to final invoices will be implemented only on the express agreement of both parties. Discussions of this nature need to take place with the Directors of Finance (or equivalent) from the respective organisations.

5.5 Activation Process – Communicable Disease Incident

An initial risk assessment by PHE, will consider both the nature of the health protection threat and the complexity of the required response including communications and coordination.

PHE can declare an incident and respond directly without the need to involve a co-ordinated response via the activation algorithm.

Response to a public health incident frequently requires the assistance, both in and out of hours, of NHS providers, particularly when clinical investigations and treatment of patients is necessary (e.g. taking swabs, prescribing medicines or vaccinating patients).

Normally this is straightforward and can be arranged by the Public Health England through local general practitioners for their own registered patients (without needing to convene an IMT), however sometimes this is not feasible for a number of reasons e.g.:

- The incident occurs, or interventions are urgently required, outside normal GP service hours
- There are too many cases, requiring complex coordinated interventions, and this is not feasible within normal GP service delivery arrangements
- There are too many individual GP practices involved making a coordinated response difficult
- It would be more effective to provide a community ‘settings based’ response to the incident (e.g. through a dedicated mini-clinic providing investigations and treatment in a school or other community setting)
- The urgency of providing a particular intervention

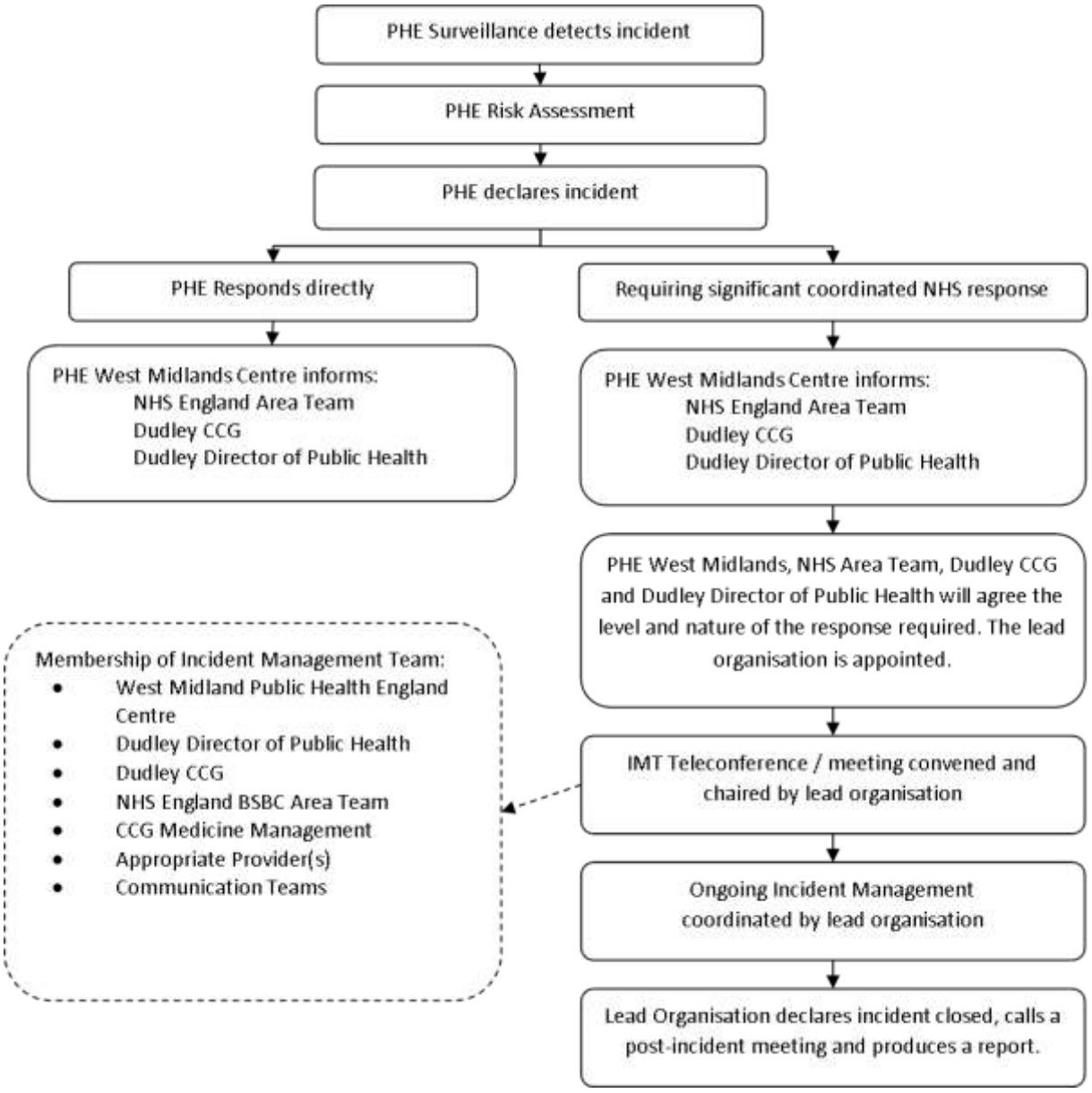
Where the risk assessment identifies that complex NHS resources need to be deployed, West Midland PHE Centre will declare an Incident and contact the Dudley MBC Director of Public Health, the NHS England

Birmingham Solihull and Black Country Area Team and Dudley CCG to discuss the risk assessment, response requirements and arrangements for an IMT. Out of hours contacts in Appendix 3.

West Midlands PHE Centre / NHS England Birmingham Solihull and Black Country Area Team will then arrange for an IMT to be held, provide the secretariat and, through normal on call arrangements, will notify relevant organisations.

In the event that a complex multi-agency response is required to a public health incident, relevant organisations will be required to participate in an Incident Management Team (IMT). The IMT will enable West Midlands PHE Centre and NHS England Birmingham Solihull and Black Country Area Team to effectively coordinate and command the provision of necessary staff and supplies which enable a swift and timely response to the incident, and enables the Dudley Director of Public Health to have appropriate strategic oversight. A request for participation in an IMT can be made at any time. Providers of NHS services have a duty to respond (in line with the requirements of the NHS Standard Contract) and may be called on to participate in the IMT.

Fig 2. Activation Algorithm for when NHS resources are required or have the potential to be required.



5.6 Activation Process – Environmental or Chemical Incident

These incidents may be insidious or catastrophic. For catastrophic/ short term incidents in Dudley the Emergency Response Arrangements of DMBC will be enacted. Local Responses are detailed at Appendix 4b.

For insidious incidents, these would be led by West Midlands PHE Centre, actions similar to those in para 5.5 would be instigated.

5.7 Ongoing Incident Management

The IMT will provide ongoing leadership, direction, and will have overall responsibility for co-ordinating the response to an incident. The team will ensure that a systematic approach to the investigation and the rigorous application of control measures are implemented. The investigation and measures required will be dependent on the particular circumstances of the incident. It is important that the IMT meet regularly (either in person or virtually) to assess the effectiveness of any actions taken maintaining accurate records of those decisions.

5.8 Incident Closure

The IMT will decide when an incident is over and will make a statement declaring this.

The IMT will convene a meeting following the closure of the incident, which will act as a debrief, look at any lessons learned, and consider any further preventive actions required. Following this meeting a full and final report will be prepared by the lead organisation and will be agreed by members of the IMT. The report should be suitable for confidential publication and will be circulated as appropriate.

6.0 Dudley Responsibilities in a Health Protection Incident.

On 22nd May 2013 the Office of Public Health facilitated an exercise to test Health Protection emergency resilience, understand new structures and responsibilities, and identify any gaps in provision across Dudley.

The agencies and services represented at the event were:

- Dudley MBC Office for Public Health
- Dudley MBC Environmental Health
- West Midlands Police
- West Midlands Ambulance Service
- Public Health England
- Dudley Group Foundation Trust
- NHS England Birmingham, Solihull, Black Country Area Team
- Dudley Clinical Commissioning Group
- Black Country Partnership Foundation Trust
- Dudley MBC Resilience & Emergency Planning
- Dudley MBC Communication & Public Affairs

In a table top exercise delegates worked through public health related scenarios that covered 2 areas of risk; infectious disease and chemical/environmental.

Overall there was a significant level of assurance that agencies understand what would be required of them and feel that they are in a position to fulfil their responsibilities.

Since Dudley's tabletop exercise, national regional and local clarification has been ongoing. The responses and responsibilities of organisations in Dudley are summarised at Appendix 4.

6.1 Scenario Testing and Assurance

Dudley Health Resilience Partnership will facilitate a Dudley Economy exercise and testing of Health Protection arrangements.

7. References

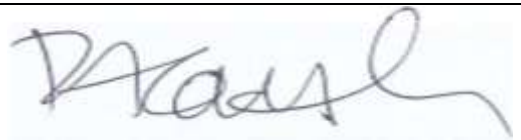
NHS England (2013) *NHS Emergency Preparedness Framework 2013,* London, NHS England, Publication Gateway, http://www.england.nhs.uk/ourwork/gov/eprr/

Professional Letter - Co-Chairs of Local Health Resilience Partnerships (2012) *Agreeing local roles for responding to Health Protection Incidents,* London: Public Health England, Publication Gateway Number: 2013-357

Public Health England (2013) Health Emergency Preparedness, Resilience and Response from April 2013 - Local health Resilience Partnership: Model Concept of Operations, London: Department of Health, Publication Gateway Number: 17820

Williams, L (2014) Item 2, Funding *Notes of a meeting to discuss Agreement of local roles for responding to Health Protection incidents*, 28th February 2014, NHS England Birmingham, Solihull and the Black Country Area Team. (P2)

Appendix 1: Signatories to the Co-operation Agreement

Organisation	Chief Executive/ Officer Signature	Date	Contact Name	Telephone	Email
West Midlands Public Health England Centre		12/5/14	David Kirrage, Local Director of Health Protection, West Midlands West PHE Team	0844 225 3560 (opt 2, 3)	david.kirrage@phe.gov.uk
Office of Public Health, Dudley Metropolitan Borough Council		12/5/14	Pauline MacDonald, Nurse Consultant in Communicable Disease	01384 816706	pauline.macdonald@dudley.gov.uk
Dudley Clinical Commissioning Group		29/5/14	Paul Maubach, Accountable Officer	01384 321754	paul.maubach@dudleyccg.nhs.uk
NHS England - Birmingham, Solihull and Black Country Area Team		12/5/14	Les Williams Director of Operations	01138 251706	leswilliams@nhs.net
Dudley Group Foundation Trust		12/5/14	Richard Cattell, Director of Operations	01384 321019	richard.cattell@dgh.nhs.uk

Appendix 2: Standard Contract clause pertaining to Emergency Preparedness and Resilience requirements for NHS Organisations.

SC30 Emergency Preparedness and Resilience Including Major Incidents

30.1 Each Party must identify and have in place an Accountable Emergency Officer

30.2 Each Party must have and maintain an up-to-date Business Continuity Plan

30.3 Each party must have and maintain an Incident Response Plan

30.4 The Provider must have in place evacuation plans which provide for relocation of Service Users to alternative secure premises in the event of any Significant Incident or Emergency and how that relocation is to be effected in such a way as to maintain public safety and confidence.

30.5 The Provider must:

30.5.1 assist in the development of and participate in joint planning and training exercises connected with its Incident Response Plan, including by conducting as required:

30.5.11 a communication exercise every 6 months

30.5.12 a desktop exercise annually; and

30.5.13 a major live or simulated exercise if such an exercise has not been conducted within the previous 3 years;

30.5.2 have in place and maintain Staff who are suitably trained and competent in emergency preparedness, resilience and response;

30.5.3 have in place and maintain adequate facilities (including an Incident Co-ordination Centre) from which a Significant Incident or Emergency can be effectively managed,

In accordance with NHS England Emergency Planning Framework

30.6 For ambulance services the training requirement referred to in Service AM Condition 30.5.2 will be in addition to the enhanced training for Hazardous Area Response Team (HART) support staff.

30.7 The Provider must comply with:

30.7.1 national and local civil contingency plans;

30.7.2 the Civil Contingencies Act 2004;

30.7.3 any other Law and/or guidance, in relation to Significant Incidents or Emergencies, including the EPRR Guidance, to the extent applicable

30.8 The Parties must, through the LHRPs and any applicable sub-groups of the LHRPs, co-operate with and contribute to the co-ordinated development and review of any local area Business Continuity Plans and Incident Response Plans.

30.9 If there is a Significant Incident or Emergency:

30.9.1 the Parties must comply with their respective Incident Response Plans; and

30.9.2 each Party must provide the others with whatever further assistance they may reasonably require to respond to that Significant Incident or Emergency; and

30.9.3 the Provider must comply with its Business Continuity Plan

30.10 The Provider must notify the Co-ordinating Commissioner as soon as reasonably practicable and in any event no later than 5 Operational Days following:

30.10.1 the activation of its Incident Response Plan

30.10.2 any risk or any actual disruption, to Commissioner Requested Services or Essential Services; and / or
30.10.3 the activation of its Business Continuity Plan

30.11 The Commissioners must have in place arrangements that enable the receipt at all times of a notification made under Service Condition 30.10

30.12 The Provider must at the request of the Co-ordinating Commissioner provide whatever support and assistance may reasonably be required by the Commissioners and/or NHS England and/or Public Health England in response to any national, regional or local public health emergency or incident.

30.13 If the Provider is subcontracting all or part of a Service, the Provider must;
30.13.1 ensure that its Incident response Plan and its Business Continuity Plan make provision in relation to the subcontracted services; and
30.13.2 require the Material Sub-Contractor or Permitted Sub-Contractor to have in place and maintain plans which are equivalent to the Provider's Incident Response Plan and Business Continuity Plan

30.14 The right of any Commissioner to:
30.14.1 withhold or retain sums under General Condition 9 (Contract Management); and/or
30.14.2 suspend Services under General Condition 16 (Suspension), will not apply if the relevant right to withhold, retain or suspend has arisen only as a result of the Provider complying with its obligation under this Service Condition 30.

30.15 The Provider must use its reasonable efforts to minimise the effect of a Significant Incident or Emergency and to continue the provision of Elective Care, as well as Non-elective Care. If a Service User is already receiving treatment when the Significant Incident or Emergency occurs, or is admitted after the date it occurs, the Provider must not:

30.15.1 discharge the Service User, unless clinically appropriate to do so in accordance with Good Practice; or

30.15.2 transfer the Service User, unless it is clinically appropriate to do so in accordance with Good Practice

30.16 Subject to Service Condition 30.15 if the impact of a Significant Incident or Emergency Incident is that the demand for Non-elective Care increases, and the Provider establishes to the satisfaction of the Co-ordinating Commissioner that its ability to provide Elective Care is reduced as a result, Elective Care will be suspended or scaled back as necessary for as long as the Provider's ability to provide it is reduced. The Provider must give the Co-ordinating Commissioner written confirmation every 2 calendar days of the continuing impact of the Significant Incident or Emergency on its ability to provide Elective Care.

30.17 During or in relation to any suspension of Elective care in accordance with Service Condition 30.16:
30.17.1 General Condition 16 (Suspension) will not apply to that suspension;
30.17.2 if requested by the Provider, the Commissioners must use their reasonable efforts to avoid any new referrals for Elective Care and the Provider may if necessary change its waiting lists for Elective care; and
30.17.3 the Provider must continue to provide Non-elective Care (and any related Elective Care) subject to the Provider's discretion to transfer or divert a Service User if the provider considers that to be in the best interests of all Service Users to whom the Provider is providing Non-elective care whether or not as a result of the Significant Incident or Emergency (using that discretion in accordance with Good Practice)

30.18 If, despite the provider complying fully with its obligations under this Service Condition 30, there are transfers, postponements and cancellations the Provider must give the Commissioners notice of:
30.18.1 the identity of each Service User who has been transferred and the alternative provider;
30.18.2 the identity of each Service user who has not been but is likely to be transferred, the probable date of transfer and the identity of the intended alternative provider;

30.18.3 cancellations and postponements of admission dates;
30.18.4 cancellations and postponements of out-patient appointments;
30.18.5 other changes in the Provider's list 16

30.19 As soon as reasonably practicable after the Provider gives written notice to the Co-ordinating Commissioner that the effects of the Significant Incident or Emergency have ceased, the Provider must fully restore the availability of Elective Care of Elective Care.

Appendix 3 Local Contact Arrangements

	Office Number (Normal Hours)	Out of Hours Number	Email	Incident Co-ordination Centre
Public Health England				
Midlands And East Region		0303 444 6753	icc.midlandseast@phe.gov.uk	1st Floor 5 St Philips Place, Birmingham B3 2PW
West Midlands Centre	HPT WM East 0844 225 3560 Option 1,1 HPT WM North 0844 225 3560 Option 1,2 HPT WM West 01562 756300	0121 232 9000 Fax 0121 3525107	icc.westmidlands@phe.gov.uk	6th Floor 5 St Philips Place, Birmingham B3 2PW EPRR 0844 225 3560 Option 3 CRCE 0844 225 3560 Option 2 0845 6015374 (HPT) 07659 101 378 (EPRR)
NHS England				
Birmingham, Solihull & the Black Country AT	0121 695 2222	0845 601 5377 Ask for "Birmingham, Solihull & the Black Country Area Team Director On-Call" Page One (pager numbers): 1st on-call: 07623 503 845 2nd on-call: 07623 503 846 AT EPRR On-Call: 07623 503 847	england.bsbc-icc@nhs.net england.bsbc-eprr@nhs.net	Triplex House, 1st Floor, Eckersall Road Birmingham B38 8SR Primary Contact 0121 465 8086 Secondary Contact 0121 465 7979
Local Authority				
Dudley MBC	0845 155 0076 Fax 01384 814 865	0300 555 8283	disaster.mgt@dudley.gov.uk dudley.emergency@dudley.gov.uk	

Clinical Commissioning Group				
Dudley CCG	01384 322777	On-Call rota covering all 4 CCGs (Dudley, Walsall, Sandwell and West Birmingham, Wolverhampton). via Sandwell and West Birmingham Hospitals Switchboard. 0121 553 1831		
Commissioned Providers				
Dudley Group NHS Foundation Trust	Director of Operations 01384 456111	Director on Call 01384 456111		
West Midlands Ambulance Service		Incident Command Desk 01384 246329 Fax: 01384 246 319	FOR INCIDENTS RUNNING ONLY : Incident Command Desk: DGOCStaffMPIncidentCommandDesk@wmas.nhs.uk Regional Gold email gold@wmas.nhs.uk	
Other Agencies				
NHS Property Services	01384 366424 (Karen Griffin, Facilities Manager (Dudley)	07789 006753	karen.griffin@property.nhs.uk	NHS Property Services Ltd Central Clinic Hall Street Dudley DY2 7BX
West Midlands Police		24/7 Switchboard Number 0345 113 5000 Events Control Suite Tally Ho! (Silver) Direct Tel: 0121 626 6014 Direct Fax: 0121 626 6017		
West Midlands Fire Service		24 Hour Control Number 0121 380 6832 0871 528 9857	EmergencyResponsePlanning@wmfs.net	

Environment Agency		24 Hour Incident Control Centre: 08458 503 518		
Health & Safety Executive		Out of Hours Duty Officer 0151 922 9235 Duty Press Officer 0151 922 1221		
Severn Trent Water Ltd		24 Hour Priority Number for Cat 1/2 Responders (water / waste). Ask for 'Resilience Duty Manager' 08456 020669		
South Staffordshire Water		24 Hour Control Number 01922 624 979		

Appendix 4

4a) Agreed Responsibilities in a Health Protection Incident (Communicable Disease)

West Midlands Public Health England Centre

Lead Organisation for notification of confirmed or probable cases of Infectious Disease
Responsibility to formally declare an Incident, and call and manage an incident meeting
Responsibility to arrange a teleconference to agree declaring an Incident
Responsibility for Case Management (liaising with relevant organisations)
Responsibility for incident investigation & contact tracing
Provide health protection advice to the IMT (drawing on regional and national PHE Experts)
Liaison with Primary Care, DGFT Community Services to take samples (where necessary)
PHE Communication Team to coordinate media responses as directed by the IMT
Production of draft alerts and letters
Communications to Schools (in liaison with OPH if necessary)
Report to Regional/National Public Health England
As Lead Organisation:
Lead the Incident Management Team, provide the Secretariat
Responsibility to liaise with relevant organisations
Liaison with providers to mobilise NHS Resources where necessary (via Commissioners if necessary)
Set up or contribute staff/resources to a helpline for the public (as required)
Responsibility to formally close an Incident, and call a post-incident meeting, and produce a post incident report.

NHS England - Birmingham, Solihull and Black Country Area Team

Liaison with providers to mobilise NHS Resources where necessary (via Commissioners if necessary)
Communications & Alerts to directly commissioned providers (General Practitioners)
Commission Primary Care – ensure the responsibility to collect samples from patients is in contracts
Organisation of Investigation / Treatment / Prophylaxis Centres
Provide funding for investigation and prophylaxis
Ensure commissioned services have appropriate Personal Protective Equipment and suitably trained staff
As Lead Organisation (where not West Midlands PHE Centre)
Lead the Incident Management Team, provide the Secretariat
Responsibility to liaise with relevant organisations
Liaison with providers to mobilise NHS Resources where necessary (via Commissioners if necessary)
Set up or contribute staff/resources to a helpline for the public (as required, probably via 111 in the future)
Responsibility to formally close an Incident, and call a post-incident meeting, and produce a post incident report.
(Commissioned providers: Primary Care General Practices)

Office of Public Health, Dudley Metropolitan Borough Council

Communications & briefing to Elected Members
Communication Team to give media briefings to the public as directed by the IMT
Support to West Midlands PHE Centre with communications/cascades within Dudley MBC Settings (i.e. schools reluctant to release contact details of parents/children)
Implementation of Care Home Business Continuity Plans
Contingency for Carer Support (within the Directorate of Children's Services and Directorate of Adult, Community and Housing Services)
Ordering of prophylactic treatment via Medicines Management Team (i.e. Antibiotics / Vaccines) as directed by IMT
Commission School Health Advisors - ensure the responsibility to respond to Public Health Incidents is in contracts

Set up or contribute staff/resources to a helpline for the public (as required)
(Commissioned providers: Black Country Partnership NHS Foundation Trust School Health Advisors)

Dudley Clinical Commissioning Group
Communications & Alerts to commissioned providers - (DGFT/GP Out of Hours services/ Walk in Centre)
Support to Led Organisation with communications/cascades within NHS Settings
Commission Community Care - ensure the responsibility to collect samples from patients is in contracts
Commission administration of prophylactic treatment (i.e. Antibiotics / Vaccines) via Community Pharmacies
Commission contingency for nursing support (Community Nurses) via DGFT contract
Commission Secondary Care transport of samples to regional/national laboratory for testing - via DGFT contract
Ensure commissioned services have appropriate Personal Protective Equipment and suitably trained staff
Set up or contribute staff/resources to a helpline for the public (as required)
(Commissioned providers: Dudley Group Foundation Trust (Acute/Community Services), Out of Hours Service and Walk in Centre

4b) Agreed Responsibilities in a Health Protection Incident (Chemical / Environmental)

West Midlands Emergency Services
Lead Organisation – coordinating on scene containment/ triage
Initial Lead for Communications (on site)

Resilience and Emergency Planning (REP), Dudley Metropolitan Borough Council
Responsibility to support Emergency Services (rest centres etc)
Responsibility to Support on Communications
Responsibility to liaise with relevant organisations
Transport of evacuees to Rest Centre/s
Responsibility for provision of temporary accommodation, transportation and welfare facilities.
Work alongside health services to ensure the welfare of those pre-identified as vulnerable people
DMBC will also be the lead agency in the recovery phase

West Midlands Police
Responsibility to collect details of evacuees for follow up

West Midlands Ambulance Service
Coordination of patients to receiving hospitals Emergency Departments (ED)
Advice to ED on treatment of patients/evacuees

West Midlands Public Health England Centre
Advice to ED on treatment of patients/evacuees

Dudley Group Foundation Trust
Enact Emergency / Contingency plans for dealing with chemical incidents.

Dudley Clinical Commissioning Group
Coordination of non-emergency ED patients to be referred to Dudley Walk in Centre (as commissioner of Walk in Centre and Out of Hours Services.

Office of Public Health

Responsibility to liaise with relevant organisations (Dudley CCG / NHS England)
Brief to Cabinet Members

NHS England Birmingham, Solihull and Black Country Area Team

Communications & Alerts to commissioned providers (General Practitioners)

SEN Reforms

Huw Powell
Acting Assistant Director
Educational Services

Dudley
Metropolitan Borough Council

What's been going on in the SEN world?

1. SEN Funding reforms

2. Children and Families Act

- Code of Practice
- The Local Offer
- EHCPs
- Personal Budgets

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SEN Funding Reforms – Situation pre April 2013

- Statements seen as route to money! Statements describe 'hours of support' that will be needed for pupil to access education. Support hours = money for teaching assistants

- Dudley funding arrangements for statements – unchanged, when other LAs choose to delegate the money to schools

- Dudley's statement population has been gradually increasing (to >1700 = 3.6% of school age population)

- National funding reforms introduced by DfE for April 2013

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SEN funding reforms

Key Message

A

statement of special educational needs **no longer** (in general) **brings additional funding**!

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Summary: Funding arrangements

- School funding formula now based on 10 pupil led factors – 2 mandatory (pupil nos and deprivation) + 8 optional (e.g. EAL, LAC) which include '*low cost, high incidence SEN*' (using under-attainment scores from EYFS and KS2).
- Introduces concept of a '**notional SEN budget**' (of £6,000) – from which schools expected to:

  a) meet the needs of pupils with low cost, high incidence SEN;

  b) contribute, up to a level set by the LA, towards the costs of provision for pupils with high needs (including those with high cost, low incidence SEN).

(**this means most of the cost of providing a statement is already in school budgets**)

Dudley Metropolitan Borough Council

SEN Funding in mainstream schools

Element 1: per pupil funding

- Schools get an AWPU (age weighted pupil unit) – covers the running costs of the school, to provide the universal elements.

Element 2: notional SEN funding of £6,000

- The DFE recommends schools use this to provide up to £6000 worth of support to pupils with SEN (including those with statements.) This support is *'additional or different from'* what is generally or universally provided.

Element 3: Top-up funding for more complex SEN

- In Dudley, it has been agreed that top up funding will be made available for pupils who have statements of >20 hours i.e. those with the most severe and complex needs.

Dudley Metropolitan Borough Council

Banded Framework and Notional SEN funding

Dudley has formulated a Banded approach to SEN funding. The banded framework will only be applicable for SEN pupils with statements.

Previously, schools receive additional funding for statemented pupils based on the number of support hours written into their statement. The great majority of Dudley pupils have between 10 – 25h support identified.

The Mainstream Banded Framework determines an equivalent monetary value for each block of 5 hours of support. As a result, the funding for pupils requiring up to 20 hours support will found through the 'notional SEN' element within school budgets. Pupils requiring more support hours than this will qualify for top up funding.

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Dudley's Banded Framework for SEN – secondary mainstream

Funding BANDS	AWPU	Element 2 (notional SEN)	High Needs top up	Total	Old hours
Band Ai	£4,400	**£1,500**	£0	£5,900	5h
Band Aii	£4,400	**£3,000**	£0	£7,400	10h
Band Aiii	£4,400	**£4,500**	£0	£8,900	15h
Band Aiv	£4,400	**£6,000**	£0	£10,400	20h
Band Bi	£4,400	**£6,000**	**£1,500**	£11,900	25h
Band Bii	£4,400	**£6,000**	**£3,000**	£13,400	30h
Band Biii	£4,400	**£6,000**	**£3,750**	£14,150	32.5h

Dudley's Banded Framework for SEN – primary mainstream

Funding BANDS	AWPU	Element 2 (notional SEN)	High Needs top up	Total	Old hours
Band Ai	£3,100	**£1,500**	£0	£4,600	5h
Band Aii	£3,100	**£3,000**	£0	£6,100	10h
Band Aiii	£3,100	**£4,500**	£0	£7,600	15h
Band Aiv	£3,100	**£6,000**	£0	£9,100	20h
Band Bi	£3,100	**£6,000**	**£1,500**	£10,600	25h
Band Bii	£3,100	**£6,000**	**£3,000**	£12,100	30h
Band Biii	£3,100	**£6,000**	**£3,750**	£12,850	32.5h

2013 on: Funding arrangements – special sch.

Prior to 2013 Dudley Special School funding was determined via the **Dudley Matrix of Needs**. The Matrix was made up of brief descriptors of pupil need for the 4 categories of Special Needs outlined in the SEN Code of Practice. Special Schools made a return to the LA showing the number of pupils on their roll and where they were on this matrix.

The 2013 funding reforms mean all LAs fund their special schools using a national formula. Funding now consists of two elements:

- **Place funding** of £10,000

The LA has to decide on the number of places it anticipates it will need in each school – and send this number to the DfE in Dec. for Sept. funding.

- **Top-up funding** dependent on assessed need

Top-up is determined using the **Dudley Special Sch Banding Framework**

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Dudley's Banded Framework – Special Schools

Comparison of 2012/13 and 2013/14 funding

Degree of Need		Old Funding			Current Funding			
Mild ↓ ↓ ↓ Complex	Pupil Weighting. Higher weighting = more money	Weighting	Approx funding		Band	Place	Top-up	Total funding
		1	£11,700		B	£10,000	£1,333	£11,333
		1.2	£13,240		C	£10,000	£3,600	£13,800
		1.3	£14,000		D	£10,000	£4,167	£14,375
		1.8	£17,850		E	£10,000	£7,000	£17,250
		2.3	£21,700		F	£10,000	£12,667	£23,000
		3.0	£27,100		G	£10,000	£17,200	£27,600
					H	£10,000	£24,000	£34,000

SEN Funding - Impact on special educational needs in schools

- There has been a decrease in the number of referrals for statements received.
- There has been an increase in number of schools requesting a reduction in provision or requesting the statement is ceased.
- Over time it is likely that there will be fewer statemented pupils or EHCPs in mainstream schools.

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Children and Families Act (March 2014)

The key changes for children with SEN and their families are:

- replacing Statements of SEN with a single assessment process and an **Education, Health and Care Plan**
- placing a requirement on health services and local authorities to **jointly commission and plan services** for children, young people and families
- providing **statutory protection** comparable to those in Statements for young people who are in education or training up **to the age of 25**.
- giving parents or young people the right to a **personal budget** for their support
- obliges the LA to publish a **Local Offer**
- introduces a **revised Code of Practice**

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Draft SEN Code of Practice

- The practical application of the SEND arrangements, required within the Children and Families Act, can be found in the current draft code of practice

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251839/Draft_SEN_Code_of_Practice_-_statutory_guidance.pdf

- Due to be finalised in the “spring” of 2014. It will be in force on 1 September 2014.
- “Statutory guidance for organisations who work with and support children and young people with SEN”

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Contents of Code of Practice

1. Introduction
2. Principles
3. A Family Centred System
4 **Working together across education health and care**
5. **The Local Offer**
6. Early Years, Schools, Colleges and Other Providers
7. Assessments and **Education, Health and Care Plans**
8. Children and young people in specific circumstances
9. Resolving Disputes

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The SEN Code Practice applies to:

- local authorities (education, social care and relevant housing and employment and other services)

- early years providers
- schools
- further education colleges
- sixth form colleges
- academies (including free schools)
- independent special schools and independent specialist providers
- pupil referral units and alternative providers

- NHS England & NHS trusts & NHS Foundation Trusts
- Local Health Boards and Clinical Commissioning Group (CCG)

- SEND Tribunal (see 1.5 and 9.6)

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Chapter 4: Education, Health and Social Care – working together for positive outcomes

- Clause 25 places a duty on LAs to exercise their functions to promote integration between special educational provision, health and social care provision where this would promote well-being and improve the quality of provision.
- Clauses 28 and 31 require health authorities and other bodies to co-operate with the LA to identify and support children and young people with SEN.
- Clause 26 requires local authorities and CCGs to commission services jointly for children and young people with SEN, including putting effective dispute resolution procedures in place where local agencies disagree.

- The Health and Social Care Act 2012 requires Health and Wellbeing Boards to develop Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, both of which support prevention, identification, assessment and early intervention and a joined up approach from those providing services.

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The Local Offer

- C&F Act places a duty on all local authorities to publish details of services and provisions in their area to support families with a child or young person with a special educational need and/or a disability (SEND)

- “One-stop shop” approach brings together, in one place, all of the information about SEND. It will cover education, health, social care, transport and leisure activities.

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The Local Offer

What is it expected to achieve?

- To provide information about the support and opportunities that are available for pupils with SEN.
- To make provision more responsive to local needs and aspirations, building on parental feedback. Make it easier for parents/carers to find the information that matters to them
- Provide clarity and confidence for parents
- Help parents and carers in knowing what should be provided by schools within their existing budgets
- Identify gaps in provision
- Provide an evidence base for improving services

Who is it for?

- Parent, carers of children and young people with SEND.
- Practitioners and professionals.
- Anyone who has an interest in delivering services for SEND pupils.

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The Local Offer Contents

- LA funding arrangements
- Special schools resources bases units and specialist services colleges and alternative providers, training providers
- What schools are expected to provide from within their budget
- Requesting an EHCP assessment
- Short break information and child care opportunities
- Transfer to adult services - independent living and housing options
- Health therapy services and the access criteria including mental health and medical conditions
- Leisure activities for children with learning difficulties e.g. after school clubs
- Parent Partnership and dispute arrangements – support for parents and carers
- Transport

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What is an Education, Health and Care Plan?

- The Education, Health and Care Plan (EHCP) will be the 'new style' Statement of Special Educational Needs in September 2014. No more 'statements' will be issued after this date.

- Existing statements will remain in the system until converted. It is anticipated there will be a 3 year conversion period.

- The EHCP brings together the education and health and social care services necessary to meet a child or young person's needs. The plan places the child/young person and their family, at the centre of the process, describing the needs and outcomes to be achieved and the support required to achieve them.

- An EHCP can start from birth and potentially last until the young person is 25 years old.

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Who will need an EHCP?

- *'the majority of children and young people with SEN will have their needs met within local mainstream early years providers, schools or colleges'*

An EHCP assessment and possible plan is only likely

- *'where the child or young person needs cannot be reasonably met from within the resources normally available to mainstream early years providers, schools and post 16 institutions'*

Dudley Metropolitan Borough Council

DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item No 12**

REPORT SUMMARY SHEET

DATE	17th June 2014
TITLE OF REPORT	Dudley Clinical Commissioning Group Strategic Plan 2014 - 2019
Organisation and Author	Dudley Clinical Commissioning Group - Paul Maubach, Chief Accountable Officer
Purpose of the report	To approve the CCG's Strategic Plan for 2014 - 2019
Key points to note	1. At their last meeting the Board approved the CCG's Operational Plan for 2014-2016. This plan sets out key priorities for the CCG over a two year time horizon and the Board agreed that it was informed by and consistent with the Joint Health and Wellbeing Strategy (JHWS). 2. The CCG is also expected to produce a Strategic Plan for a 5 year period. This is intended to relate to a "unit of planning" sensitive to the local organisational geography for both NHS and local government. In our case Dudley is the unit of planning. In areas such as Sandwell and Birmingham the unit of planning is more complex given the number of CCGs, other NHS bodies and local authorities involved. 3. A three-page summary of the plan is included as Appendix 1. The longer version of the plan, including the "plan on a page", as approved by the CCG Board, is attached as Appendix 2. It builds on the key initiatives set out in the CCG's Operational Plan and recognises the 5 JHWS priorities.
Recommendations for the Board	That the CCG's Strategic Plan be approved.
Item type	Strategy
H&WB strategy priority area	All

DUDLEY HEALTH AND WELLBEING BOARD

DATE 17th June 2014

REPORT OF: Dudley Clinical Commissioning Group - Paul Maubach, Chief Accountable Officer

TITLE OF REPORT: Dudley Clinical Commissioning Group Strategic Plan 2014 - 2019

HEALTH AND WELLBEING STRATEGY PRIORITY

1. The CCG's Strategic Plan links to all priorities of the JHWS

PURPOSE OF REPORT

2. To approve the CCG's Strategic Plan for 2014 – 2019

BACKGROUND

3. The Board will recall that at their last meeting they approved the CCG's 2 year Operational Plan as being consistent with the Joint Health and Wellbeing Strategy (JHWS).

4. The CCG is also required to produce and agree with the Board a 5 year strategic plan for the Dudley unit of planning.

5. A three page summary is attached as Appendix 1. The plan, as agreed by the CCG Board, is attached as Appendix 2.

OUTCOME OBJECTIVES

6. The CCG has set out four key outcome objectives informed in part by the Health and Wellbeing Board's Joint Strategic Needs Assessment ((JSNA). These are:-

- effective and efficient care
- healthy life expectancy
- mutual approach to achieving best possible outcomes
- high quality care for all

REIMAGINING HEALTHCARE – WHAT WILL IT LOOK LIKE IN 2019?

7. The Strategy makes a clear statement about what the healthcare system will be like in 5 years' time characterised in terms of:-

- a mutualist culture
- a new structure of delivery
- population health and wellbeing
- health and Wellbeing centres for the 21st Century
- innovation and learning

8. These characterises have their roots in the JHWS priorities.

9. The plan is underpinned by the 2 year operational plan, an organisational development plan and a 5 year financial strategy.

FINANCE

10. The financial implications are dealt with in the CCG's 5 year financial strategy.

LAW

11. The provisions of the NHS and Social Care Act 2013 require the CCG to consult the Board on its plans.

EQUALITY IMPACT

12. Individual commissioning initiatives will be subject to equality and quality impact assessments.

13. The plan is predicated on reducing health inequalities. Specific initiatives are set out in the CCG's Operational Plan.

RECOMMENDATIONS

14. That the CCG's Strategic Plan be approved.

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Paul Maubach
Chief Accountable Officer

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NHS
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Long-term Strategic Plan 2014-2019 Summary

Our Vision

This document provides a summary of our strategic plans. Our overall vision is to promote good health and wellbeing and to ensure high quality health services for the people of Dudley.

The Principles which we work to:

1. **Meaningful involvement of patient and public**

Helping the public to take control of their care, receive a more personalised service, have clear information to inform their choices; and more easily share how services are working for them.

2. **A clinically led system of healthcare**

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.

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. So we will co-commission these services with NHS England to deliver our strategy for primary care.

4. **Working with partners in our communities**

Our locality-based approach to the national Better Care Fund initiative recognises the need to bring together our GPs, patients, 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.

5. **Focus on quality and continuous improvement**

We will encourage 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.

6. **Live within available resources**

Dudley CCG will meet its financial responsibilities to address the reasonable needs of our population within available resources. 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; from the priorities set by the Dudley Health and Wellbeing Board; and designed to meet the future needs of our population.

1. **Effective and Efficient Care**

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:- reducing time spent avoidably in hospital; increasing the proportion of older people living at home; ensuring clinicians have more time to spend with those who need it most; ensuring pathways of care (both urgent and planned care services) are as efficient as possible with minimal variations in performance.

2. **Healthy Life Expectancy**

Our overarching objective is to improve the healthy life expectancy of the population we serve. So we will:- reduce avoidable years of life lost for people with treatable conditions; improve quality of

life for people with long-term conditions; support improvements to reduce the inequalities in health between different groups; and prioritise health and wellbeing services.

3. Mutual approach to achieving best possible outcomes

Improvements needs to be measured both clinically but also by how patients see the value of the care that they receive. So we will seek to improve people's positive experience of all services (hospital, community and primary care). We will: enable patients to quantify the real value of the services that they receive; demonstrate how individuals achieve greater autonomy from healthcare; and ensure all service providers network better around the needs of patients

4. High Quality Care for all

The public expect the NHS to provide safe and effective services. We will use and 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 and providers are transparent and learns and improves with the public.

How our services will be different to achieve these aims

1. A Mutual health and social care system

Our objective is to support individuals to take as much responsibility for their own health and wellbeing as they can - and so both improve their wellbeing as well as reduce their demands on healthcare. We will therefore: invest in activities that provide proactive intervention and advice to the population; promote ways of working which encourages mutual responsibility between patient and professional; and support increased personalised care which enables individuals to have a greater say in the outcomes that they want to achieve.

We will foster 'health as a community responsibility' by supporting integration with the voluntary sector; and active community engagement between NHS services, Public Health and VCSE services.

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. A 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.

2. A new structure to the way health and social care is provided

The existing separation of services into primary care, community services, mental health services and acute services is artificial; creates barriers; and doesn't reflect the needs of the modern population. We have already started to rethink the organisation of care into four different groupings:

2.1 Planned Care: planned treatment interventions with defined outcomes

In planned care we will improve the efficiency of services the whole pathway of care that patients go through, as well as improve the outcomes of treatment. We will set prices for planned care on the basis of best practice performance 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.

2.2 Urgent Care short-term interventions to help and treat you in a crisis

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 also commission emergency medical care as an extension and integral part of population-based health and wellbeing services. This will both enable more patients to stay at home as well as enable clinicians to better co-ordinate care across the system.

2.3 Reablement Care services designed to help reduce your dependency

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. 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.

2.4 Proactive Care population-based care to help you manage your health needs

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. 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.

3. An emphasis on population health and wellbeing services

Over the next five years we will develop our integration model into comprehensive, population based, health and well-being services.

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.

We will also 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.

4. Health and wellbeing facilities for the 21st Century

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.

During the next five years we will encourage our 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 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.

5. An emphasis on innovation and learning

We are a learning organisation and as such we highly value, and are investing in, research and organisational development.

In the first year we will make significant steps to improved working with technology – as all our GPs will be using the same clinical IT system.

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. This approach to commissioning-led information will improve provider efficiency and effectiveness; reduce barriers to market entry; and improve contractual efficiency with our CCG and enable more rapid sharing of innovations and best practice.

Overall our emphasis on innovation will be to find ways to promote best practice in front-line care.

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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.

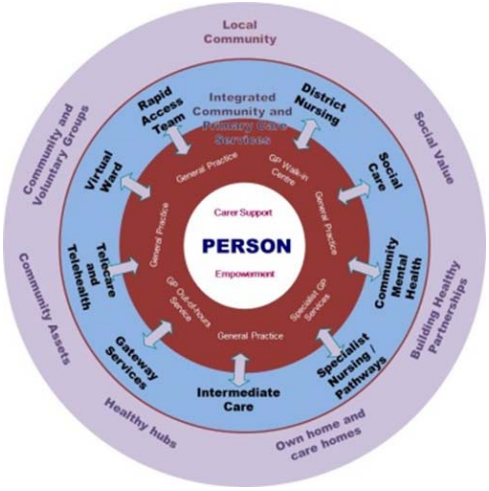
In planned care we will be commissioning based on measureable value-based outcomes of the services provided. We will have systems in place to monitor and report on variations in individual clinical performance – with the aim of improving both the whole pathway efficiency of services (left-shifting the 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.

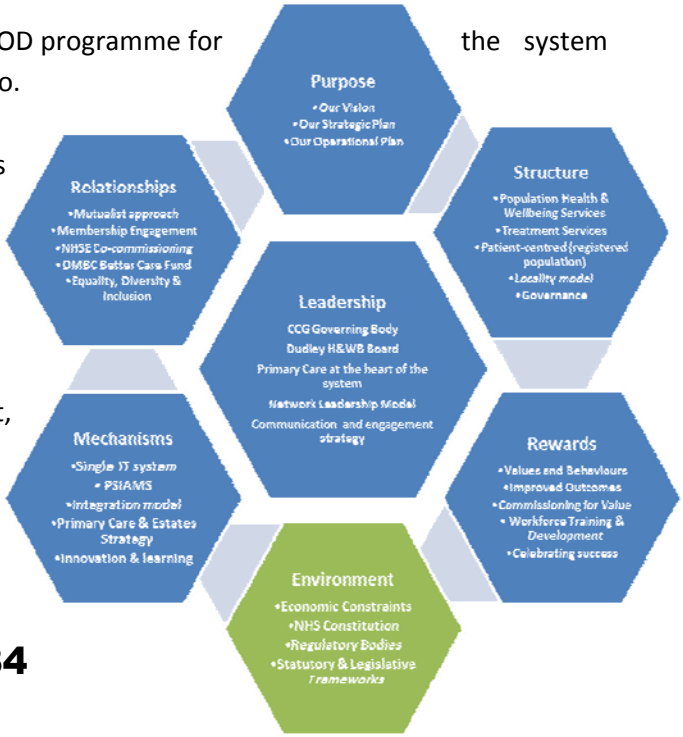
We also believe that we have a responsibility with the wider NHS to share our good practice and also learn from others. So we will work with other CCGs to establish an Organisational Development and Learning network to exchange ideas and learning. We will also develop a franchise approach to our population 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

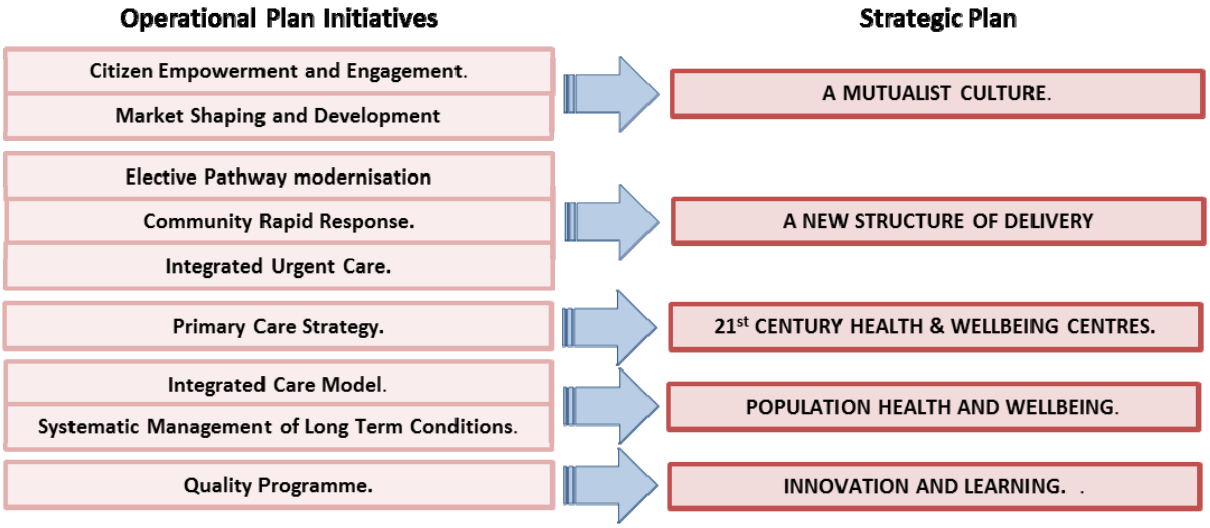


2

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.

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

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

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

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

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: 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.

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.

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.

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.

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: A mutualist based relationship with member practices and responsible local citizens – developing PPGs and an autonomous registered membership.

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

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

Enabler: Our Primary Care Strategy and Estates Strategy – with Co-Commissioning of Primary Care with NHS England.

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**