

*Thinking Differently*



**Dudley Clinical Commissioning Group  
Long Term Strategic Plan 2014 -2019  
From: Dependency, Hierarchy and  
Modernism  
To: Autonomy, Networks and Mutualism**



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## **Dudley Clinical Commissioning Group**

### **Long Term Strategic Plan 2014 -2019**

**From: Dependency, hierarchy and modernism**

**To: Autonomy, Networks and Mutualism**

#### **1. Background**

This plan sets out where we expect the Dudley health and care system to be in five years' time, the objectives we wish to fulfil and the characteristics it will display.

It reflects our vision to promote health and wellbeing and to ensure high quality services for the people of Dudley.

It is designed to support our overarching objective to improve the healthy life expectancy of the population. 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;
- privilege services which operate on a population basis and which are designed to support health and wellbeing – particularly primary prevention services;
- 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 wellbeing; 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 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 the delivery of services to reflect different needs and inequalities in health in our local communities and we must remove variations in performance and clinical practice which adversely affect the delivery of health outcomes.

In so doing, our system will be built in a way which reflects the 5 domains of: -

- preventing premature deaths;
- best quality of life for people with long term conditions;
- quick and successful recovery following ill health;
- great care experience;
- keeping patients safe and protected from harm.

## **2. Re-Imagining Healthcare**

We have re-imagined healthcare in terms of:-

- a mutualist culture
- the structure of the system
- population health and wellbeing services
- health and wellbeing centres for the 21<sup>st</sup> Century
- Innovation and learning

and in a way which reflects the 6 key system characteristics necessary for a sustainable health and care system set out in “Everyone Counts: Planning for Patients 2014/15 to 2018/19”.

# Five-year Strategy 2014-1019 Plan on a Page

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
- 20% efficiency gain for planned care
- 15% reduction in urgent care
- Avoidable emergency admissions reduced to 2332 per 100,000 by 2018/19

## Reimagining: A MUTUALIST CULTURE.

Creating opportunities for active citizenship in vibrant communities and a participative mechanism of engagement for all registered members. Changing the way we evaluate healthcare so that the patient can articulate the value of the services they are receiving. Promoting mutual responsibility between patient and professional to manage risk and personalise healthcare planning.

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

## Objective:

### Healthy Life Expectancy

- Premature mortality is reduced
- Inequalities in Health between all population groups are reduced
- Health and wellbeing services are at the heart of healthcare delivery
- 3.5% reduction in potential years of life lost per annum to 1685/100,000 by 2018/19

## Reimagining: A NEW STRUCTURE OF DELIVERY

Changing the definitions of services from primary, community, mental health, social care and acute to: planned care, urgent care, reablement care and proactive care. Removing the boundaries between different professions to privilege population-based healthcare in the community with a networked primary care and registered population at the centre.

Enabler: Development of person-centred information: PSIAMS – personalised patient-driven reporting on the value of care ; Risk stratification to target resources based upon individual patient risk profiling.

## 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
- EQ – 5D Score 74% of people reporting health has improved by 2018/19

## Reimagining: POPULATION HEALTH AND WELLBEING.

Enabling a step change in how our GPs coordinate the systematic management of long term conditions to achieve healthy life expectancy. Differentiating between: population health and wellbeing services - where continuity is key; from urgent care - where responsive access is the priority.

Enabler: Commissioning for value: removing unwarranted variation in care and evaluating individual clinical performance to inform patient choice

## 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
- Eliminating avoidable hospital deaths
- MRSA – zero tolerance
- Grade 4 pressure ulcers – zero tolerance

## Reimagining: HEALTH & WELLBEING CENTRES FOR THE 21<sup>st</sup> CENTURY.

Supporting the development of new centres of care across the borough to provide modern facilities in our communities. Investing in front-line staff so they have the best possible training, support and satisfaction from a job well done – and by extension providing best possible care to our population.

Enabler: 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

## Reimagining: INNOVATION AND LEARNING.

Using research to test and evaluate the key components of this strategy. Making it our business to focus on achieving efficiency and best practice in front-line care. Working better with technology: both within the health and social care eco-system as well as with individual patients .

Enabler: Joint governance, performance and commissioning frameworks with all partners. Better Care Fund with Dudley MBC. Memorandum of Understanding with the Office of Public Health.

Enabler: Network leadership, training, evaluation and research programmes

### 3. Arriving At and Agreeing Our Vision

Our re-imagined system has been designed and based upon our analysis of the challenges our system faces. These are described further below.

This is a Dudley system arrived at by working with our partners. Our 2 year operational plan, our Better Care Fund Plan, the associated metrics and outcome targets were approved by the Dudley Health and Wellbeing Board, in the context of Dudley's Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS), on 26<sup>th</sup> March 2014. This strategic plan was subsequently approved by the Health and Wellbeing Board on 17<sup>th</sup> June 2014.

From a system perspective there are two key issues which partners face across the NHS and local government – delivering an effective urgent care system and integrating services in such a way as to deliver the objectives of the Better Care Fund. Our system wide governance arrangements reflect this. Our Urgent Care Working Group and our Integrated Services Working Group both report to The Health and Social Care Leadership Group which consists of chief executive/director representatives from the NHS, local government and the voluntary sector. This in turn reports to the Health and Wellbeing Board on key aspects of system wide performance which includes delivery of:-

- Joint Health and Wellbeing Strategy priorities;
- this plan;
- Better Care Fund outcomes.



Our Strategy reflects our system values and principles:-

- aiming for the provision of innovative, integrated, localised and personalised services that give excellent value for money;

- focusing services on prevention and early detection and recognising the need for people to take responsibility for their own health and wellbeing;
- recognising the potential for individuals and communities to maintain and sustain health and wellbeing and the contribution they can make to shaping services;
- tackling health inequalities through the concept of “proportionate universalism”;
- working in partnership to improve health and wellbeing;
- continued improvement in the quality and safety of our services;
- safeguarding children, young people and adults.

The analysis set out below provides the basis for our re-imagined system. Much of the detail is contained within our operational and organisational development plans.

### **a) Challenges**

There are a number of significant challenges in terms of the system, the financial environment, performance and health status. These are described in our operational plan (pp. 8 – 13).

#### **i) The system**

The key system challenges are:-

- growing demand from an ageing population;
- sustainability of our main provider – Dudley Group NHS FT and our local authority;
- inflexibility of local organisations and unresponsive service provision;
- cultural changes required to secure the engagement of clinicians and deliver our integrated service model.

#### **ii) Financial**

The key financial challenges are:-

- delivering a redesigned urgent care system and an integrated service delivery model capable of reducing demand on hospital services;
- delivering the efficiencies required to achieve a balanced Better Care Fund Plan.

#### **iii) Provider Performance**

Specific performance challenges remain in relation to:-

- ED 4 hour wait;
- referral to treatment times for elective care;
- waiting times for some community services.



Our operational plan sets out the specific initiatives we will put in place to address these challenges.

#### **iv) Health Status and Health Inequalities**

We have examined the JSNA, “Commissioning for Prevention”, “CSU QIPP Opportunities Pack”, the “Commissioning for Value Pack” and the “CCG Outcome Indicators Framework”. These show that:-

- we have specific health inequalities for the male population both in terms of mortality rates in the 60 – 74 year age band and alcohol specific problems for the 40-59 year age band;
- this is contributing to a widening of the life expectancy gap between the most and least deprived parts of our population;
- we need to ensure our locality based service delivery model (see below) provides an appropriate, differential intervention at neighbourhood level to respond to local health inequalities;
- interventions in relation to cancer, heart disease, stroke, liver disease and stroke are required. We must ensure that our practices perform well in delivering smoking cessation services;
- the systematic management of patients with long term conditions in primary care and community health services will be a major contributor to our success, including the management of diabetes;
- we need to “make every contact count” in primary care and other settings;
- we have a growing frail elderly population, we need to improve the care pathway to prevent unnecessary admissions and create the conditions to enable people to be re-abled and retain their independence in their communities;
- we require a continued focus on mental health, in the context of achieving “parity of esteem”, as well as the relationship between mental health, physical health and the management of long term conditions;
- we need to ensure that our approach to prescribing and the input of our practice based pharmacists continues to improve our performance in relation to the use of drugs to reduce cholesterol, reduce blood pressure and manage atrial fibrillation;
- we need to ensure that our work on the systematic management of long term conditions, redesigning urgent and planned care pathways and integrating services in our localities is sensitive to the needs of our child population;
- as part of our approach to the Equality Delivery Scheme, we need to facilitate work with those groups protected by legislation where the difference in health outcome and need is greatest, as well as analyse the barriers to improved patient access and experience for these groups. This will be reflected in our Equality Objectives;

- we need to use an asset based approach to our work with partners in addressing the wider determinants of health.

## **b) Community and Clinician Engagement**

Our re-imagined system has been formed by engaging with:-

- our healthcare forum
- our network of patient participation groups
- the Health and Wellbeing Board and our JHWS
- our GP membership
- stakeholders through the “Call to Action” process

This engagement has informed, in particular, our plans for:-

- a simplified emergency and urgent care system
- improved access to primary care
- integrated community health and social care services
- more support to enable patients to manage health problems, including long term conditions

## **4. 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 from 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 individual patient 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 (10 – 15 locations across 5 localities) 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 GP practices (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.

## **5. Our Underlying Principles**

We operate to six key principles:

### **a) 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.

### **b) Clinically Led**

The public register with their GP and through the coordination that their GP provides, that they are able to best access the healthcare 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.

### **c) 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.

### **d) 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.

### **e) 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.

### **f) 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.

It is against these principles that we test out each commissioning initiative. Our analysis of two key initiatives – urgent care and services integration – is set out below:-

<i>Principle</i>	<i>Urgent Care Model</i>	<i>Service Integration</i>
Patient and Public Involvement	Informed by patient and public engagement via Healthcare Forum and other mechanisms	Informed by patient and public engagement via Healthcare Forum and other mechanisms
Clinically Led	The prime point of contact for registered patients, in the first instance, should be their general practice. Through our co-commissioning arrangements we will work with our membership to increase access to primary care for registered patients and ensure that unregistered patients are given the opportunity to register.	A common population base is the pre-requisite for this model. Services will be organised at practice, locality and borough levels led by clinicians.
Primary Care at Our Heart	A better service model, enabling GPs and other clinicians to use their skills to manage urgent care better within a supportive system will enhance the workforce and attract staff to Dudley.	Enhancing clinical leadership and giving clear responsibility to deliver effective services for their registered patients will be a key factor in building an enhanced workforce and attracting staff to Dudley.
Working with Partners in Our Communities	Being able to access care appropriately is a key mechanism for responding to health need. Variability of access leads to health inequality. Our urgent care model is designed to facilitate access, whilst ensuring that other community based responses to urgent care situations are available.	Our service model will provide a targeted response to health need and health inequality. A voluntary sector link worker in each locality will ensure that services are connected to voluntary and community sector services and opportunities to enhance capacity identified for action.
Focus on Quality and Continuous Improvement	We will develop clear clinical protocols that provide a consistent response to those patients accessing the system	We will have clear indicators in place for all our integrated teams at each population level, linked to the Better Care Fund metrics. These will

		be used to drive up performance and reduce unnecessary variation.
Live Within Available Resources	Our urgent care service will ensure appropriate access to urgent care, avoid unnecessary use of ED and deliver an economic benefit.	Our integrated services model is designed to remove unnecessary admissions to secondary care and nursing/residential care, as well as facilitating early discharge and reducing the dependency of individuals. This will deliver a clear economic benefit to the system.

## 6. Our Key Outcome Objectives

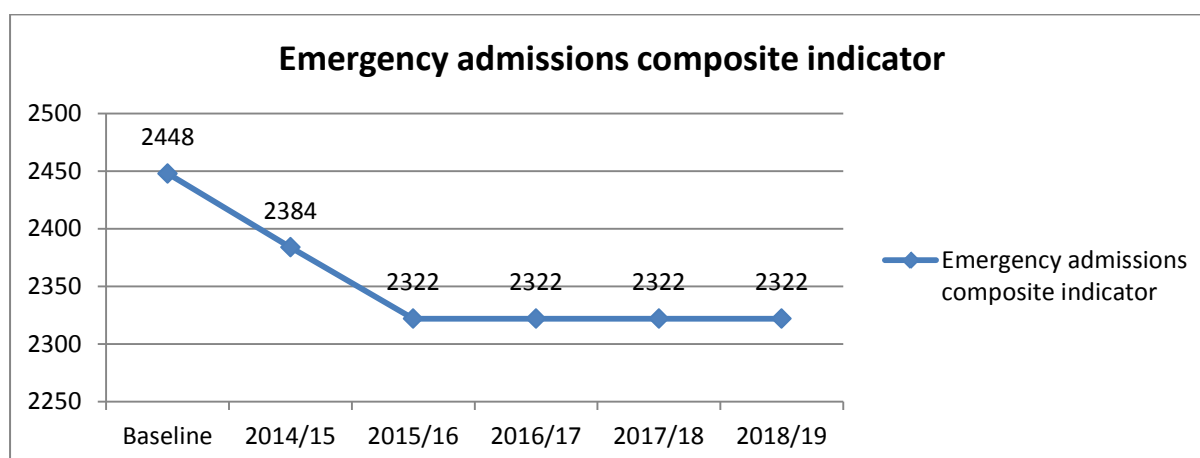
Our key outcome objectives are derived from the findings in our Joint Strategic Needs Assessment and designed to meet the needs of our population. These objectives include parameters that we can currently measure; however we will also be designing new measures which in the future will more accurately reflect the new structure and design of services that we are trying to create. Our operational plan (pp14 – 18) and Appendix 1 to this plan sets out our outcome ambitions, their relationship to the JSNA and our initiatives to respond to them.

### a) 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 - 2,322 avoidable admissions per 100,000 by 2018/19**



- increasing proportion of older people living at home: People still at home 91 days after discharge 230 as at 2018/19

We will identify the most efficient pathway for each intervention and de-commission pathways that do not meet this standard

Future measures will evaluate:-

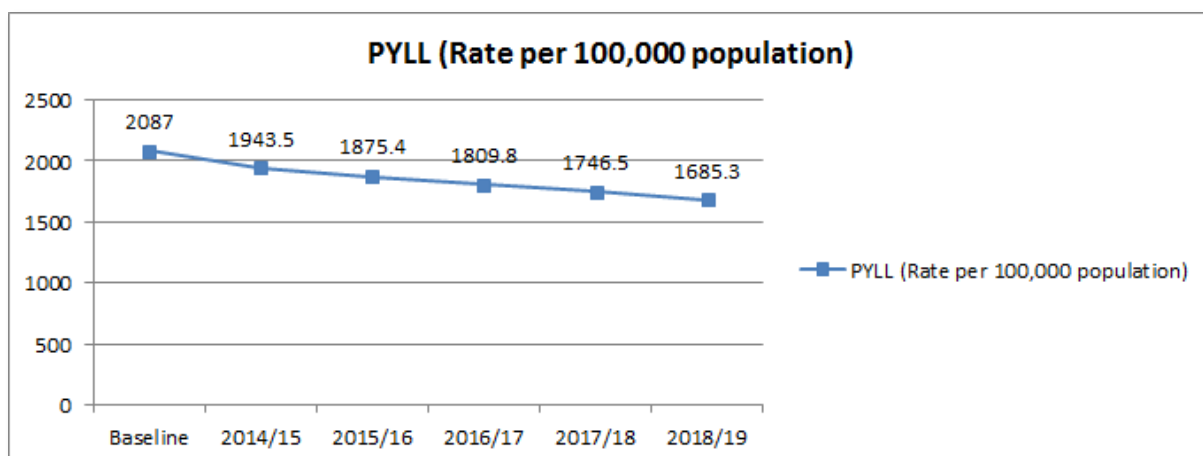
- ensuring clinicians have more time to spend with those who need it most
- pathways of care (both urgent and planned care services) are as efficient as possible with minimal variations in performance between clinicians

## **b) Healthy Life Expectancy**

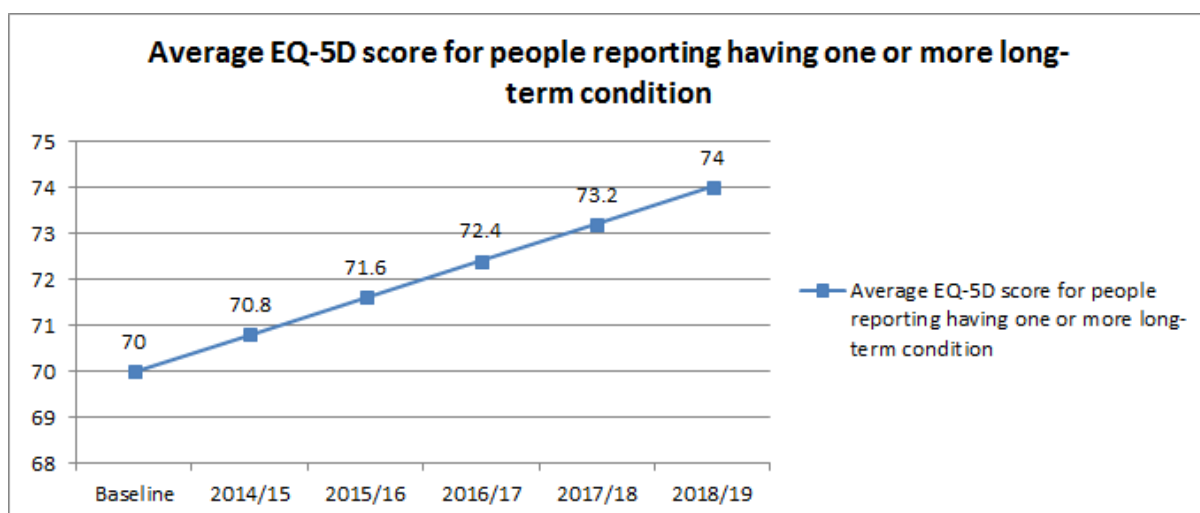
Our overarching objective is to improve the healthy life expectancy of the population we serve.

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 to bring the CCG up to the performance of comparator CCGs



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.

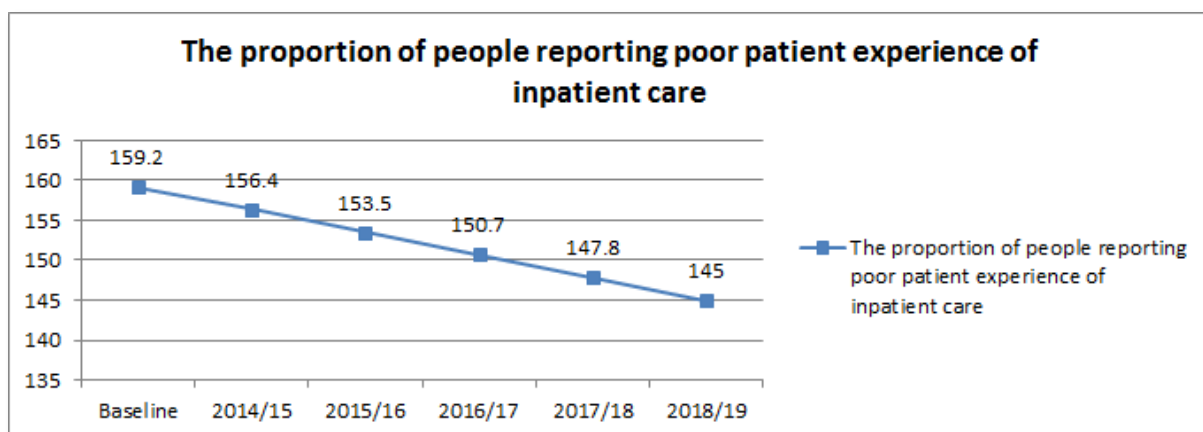
### c) Mutual Approach to Achieving Best Possible Outcomes

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.

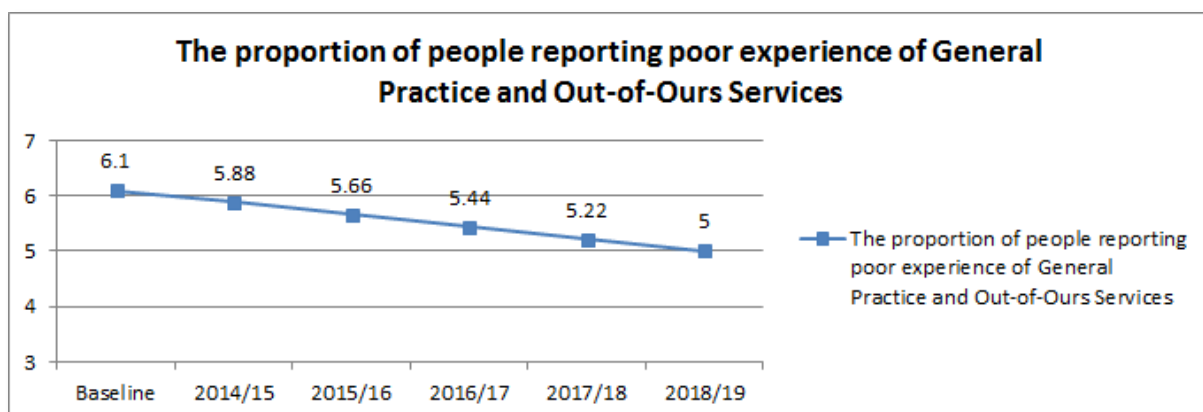


Existing measures in place include a variety of patient related outcome measures for certain treatments and somewhat limited patient experience measures:-

- **increasing people's positive experience of hospital care: average number of negative responses per 100 patients reduced to 145 by 2018/19 to bring the CCG up to the performance of comparator CCGs**



- **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 to bring the CCG up to the performance of comparator CCGs**



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

- enable patients to quantify the real value of the services that they receive;
- ensure our PSIAMS system of personalised patient driven reporting is in place for all commissioned services.
- demonstrate how individuals achieve greater autonomy from healthcare;
- demonstrate how all service providers network better around the needs of patients.

#### **d) 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

### **7. A Re-Imagined Health and Care System**

#### **a) 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 voluntary/community sector 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 mechanism currently being piloted through

our Building Healthy Partnerships programme is the PSIAMS tool – see Operational Plan pp. 25 and 26). 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 a new way of working which encourages mutual responsibility between patient and professional; and supports increased personalised care which enables individuals to have a greater say in managing risk and the outcomes that they want to achieve. This approach will reduce dependency and 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.

## **b) 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:

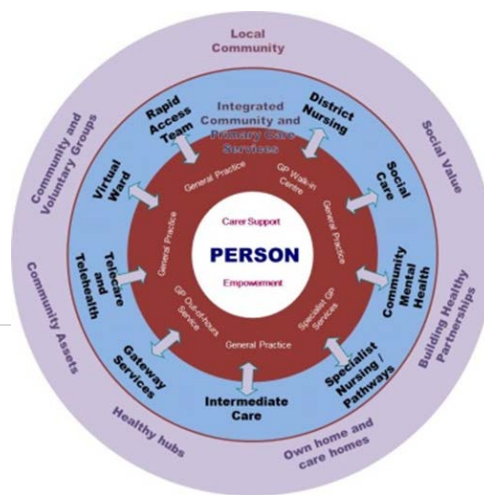
- planned care: value-added treatment interventions with defined outcomes;
- urgent care: short-term interventions to help and treat you in a crisis;
- reablement care: services designed to help reduce your dependency;
- proactive care: population-based care to help you manage your health needs.

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.

We will commission services that are available 7 days per week. The developments we are already implementing in relation to our integrated service delivery model will be available on this basis.

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.

### **c) 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 populations registered 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	high	Proactive Care	Starts with universal services for children. Includes wellbeing advice and support	Self-management	Advice on how to manage minor ailments (NHS 111)
	low	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
		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.

## **d) 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 provide 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.

### **e) 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.

Funding will be made available to support innovation at both practice and locality level. This resource, a total of £200,000 on a non-recurrent basis, will be allocated to our five localities and they will determine how it is used.

In conjunction with the HSMC, we will develop a consistent mechanism for the evaluation of our development programme and use this to inform future commissioning decisions. This will be complemented by a new research assistant post to enhance our research and development capacity and capability.

We will seek to embed the principles of invention, adoption and diffusion. Innovation, in terms of:-

- the development of our community rapid response service;
- measuring individual consultant performance;
- having one IT system for all 49 GP practices;
- using the PSIAMS system to understand commissioning impact;
- providing practices with the opportunity to innovate with our innovation fund.

lies at the heart of our plan

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
- Thirdly, 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.
- Fourthly, 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.

## **8. System Initiatives 2016-2019**

Our operational plan (pp.24 – 45) sets out the key initiatives we will implement during 2014-2016 in relation to the 6 key system characteristics of:-

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

The next step is to build on these initiatives to create our re-imagined system that is consistent with these 6 characteristics. This requires the implementation of some key system enablers:-

### **a) Co - Commissioning Primary Care**

We will review existing contractual arrangements with our member practices, establishing a clear set of financial rules. As a result of this we will work with practices to reconfigure the primary care landscape, create more efficient provider models and release revenue streams for reinvestment in our system of primary care at scale.

### **b) Developing the Estate**

We will review our existing infrastructure and agree a development plan that will support our vision of modern health and wellbeing centres. We will support the revenue consequences of the development programme through reinvesting resources released from our reconfiguration of primary care.

### **c) Exploiting Information Technology**

The implementation of a single IT system for primary care and the development of a commissioner led information system to be used consistently by our commissioned providers will provide the basis for delivering service efficiencies by:-

- removing unnecessary transaction costs
- systematising the way in which care is delivered, removing unnecessary variation
- delivering better quality emergency and urgent care through the use of a single IT platform
- improving productivity

### **d) Encouraging Market Entry**

We will create more responsive community health services geared towards our view of population health and wellbeing. These services will be consistent with our model of integrated delivery at borough, locality and practice level.

We will extend our existing delivery model through the further transfer of services from secondary care into the community such that the prime point of access to consultant level services takes place outside the hospital setting.

These actions will support:-

- wider primary care provided at scale – through revitalised general practice, delivered from first class premises using modern technology, integrated with other services around the patient and delivering consistent services.
- a modern model of integrated care – with the patient and primary care at its heart as part of a mutual culture. Where services operate at practice, locality and borough level, using the hospital as the delivery point of last resort and enhance the health and wellbeing of the population served.
- access to the highest quality urgent and emergency care – through integrated community services and a modern urgent care centre.

## **9. Impact on Providers and Partners**

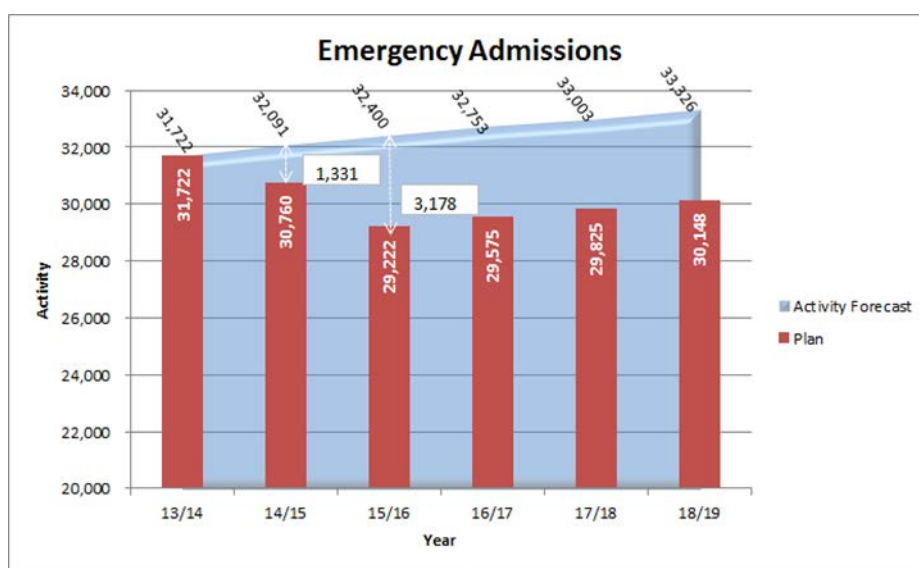
Our plan impacts on providers in two ways:-

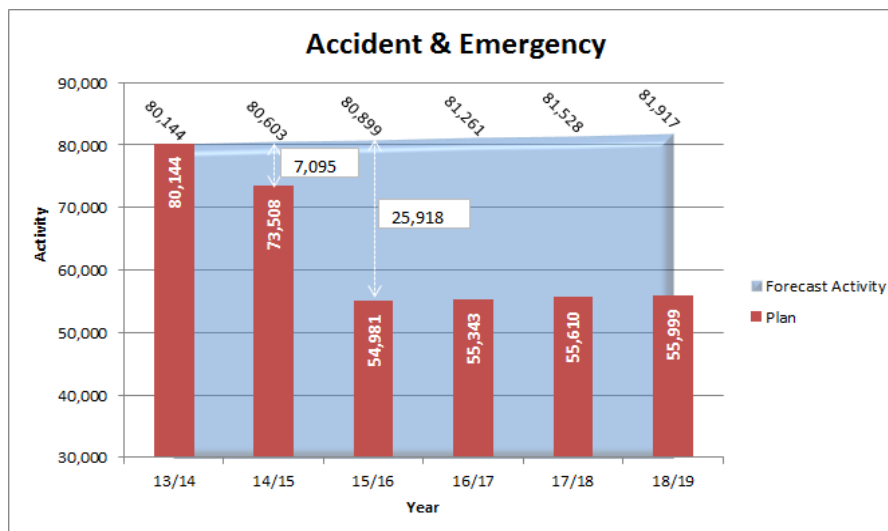
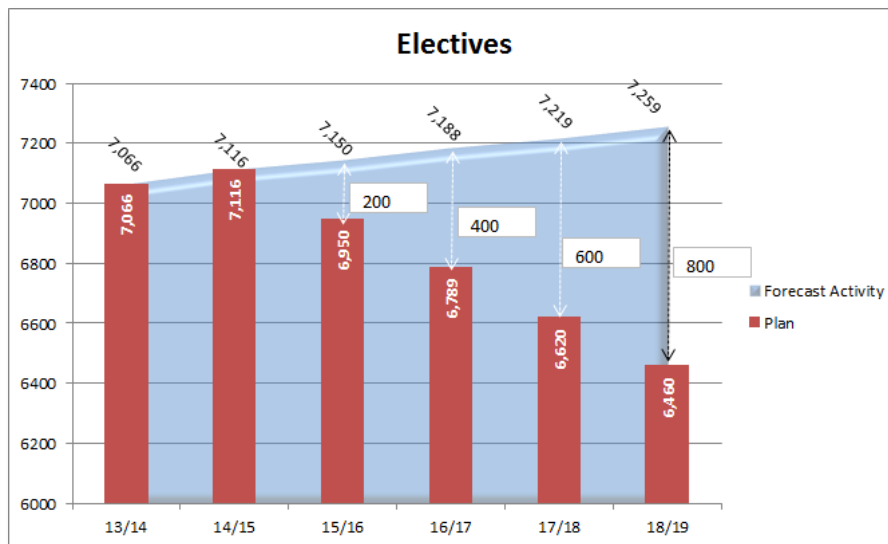
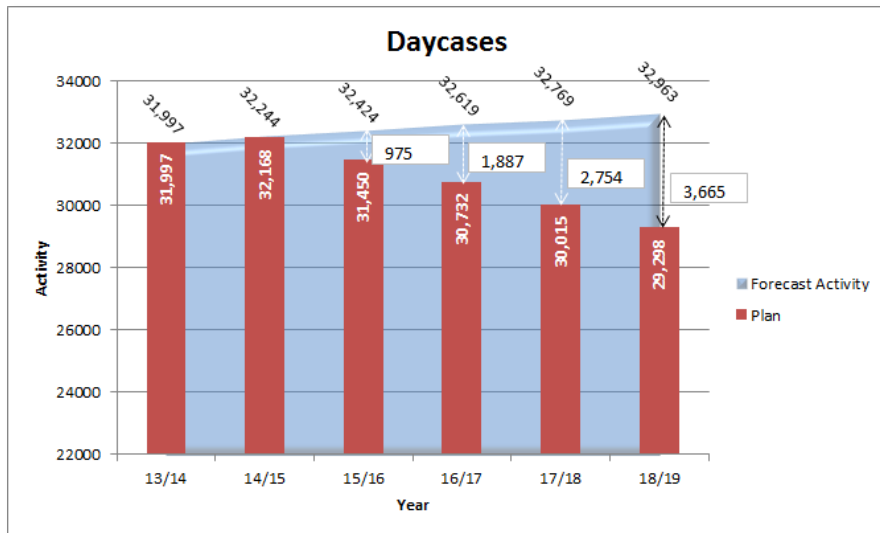
- in terms of the assumptions we have made about commissioned levels of activity and the associated impact on income;
- our view of the shape of future health and care delivery.

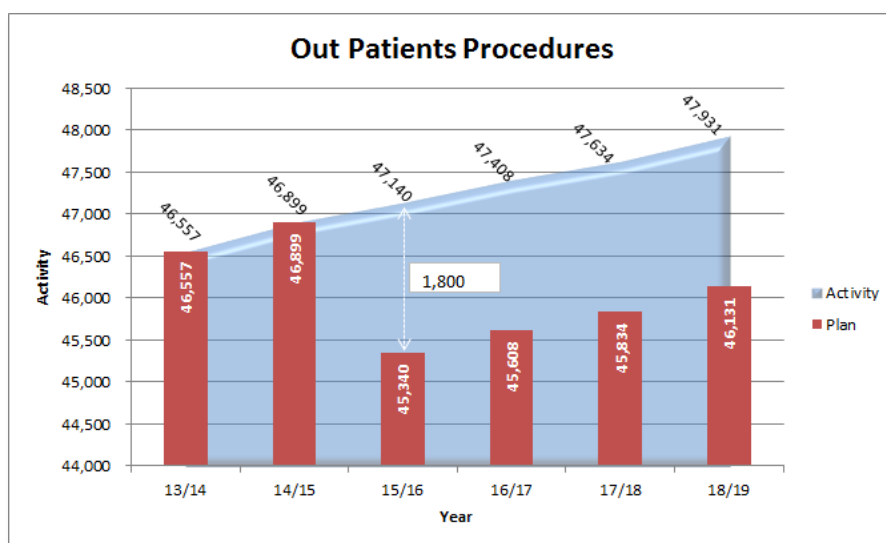
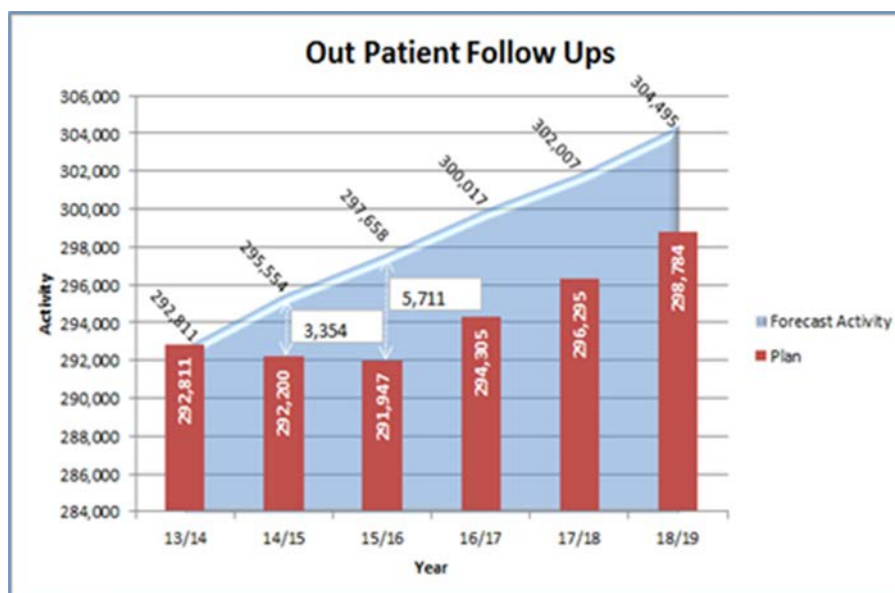
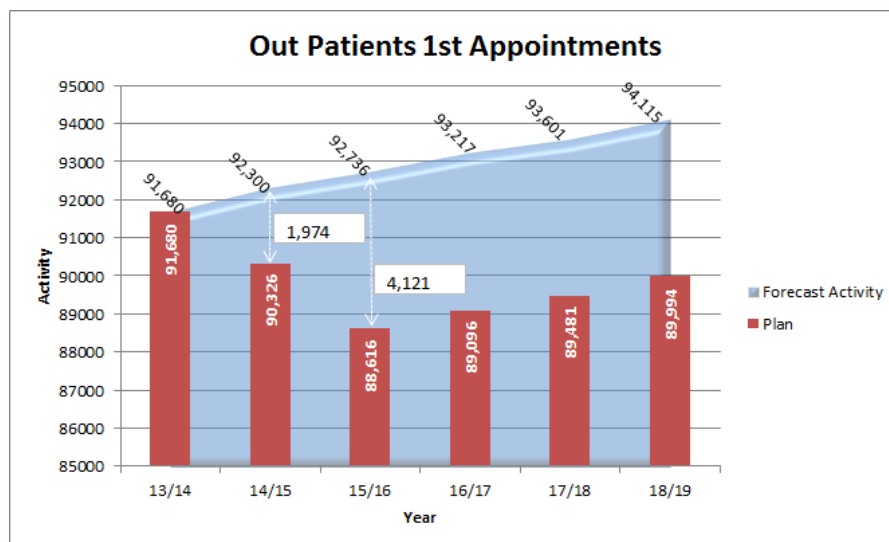
### **a) Future commissioned activity**

Our operational plan (pp.36–42) and the graphs below show that by 2018/19 activity levels, having accounted for demographic growth, will have reduced as follows:-

- emergency admissions – 1574 admissions
- ED – 24,145 attendances
- elective inpatients – 800 cases
- day cases – 3,665 cases
- out - patient first appointments – 1,686 attendances







These changes will have a prime impact on our main provider of acute and community health services – Dudley Group NHS FT. To be sustainable this requires the implementation of a significant cost reduction programme to bring income and expenditure into balance by 2015/16 in the first instance and through to 2018/19.

## **b) Future shape of health and care delivery**

Our re-imagined health and care system is based upon:-

- a renewed role for general practice at its heart;
- the integration of community health, mental health and social care services led by general practice;
- the market entry of new providers of community health, including mental health services;
- the movement of more services from hospital settings into the community supported by a refreshed 21<sup>st</sup> Century infrastructure;
- professionals organising themselves differently in teams around the patient with a distributed system of leadership.

This will have an impact upon:-

- Dudley Group NHS FT – as our provider of hospital and community health services;
- Dudley and Walsall Mental Health Partnership NHS Trust – as our provider of acute and community mental health services;
- Dudley MBC – as the provider of adult social care services.

The scenarios they face are:-

- i) Do nothing – activity levels in relation to emergency admissions to hospital and residential/nursing care will increase. Discharges from care will be delayed. Dependency levels will increase. Better Care Fund financial planning assumptions will not be delivered. Additional costs will be incurred by the CCG, Dudley Group NHS FT and Dudley MBC placing further strain on the system, requiring health and social care services to be de-commissioned.
- ii) Base Case – all partners and providers implement the integrated care model. Unnecessary admissions to hospital and residential/nursing care will be prevented. Discharges will take place in a timely manner to the most appropriate setting, reducing levels of dependency. Appropriate community infrastructure will be available to support people living in supportive settings. Better Care Fund financial planning assumptions will be met. The health and care system will be in equilibrium.
- iii) Best case – all partners and providers recognise the need to secure significant organisational change and create a more responsive and appropriate service model. A community health, mental health and social care



provider/s is/are established integrating services around the patient and led by general practice; utilising a modern estate and IT infrastructure, delivering population based health and wellbeing. There is a clear bias towards delivering more services out of acute settings and in the community. In patient services are of a specialist nature only. Better Care Fund financial planning assumptions are met. Change is continuous. Service efficiencies are driven out to maintain performance.

The best case is reflected in our activity assumptions that have been agreed with providers and reflected in our contracts.

The table below illustrates the potential impact of these changes on existing providers: -

Provider	14/15 Contract value	Potential Loss of Income due to Strategic Plan				
		15% NEL Reduction	20% Electives Efficiency	Services potentially repocured as part of new community model	CQUIN Impact	Total Value at Risk
Dudley Group of Hospitals	£184,648,535	£6,221,850	£6,635,764	£44,226,619	£1,427,106	£58,511,340
Dudley & Walsall Mental Health	£26,193,021	£0	£0	£17,209,777	£430,244	£17,640,021
Black Country Partnerships	£11,209,906	£0	£0	£4,574,526	£114,363	£4,688,889
West Midlands Ambulance	£8,405,662	£604,000	£0	£0	£15,100	£15,100
	£230,457,124	£6,825,851	£6,635,764	£66,010,922	£1,986,813	£80,855,350

The financial impact on the 15% non-elective and 20% elective efficiency targets are built into our contracts with the key providers as well as being agreed with the Health and Wellbeing Board. Further discussions will take place regarding our community services model.

## 10. Managing Relationships and the Market

The CCG and the system have a multi-faceted approach to relationship and market management. This is delivered through:-

- a) our formal contractual relationships - holding our providers to account for performance and using contractual levers such as the application of penalties, to deliver service change;
- b) testing the market - using appropriate procurement mechanisms such as AQP, where value and outcomes are not being delivered;
- c) monthly strategic partnership meetings with our main providers designed to oversee major strategic change;
- d) joint appointments to manage interface issues;
- e) clinical engagement – between CCG clinical leaders and clinicians in our providers;
- f) system wide groups ( see above) dealing with key strategic issues – service integration and urgent care;

g) an organisational development programme across the CCG, Dudley Group NHS FT, Dudley and Walsall Mental Health Partnership NHS Trust and Dudley MBC to deliver the system's distributed leadership model.

The significant steps required to deliver this are already being implemented: -

- activity levels agreed in contracts;
- acute capacity reduction plan agreed;
- procurement process for new urgent care centre commenced;
- community rapid response service commissioned and implementation commenced;
- supporting organisational development programme commenced across health and social care.

The governance process described at page 5 will continue to provide oversight of this.

## 11. Next Steps – Implementing This Vision

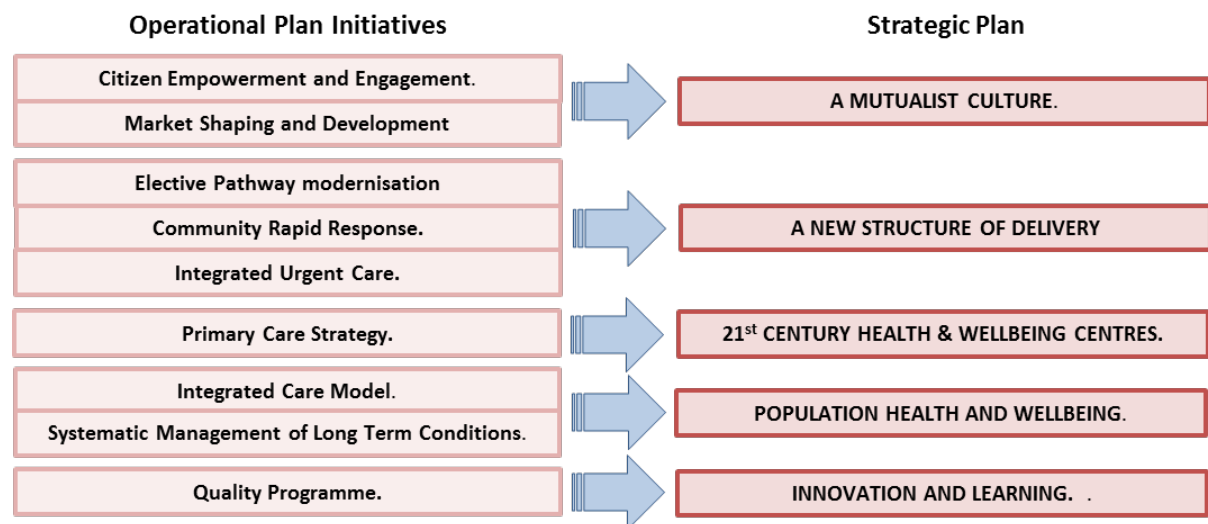
As the local leaders of the healthcare system, our OD programme for the system is one of the most important aspects of what we do.

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

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



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.

JSNA	Outcome Ambition	Initiative
Gap in life expectancy for the least and most deprived areas of Dudley has widened mostly due to chd, copd and lung cancer in men.	<p>Securing additional years of life</p> <p>3.5% reduction in potential years of life lost per annum from 2087/100,000 in 2012/13 to 1685/100,000 in 2018/19.</p>	<ul style="list-style-type: none"> <li>• Systematic management of long term conditions</li> <li>• Prescribing for heart disease</li> <li>• Prescribing for cholesterol</li> <li>• Smoking cessation</li> <li>• Diabetes LES and diabetes control</li> </ul>
Nearly one fifth of 40-59 year olds are living with a long term limiting illness.	<p>Improving the quality of life for people with long term conditions.</p> <p>Average EQ-5D score for people with one or more long term condition to increase by 1.6% from 70/100 people in 2012/13 to 74/100 in 2018/19.</p>	<ul style="list-style-type: none"> <li>• Responsive IAPT services</li> <li>• Diagnosing and responding to dementia</li> <li>• Diagnosing hypertension</li> <li>• Vascular checks</li> <li>• Improved recording in disease registers for heart failure, hypertension and kidney disease</li> <li>• Community based respiratory service</li> <li>• COPD LES review</li> <li>• Revised diabetes LES</li> <li>• Community diabetes team</li> </ul>
The rate of delayed discharges attributable to social care is higher than the national rate.	<p>Reducing time spent in hospital through more integrated care</p> <p>Avoidable emergency admissions to reduce from 2448/100,000 in 2013/14 to 2322/100,000 in 2018/19.</p>	<ul style="list-style-type: none"> <li>• Rapid Response Team</li> <li>• Redesigned virtual ward</li> <li>• Care home CPN</li> <li>• 7 day services</li> <li>• Community respiratory, diabetes and anti-coagulation services</li> <li>• Enhanced telehealth and telecare</li> <li>• Community pain, dermatology and ophthalmology services</li> </ul>
20% of single person households are in the 60+ age range.	Increasing the proportion of people living independently at home.	<ul style="list-style-type: none"> <li>• Integrated locality services</li> <li>• Rapid Response Team</li> <li>• Social prescribing</li> </ul>

	People still at home 91 days after discharge to increase by 4% from 86% at March 2013 to 90% at March 2016.	<p>scheme</p> <ul style="list-style-type: none"> <li>Community development workers</li> </ul>
Musculoskeletal services present an opportunity to improve the patient pathway, secure value for money and deliver better outcomes.	<p>Increasing people's positive experience of hospital care.</p> <p>Reducing the average number of negative responses from 159.2 per 100 patients in 2012/13 to 145 per 100 patients in 2015/16.</p>	<ul style="list-style-type: none"> <li>Clear clinical standards</li> <li>Efficient planned care pathways</li> <li>Patient safety CQUIN</li> <li>Organisational learning CQUIN</li> <li>Medication error reporting</li> </ul>
Systematic management of long term conditions is required in primary care.	<p>Increasing the proportion of people with a positive experience of GP care and in the community.</p> <p>Reducing the average number of negative response from 6.1 per 100 patients in 2012/13 to 5 in 2015/16.</p>	<ul style="list-style-type: none"> <li>Better access</li> <li>7 day services</li> <li>Active patient participation groups</li> <li>Reducing variation</li> <li>Transfer of services to primary care</li> <li>Managing long term conditions</li> <li>Single IT system for 49 practices</li> </ul>
Emergency admissions for gastroenteritis and lower respiratory disease are increasing for the 60 – 74 age group.	Eliminating avoidable deaths in hospital.	<ul style="list-style-type: none"> <li>MRSA zero tolerance</li> <li>Grade four pressure ulcer zero tolerance</li> <li>Reducing infection rates including Cdiff</li> <li>Reducing medication errors</li> </ul>