Thinking Differently

NHS
Dudley
Clinical Commissioning Group

Operational Plan 2017/18 – 2018/19

Developing and Commissioning a Sustainable Model of Care

A. BACKGROUND

In February 2016, the CCG approved its Operational Plan for 2016/17. This plan now represents our local Operational Plan for 2017/18 and 2018/19, in the context of the wider Black Country Sustainability and Transformation Plan (STP).

This plan is designed to:-

- build on our achievements in implementing our plan for 2016/17;
- implement our plans heralded in our commissioning intentions for 2017/18 and 2017/18;
- fully implement our new Dudley model of care, establishing integrated health and social care services with primary care at its heart;
- reflect the work we are doing as the local leader of the NHS, in conjunction with our NHS providers, our local government partners and the voluntary/community sector;
- meet the expectations placed upon us through the national planning system;
- redefine our role as a clinically led commissioning organisation, given the changes that will result from the commissioning of our new care model;
- respond to the significant clinical, service and financial challenges of the coming years.

In the sections below we have:-

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

We have demonstrated how we will:-

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

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

1. STPs
2. Finance
3. Primary Care

4. Urgent and Emergency Care
5. Referral to Treatment Times and Elective Care
6. Cancer
7. Mental Health
8. Learning Disability
9. Improving Quality in Organisations

The main focus of our plan is to commission and procure the MCP, such that a contract is in place by 1 April 2018 and the MCP is mobilised before the end of the planning period. This represents a significant focus of activity both in terms of the procurement process and in fulfilling our statutory duties in relation to primary care.

This will be executed in a manner that is consistent with the "5 principles" that support the delivery of the Five Year Forward View:-

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

B. STRATEGIC VISION

Our original 5 year strategic plan established a new vision for healthcare characterised by:-

A Mutualist Culture – which recognises the mutual relationship between GP and patient and the associated rights and responsibilities in an organisation of member practices and registered patients.

The Structure of The System – where we move away from traditional organisational boundaries and service categorisations to recognise the needs of individual patients in a modern world.

Population Health and Wellbeing Services – commissioning proactive population based healthcare.

Health and Wellbeing Centres for the 21st Century – providing the capacity to needed to deliver our vision of population health and wellbeing services.

Innovation and Learning – investing in research, technology and information systems as a basis for improving our organisational performance and the effectiveness of the system.

These principles are reflected in this plan, in our contribution to the Black Country STP and most of all in how we will commission a MCP.

C. THE CHALLENGES

Challenges exist in terms of the system, finance, performance, health and quality.

a) System Challenges

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

- a growing demand for healthcare from a population where, over the next two decades, the number of people over 65 will grow by 25,100 and the number over 85 by 9,900;
- the financial sustainability of our NHS partners;
- budgetary challenges facing Dudley MBC, in relation to public health, adult social care and children's services which may impact upon the development of the MCP;
- the need to secure effective transformation in leadership and cultural terms at a local level to ensure our new model of care is capable of delivery;
- the need to secure full clinical engagement from clinicians across primary, community and secondary care;
- a primary care system that is under strain and requires radical change to becomes sustainable.

b) Financial Challenges

The CCG's financial plan has been constructed to deliver a sustainable NHS in Dudley. The delivery of a financially sound health economy is, however, not without its challenges.

We have set out below how we intend to implement a financial plan that meets all our duties and the business rules set out in the planning guidance, as well as the associated risks and mitigations.

c) Performance Challenges

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

There are specific performance challenges in relation to:-

- cancer waiting times;
- diagnostic waiting times for CT, MRI and non-obstetric ultrasound;
- delayed transfers of care, both from acute hospital and community based provision.

d) Health Challenges

The Dudley population is characterised by:-

- a higher proportion of people reporting a limiting life long illness or disability;
- a female life expectancy rate similar to the national average, whilst the male equivalent is 78.5 years, lower than the England average of 78.9;
- a gap in life expectancy between the least and most deprived areas of 8.2 years;
- 25% of deaths in the 40 – 59 age band being due to cardiovascular disease, smoking, obesity and lack of physical activity;
- the percentage of people with a high BMI being significantly worse than the England average;
- rates of depression (8.6%) being higher than the England average;

e) Care and Quality Challenges

At a population level:-

- uptake rates for breast and cervical screening are below the national target of 80%;
- delayed discharges are higher than the national rate;
- the CCG is in the worst performing fifth for the percentage of ED admissions that result in emergency admissions;
- a higher percentage of emergency admissions are terminal than the England average.

In terms of provider performance:-

- failing to report serious incidents and losing the opportunity to learn;
- insufficient assurance from providers, particularly when new guidelines are published;
- independent sector providers having an insufficient overview of quality metrics;
- ensuring proper triangulation of complaints and engaging NHS England appropriately where they are the commissioner;
- gaining sufficient assurance about the quality of care within care homes and working in partnership with Council colleagues to ensure patients are safe.

A growing frail elderly population displaying multiple co-morbidities is a major factor behind our rationale for the commissioning of a MCP. In addition, we are looking to address a number of the issues identified through our proposed outcomes framework at both a population and individual patient level.

The framework has already been developed and implemented in primary care and this will now be extended with the MCP. This will move us to a position where the system as a whole works to the same set of outcome measures.

f) CCG Improvement and Assessment Framework

We have established an internal delivery plan in relation to the indicators continued within the framework. In 2017/18 there will be a specific focus on: -

- cancer
- dementia
- diabetes
- Learning disability
- maternity

D. NATIONAL PRIORITIES – "MUST DOS"

1. STP

The Black Country STP has, at its heart, a focus on standardising service delivery and outcomes, reducing variation through place based models of care provided closer to home and through extended collaboration between hospitals and other organisations. Whilst mental health and learning disabilities form part of this they are also identified separately to reinforce parity of esteem. Maternity and infant health is also a key focus.

Workforce, infrastructure and commissioning arrangements are key enablers and addressing the wider determinants of health sits alongside the need to improve health and care.

This Plan has been informed by and developed in the context of the STP. Our new care model described below is designed to have a more systematised and evidence based approach to service delivery with a strong sense of place, beginning with the registered population of general practice. The Multi-Disciplinary Teams (MDTs) that form the operating model of the MCP will have access to best practice planned and urgent care pathways for both physical and mental health, enhanced by collaboration between acute physical and mental health providers. Reducing health inequalities and promoting parity of esteem will be enhanced by health, social care and voluntary sector professionals integrating and co-ordinating their activities. Mental health, learning disability, maternal health and infant health will require their own unique development of the MDT model.

2. Financial Plan

The financial plan has been prepared taking into account NHS England specific assumptions around growth and inflation and the business rules set out in the planning guidance. These are summarised in the table below:-

NHS ENGLAND PLANNING ASSUMPTIONS & BUSINESS RULES		CCG PLAN AS SUBMITTED	
		2017-18	2018-19
Business Rules	Minimum 0.5% Contingency Fund Held	0.5%	0.5%
	Minimum 1% Cumulative / Historic Underspend	1.2%	1%
	1% Non-Recurrent Spend	1%	1%
	0.5% to be uncommitted and held as risk reserve	0.5%	0.5%
	0.5% immediately available for CCGs to spend non recurrently, to support transformation and change implied by STPs	0.5%	0.5%
Growth & Inflation Assumptions	Demographic Growth-local determination based on ONS age profiled weighted population projections	0.3%	0.3%
	Prescribing Inflation expected range 4%-7%	6.5%	6.5%
	Mental Health Investment Standard in line with allocation growth of 2.0%	2.0%	2.0%
	Net QIPP Savings – not less than 3%	3.1%	3.0%
Running Costs	Not to exceed management costs allowance in each financial year	Achieved - £21.91 per head.	Achieved- £21.75 per head.

i) **Overall Surplus** - the CCG is planning for an overall surplus of £5.3m in 2017/18 and £4.3m in 2018/19. This adheres to the business rules set in the planning guidance and adheres to the control totals set over the two financial years by NHS England. For 2017/18 this consists of £6.4m as the CCG's initial planned surplus for 2016/17, less £1.1m planned drawdown set by NHS England following a reduction to the CCG control total. For 2018/19 this

consists of the planned £5.3m surplus less the £1m planned draw down to achieve the revised control set.

ii) **Resource Limit** – the CCG's resource limit increases from £456.2m to £463.9m. The increases are due to demographic growth (£8.8m); the non-recurrent inclusion of IR change funding; HRG 4 funding and the in-year drawdown of historic surpluses achieved. The CCG remains below target allocation by 2.91% in 2017/18 and 2.60% in 2018/19.

iii) **Running Costs** – such budgets are reduced slightly due to population changes and in line with NHSE guidance. This results in a budget of £21.91 per head of population in 2017/18 and £21.75 per head of population in 2018/19.

iv) **Underlying Surplus as percentage of recurrent allocation** – this has increased slightly from 1.5% in 2016/17 to 1.7% in 2017/18 and 2018/19. This is mainly due to changes in the treatment of contingency reserves in line with NHSE planning guidance, resulting previously in a non-recurrent commitment. However, planning guidance requires it to be shown as a recurrent commitment and the additional QIPP savings required over the next two years compared to 2016/17.

v) **QIPP** – the QIPP target for 2017/18 is £14.4m, equating to 3.1% of resource. The main initiatives are Telemedicine in Care Homes, Referral Management, Prescribing and Right Care Implementation. Our QIPP plans are based upon the intention to manage demand to a position of "flat live growth".

We have agreed with Dudley Group NHS Foundation Trust that we will implement joint plans in relation to both elective and non-elective activity. This will be informed by our analysis of Right Care and focus in particular on respiratory, MSK and paediatric non-electives.

vi) **Risks and Mitigations**

- **IR Changes and HRG4** – the allocation received presents a significant cost pressure in the region of £1.8m based on initial modelling information provided by the CSU. This information is being validated and will be raised with NHSE.
- **QIPP delivery** – The cash releasing target for 2017/18 (£14.4m) and 2018/19 (£14m) has increased twofold from 2016/17 (£7.2m) and the extent of slippage against non-delivery of cash releasing savings is a significant risk to the CCG.
- **Prescribing** - Volatility of prescribing spend remains a key risk in 2017/18 and 2018/19. QIPP schemes in prescribing have been developed and amount to a net saving of £2.7m, whilst the schemes are robust and the rationale is clear there is a risk they may be too ambitious.

- **NHS Continuing Healthcare** – Further increase in demand for placements/packages of care, once assessed as meeting the eligibility criteria remains a risk. Notification of the Funded Nursing Care rates for 2017/18 are yet to be received.

Acute over-performance – A risk that demand for acute services, such as emergency care and elective care exceeds the level of growth assumed within the plan. Over-performance could also occur as a result of non-delivery of the QIPP programme.

If such risks occur, they will be mitigated by the use of contingency and non-recurrent reserves initially, although there will be the need to implement additional actions, such as extra QIPP schemes, disinvestment and decommissioning if required.

vii) Cost Pressures

HRG4+ - There is a £1.8m cost pressure relating to the difference between the HRG4+ allocation received from NHS E and the actual price change within cost. This has required the CCG to use the 0.5% non-recurrent reserve to enable agreement of contracts.

3. Activity Planning Assumptions

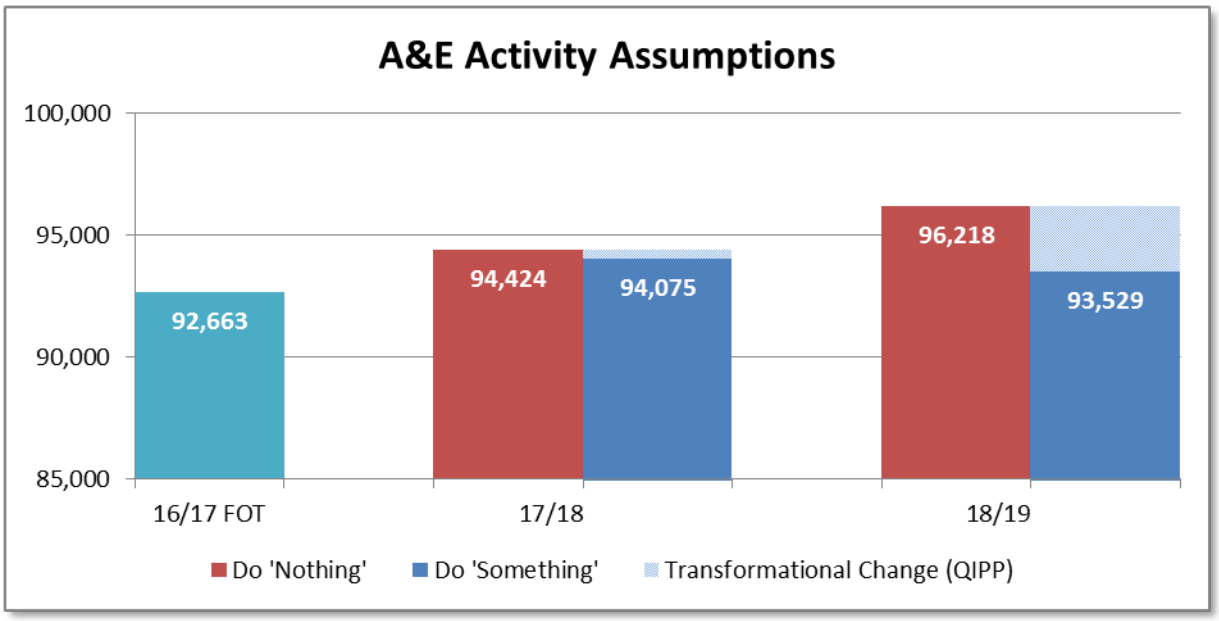
The graphs below show the 2 year planning assumptions and transformational savings in 2017/18 and 2018/19 for the following areas;

- A&E
- Elective
- Non-Elective
- First Outpatient Appointments
- Follow-Up Outpatient Appointments

In each of the above areas, the Forecast Outturn (FOT) methodology for 2016/17 has been calculated by taking actual activity at month 5 (August) and applying a monthly phased forecast for the remainder of the year based on historical trends. This is the starting point for the planning assumptions, which are followed by do ‘nothing’ and do ‘something’ plans.

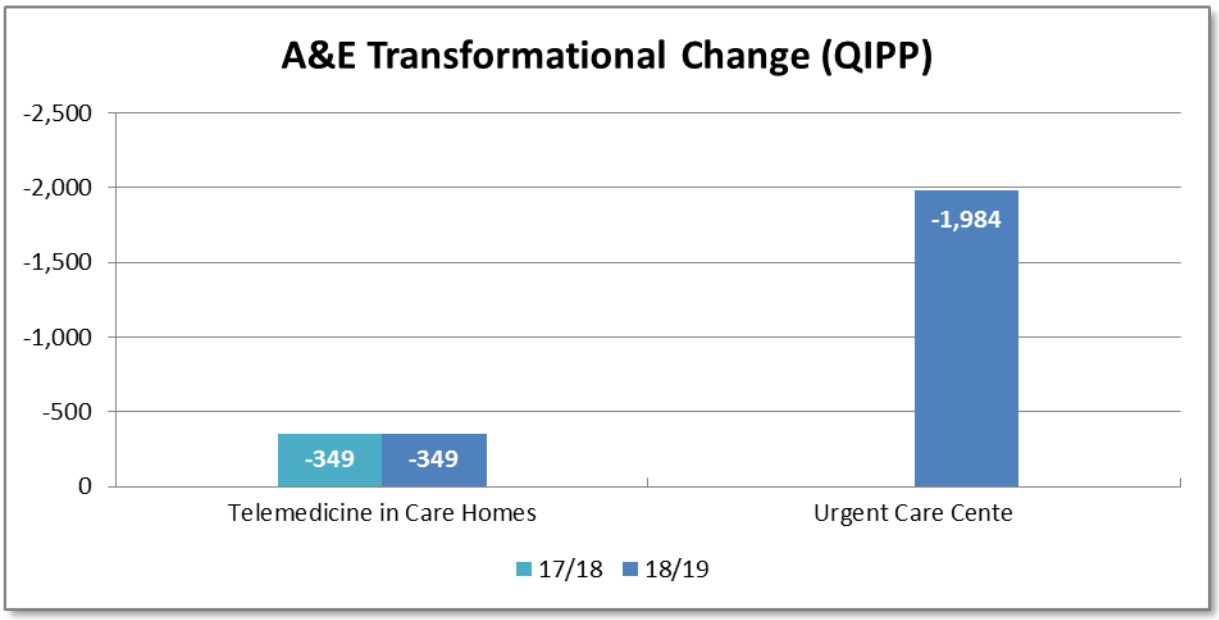
Do ‘nothing’ is a term used by NHS England introduced during this 2 year planning round to describe plans that account only for underlying trend and demographic growth. The do ‘something’ plans also account for underlying trend and demographic growth but go one step further to incorporate the impact of QIPP and STP transformational programmes.
The growth assumptions applied across 2017/18 and 2018/19 have been taken from the Indicative Hospital Activity Model (IHAM). The IHAM is an interactive tool produced by NHS England that can be used by local areas to support understanding

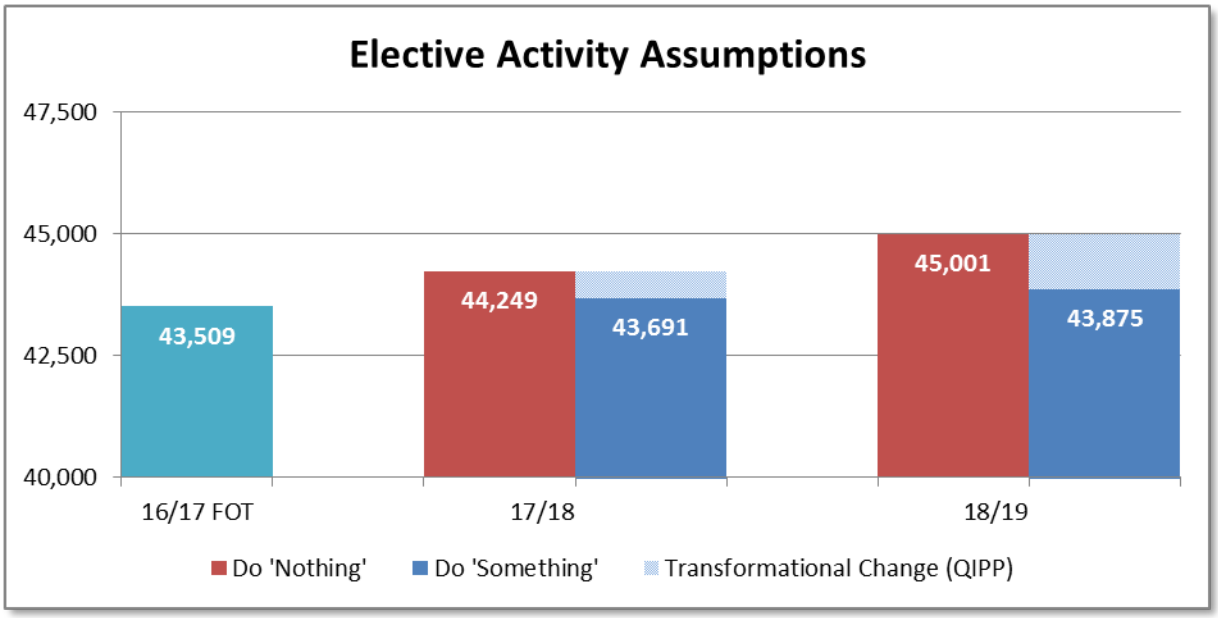
of how different planning assumptions affect secondary care activity. It generates indicative activity figures based on historic trends and demography (the 'do nothing' trajectory) which can be used by local areas in their development of activity plans. In addition, the model can be used to investigate how additional programmes and policies will affect that 'do nothing' trajectory.



The graph above demonstrates the 2017/18 and 2018/19 planning assumptions for A&E activity. The IHAM growth assumption applied across both years is 1.9%.

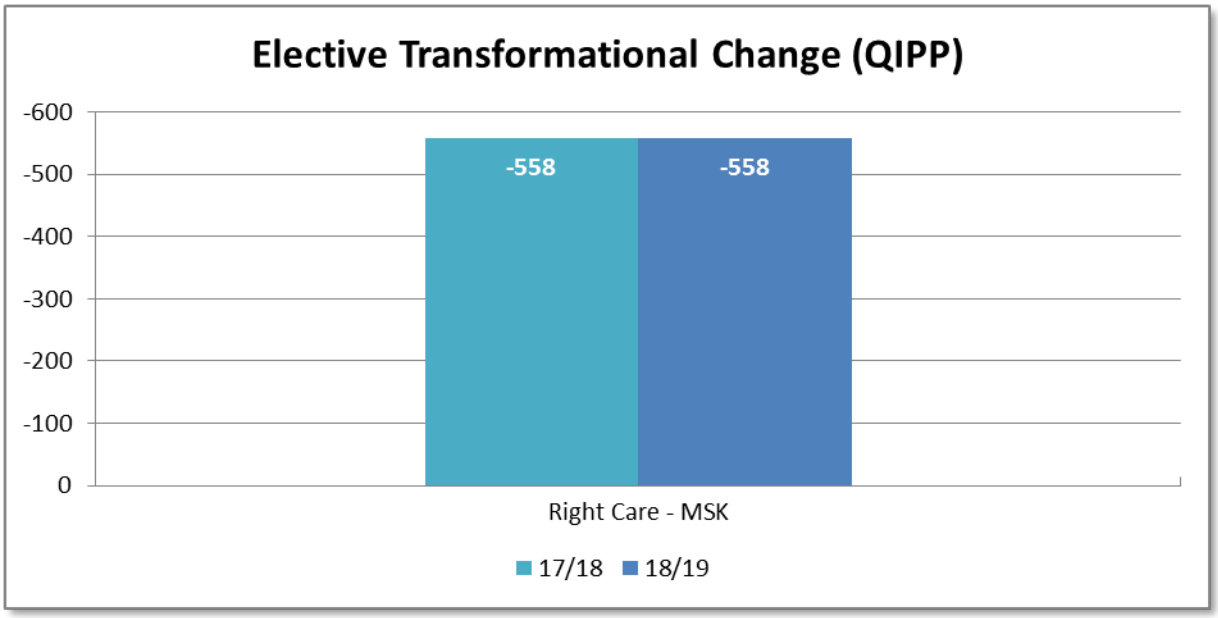
The graph below demonstrates the interventions and the respective impact required to achieve the planned reductions in A&E activity in 2017/18 and 2018/19.

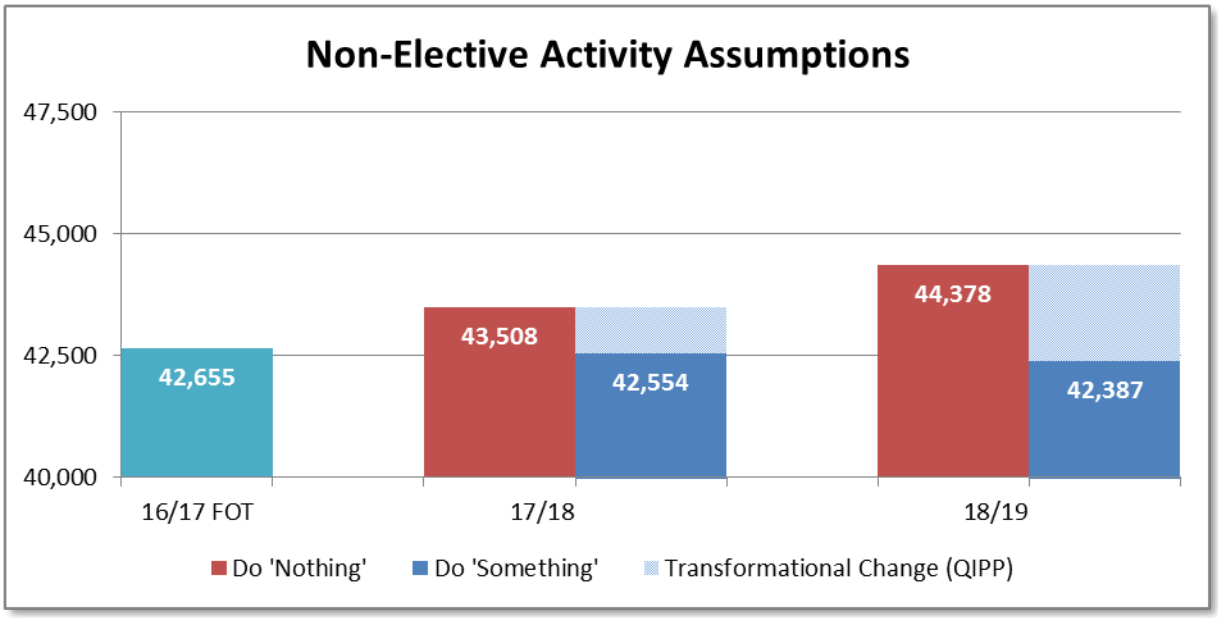




The graph above demonstrates the 2017/18 and 2018/19 planning assumptions for Elective activity. The IHAM growth assumption applied across both years is 1.7%.

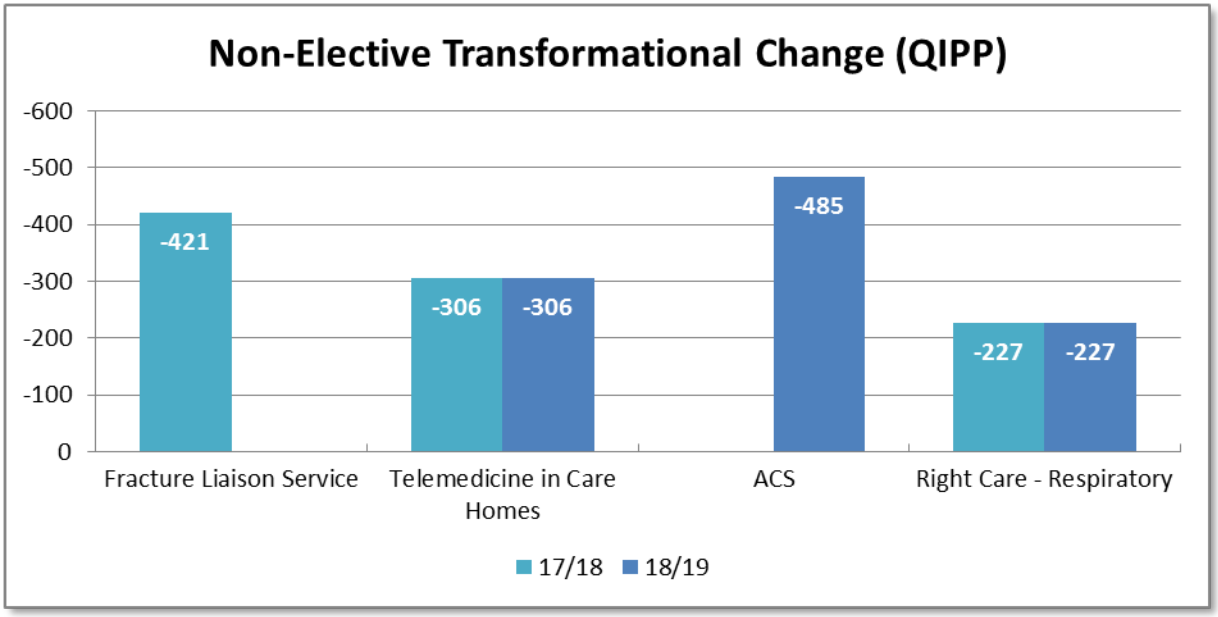
The graph below demonstrates the interventions and the respective impact required to achieve the do 'something' planned reductions in Elective activity in 2017/18 and 2018/19.

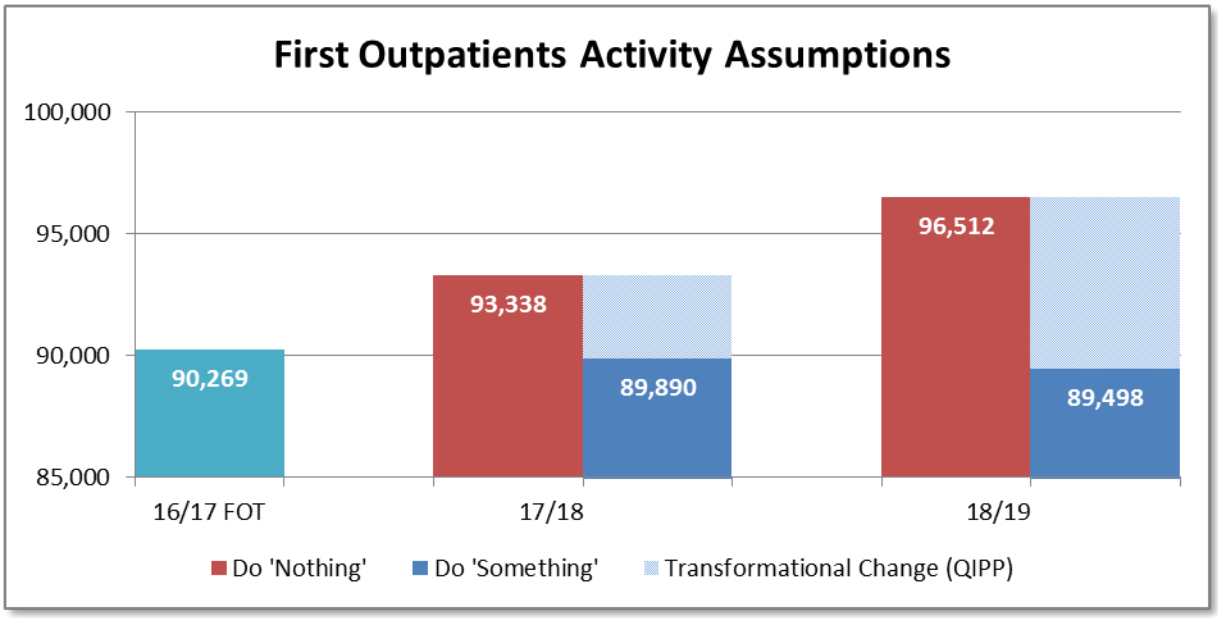




The graph above demonstrates the 2017/18 and 2018/19 planning assumptions for Non-Elective activity. The IHAM growth assumption applied across both years is 2.0%.

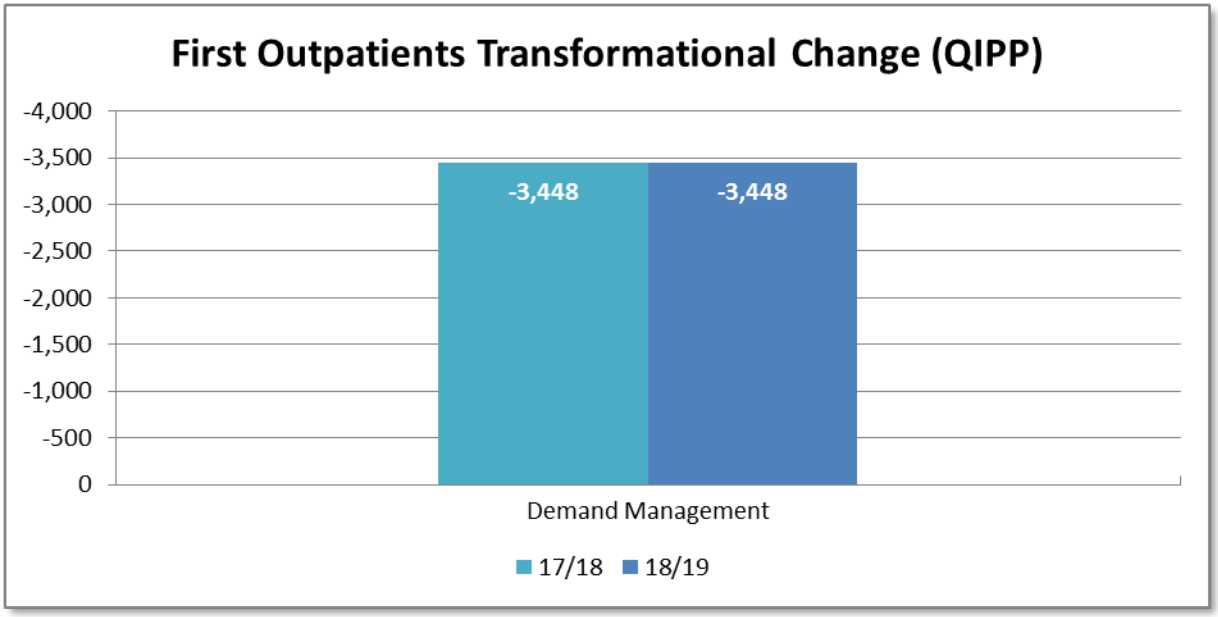
The graph below demonstrates the interventions and the respective impact required to achieve the do 'something' planned reductions in Non-Elective activity in 2017/18 and 2018/19.

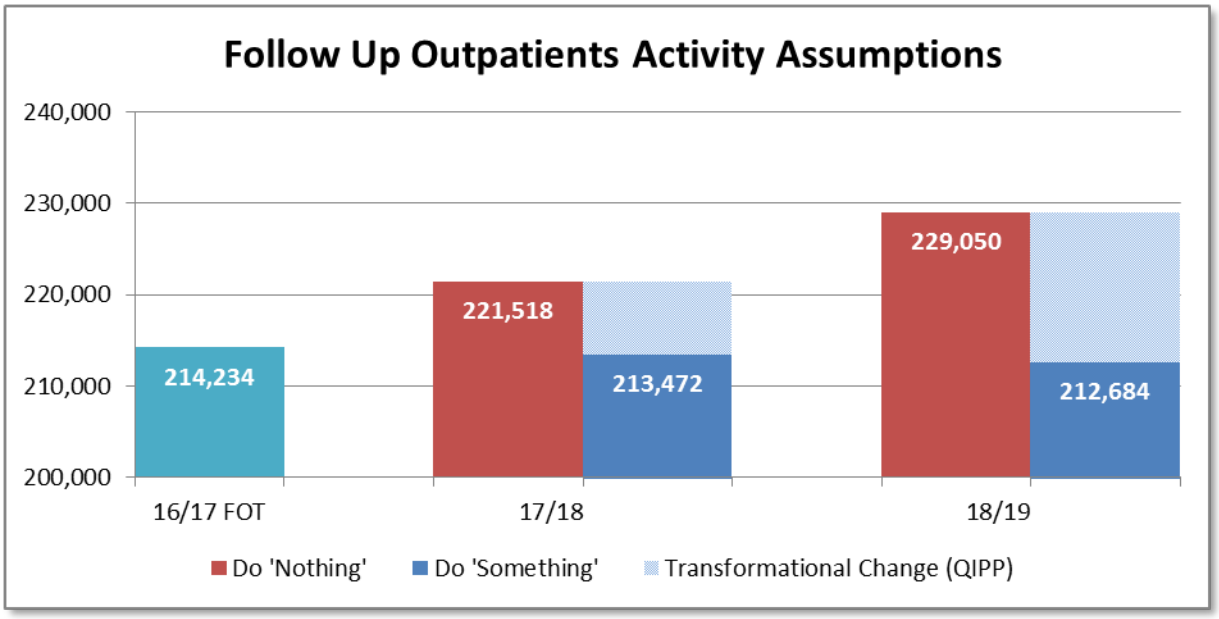




The graph above demonstrates the 2017/18 and 2018/19 planning assumptions for First Outpatient appointments. The IHAM growth assumption applied across both years is 3.4%.

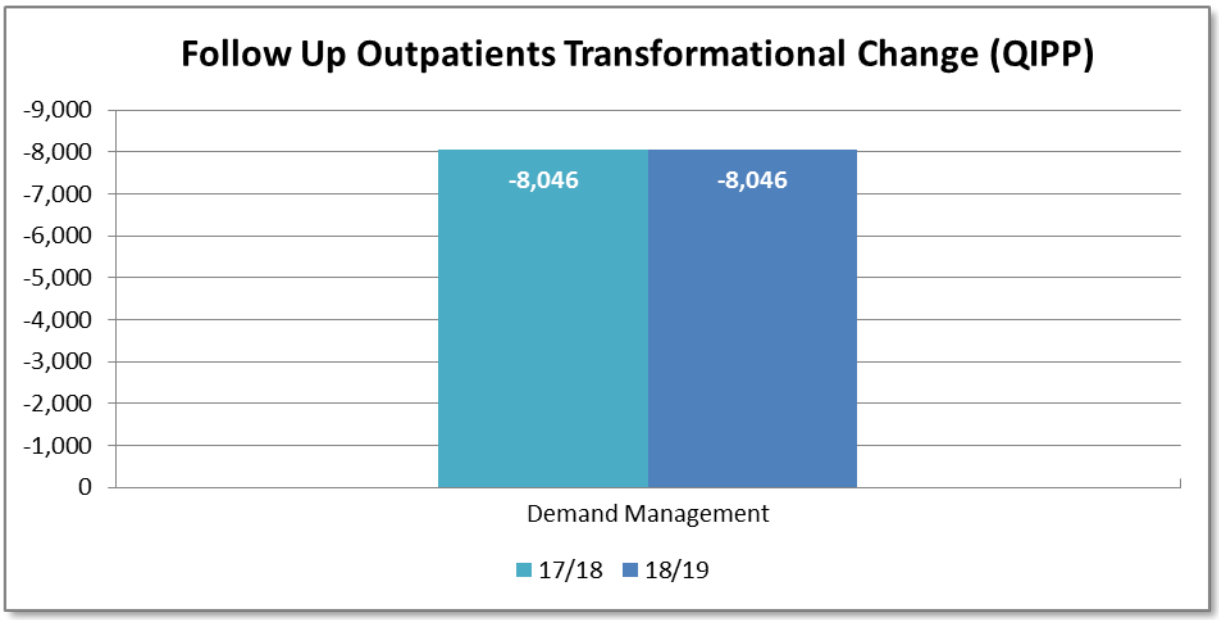
The graph below demonstrates the interventions and the respective impact required to achieve the do 'something' planned reductions in First Outpatient appointments in 2017/18 and 2018/19.

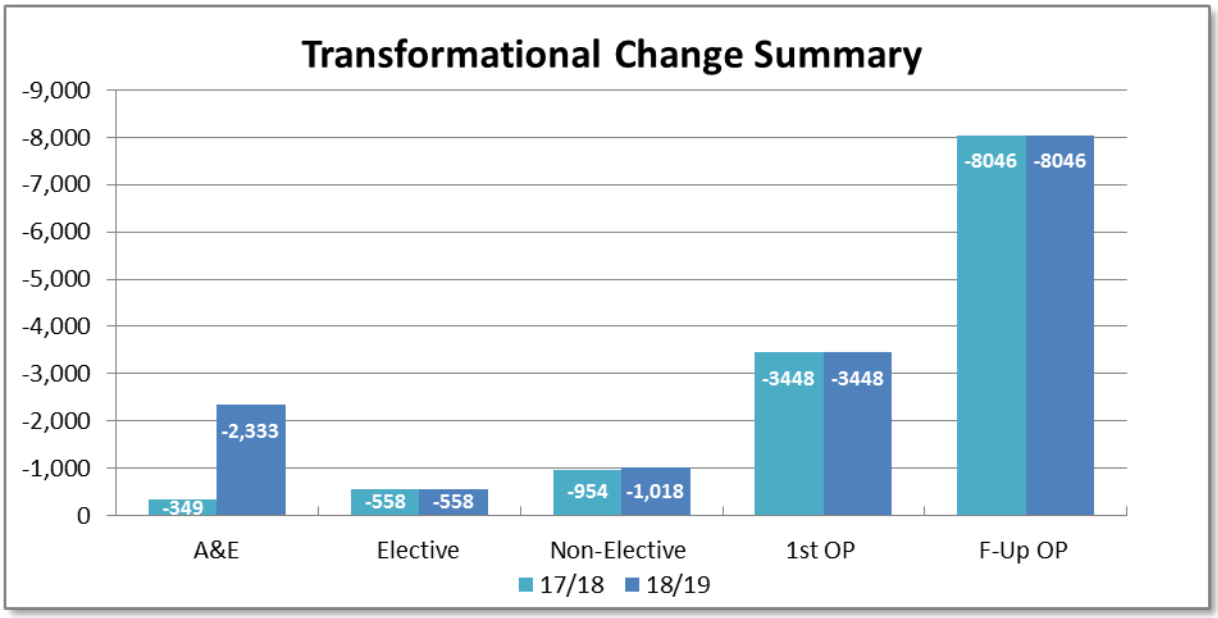




The graph above demonstrates the 2017/18 and 2018/19 planning assumptions for Follow-Up Outpatient appointments. The IHAM growth assumption applied across both years is 3.4%.

The graph below demonstrates the interventions and the respective impact required to achieve the do 'something' planned reductions in Follow-Up appointments in 2017/18 and 2018/19.





The graph above demonstrates the overall transformational change impact across each of the area's in the do 'something' plans.

d) Demand Management

Our demand management plan has been fully assured by NHS England.

Our MCP development, linked to more effective pathways for elective and urgent care, is intrinsic to how we manage demand.

We are implementing specific initiatives including:-

- rollout of NHS E-Referral and the use of advice and guidance;
- the use of triage for specific specialities – e.g. paediatrics;
- a focus on reducing follow up attendances for ENT, MSK, ophthalmology and urology;
- developing an agreed protocol for consultant : consultant referral;
- reducing the demand for medicines (see below);
- practice, locality and population level peer review of referrals;
- use of social prescribing as a positive choice for patients.

We have examined "Right Care", in conjunction with our secondary care and public health colleagues. We will be placing a particular focus on addressing issues in relation to MSK and respiratory related admissions.

e) Prevention

Our approach to prevention will be based on implementing our new evidence based outcomes framework. This will contribute to reducing existing prevalence gaps, reduce health inequalities and embed evidence based practice on a systematic basis.

Our programmes will involve delivery by primary care teams, practice based

pharmacists, community pharmacy and primary mental health care. This will be linked to a robust monitoring framework.

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

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

We will develop a life course approach to joining up our plans with the Office of Public Health. This is reflected in the service scope for the MCP which will include a number of services commissioned by the Office of Public Health including health visiting, sexual health, substance misuse and lifestyle services. Our approach will be based upon:-

Giving every child the best start in life:-

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

Enabling healthy behaviour in adults:-

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

Promoting healthy aging:-

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

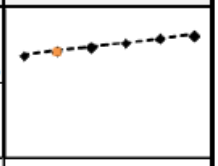
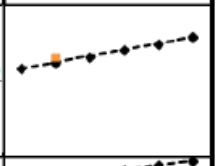
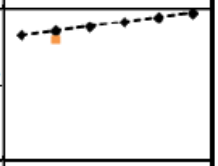
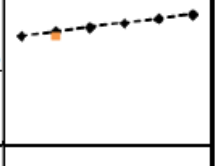
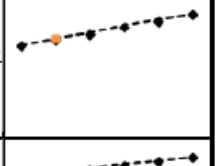
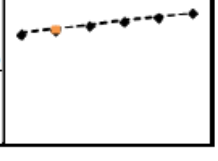
We have agreed specific targets with the Office of Public Health, broken down by locality and practice for obesity, tobacco control and alcohol. These are shown below:-

Obesity

Note: Breastfeeding initiation data stopped being reported nationally in quarter 1 of 2015-16. Local maternity provider data does not include all babies registered with Dudley CCG.

Breastfeeding Initiation

Breastfeeding Initiation (2013-14 actual, 2014-15 onwards projections based on year on year increase*)

Locality		2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	Trend (Target / Actual)
Dudley CCG Overall	Target	58.4%	60.4%	62.4%	64.4%	66.4%	68.4%	
	Actual		60.3%					
Dudley & Netherton Locality	Target	50.3%	53.3%	56.3%	59.3%	62.3%	65.3%	
	Actual		55.8%					
Halesowen & Quarry Bank Locality	Target	68.3%	70.3%	72.3%	74.3%	76.3%	78.3%	
	Actual		66.3%					
Kingwinford, Amblecote & Brierley Hill Locality	Target	60.9%	62.9%	64.9%	66.9%	68.9%	70.9%	
	Actual		60.7%					
Sedgley, Coseley & Gornal Locality	Target	52.2%	55.2%	58.2%	61.2%	64.2%	67.2%	
	Actual		55.1%					
Stourbridge, Wollescote & Lye Locality	Target	62.0%	64.0%	66.0%	68.0%	70.0%	72.0%	
	Actual		64.2%					

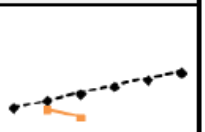
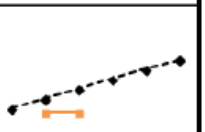
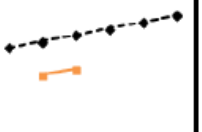
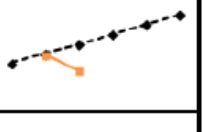
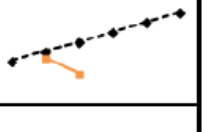
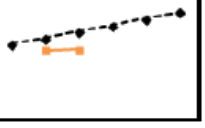
data source: NHS England

produced by: Office of Public Health, Dudley MBC

*Dudley & Netherton and Sedgley, Coseley & Gornal based on 3% increase, Halesowen & Quarry Bank, Kingswinford, Amblecote & Brierley Hill and Stourbridge, Woolescote & Lye based on 2% increase

Breastfeeding at 6-8 Weeks

Breastfeeding Prevalence at 6-8 Weeks (2013-14 actual, 2014-15 onwards projections based on based on year on year increase)**

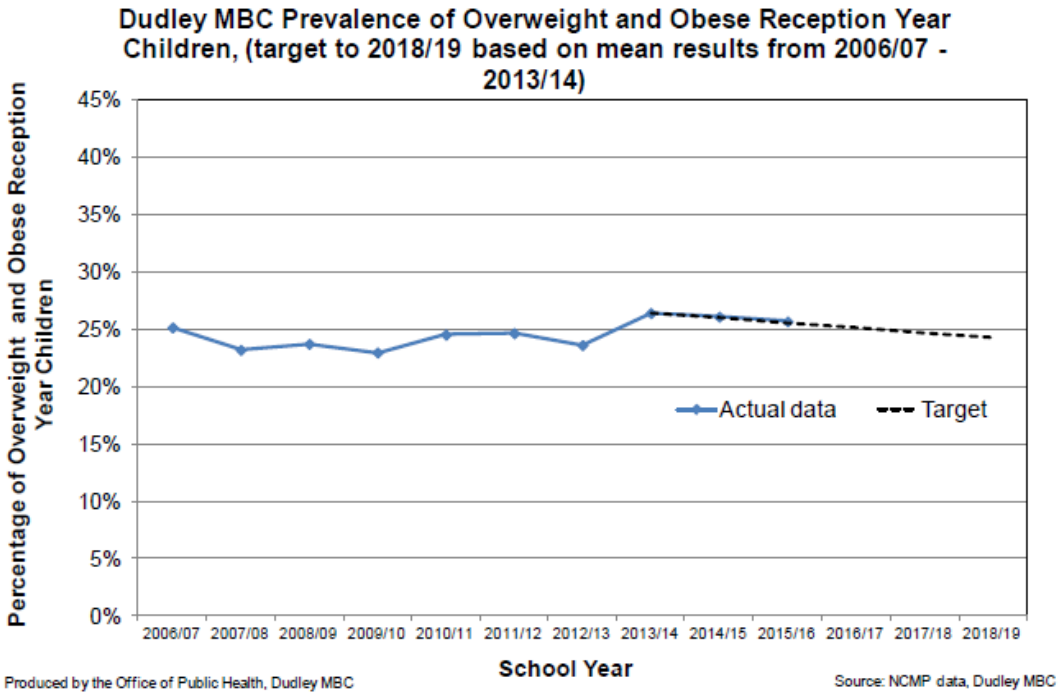
Locality		2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	Trend (Target / Actual)
Dudley CCG Overall	Target	32.3%	34.3%	36.3%	38.3%	40.3%	42.3%	
	Actual		31.7%	29.7%				
Dudley & Netherton Locality	Target	28.4%	31.4%	34.4%	37.4%	40.4%	43.4%	
	Actual		27.0%	26.8%				
Halesowen & Quarry Bank Locality	Target	44.7%	46.7%	48.7%	50.7%	52.7%	54.7%	
	Actual		36.1%	38.1%				
Kingwinford, Amblecote & Brierley Hill Locality	Target	29.1%	32.1%	35.1%	38.1%	41.1%	44.1%	
	Actual		31.7%	26.4%				
Sedgley, Coseley & Gornal Locality	Target	27.8%	30.8%	33.8%	36.8%	39.8%	42.8%	
	Actual		28.8%	23.7%				
Stourbridge, Wollescote & Lye Locality	Target	37.8%	39.8%	41.8%	43.8%	45.8%	47.8%	
	Actual		35.6%	36.0%				

data source: NHS England (2013-14/ 2014-15), Dudley CHIS (2015-16)

produced by: Office of Public Health, Dudley MBC

**Dudley & Netherton, Kingswinford, Amblecote & Brierley Hill and Sedgley, Coseley & Gornal based on 3% increase, Halesowen & Quarry Bank and Stourbridge, Woolescote & Lye based on 2% increase

Reception Year

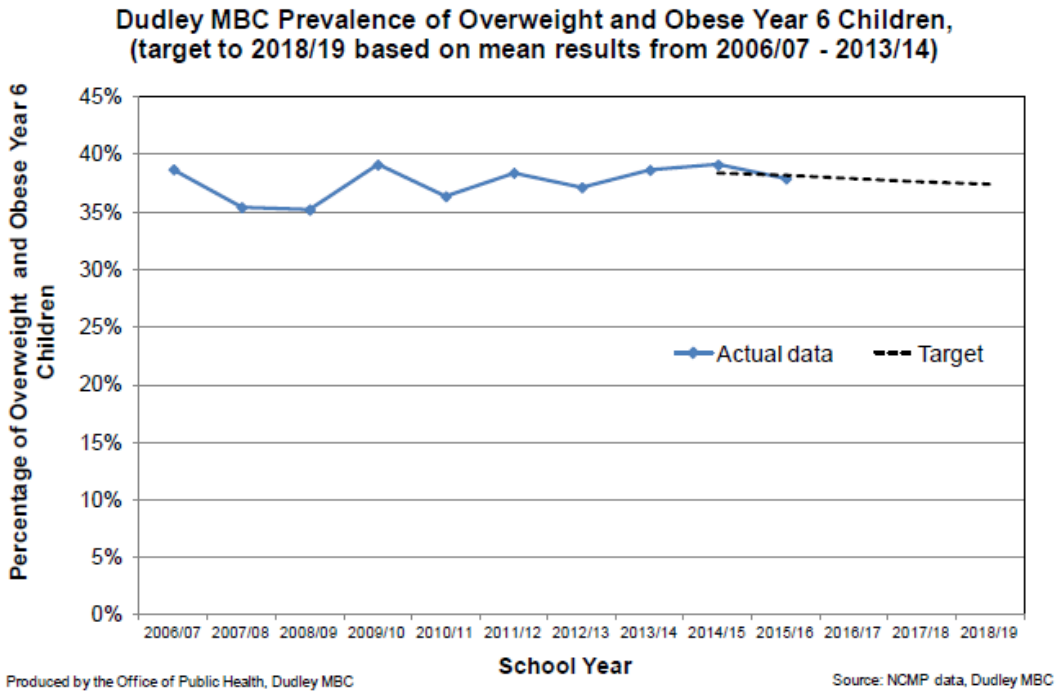


Reception Year Children classified as Overweight or Obese

Year	Target %	Actual %	Actual Number of Children
2014-15	26.0%	26.1%	985
2015-16	25.6%	25.7%	953
2016-17	25.1%		
2017-18	24.7%		
2018-19	24.3%		

Source: National Child Measurement Programme (baseline year 2013/14)

Year 6



Year 6 children classified as overweight or obese

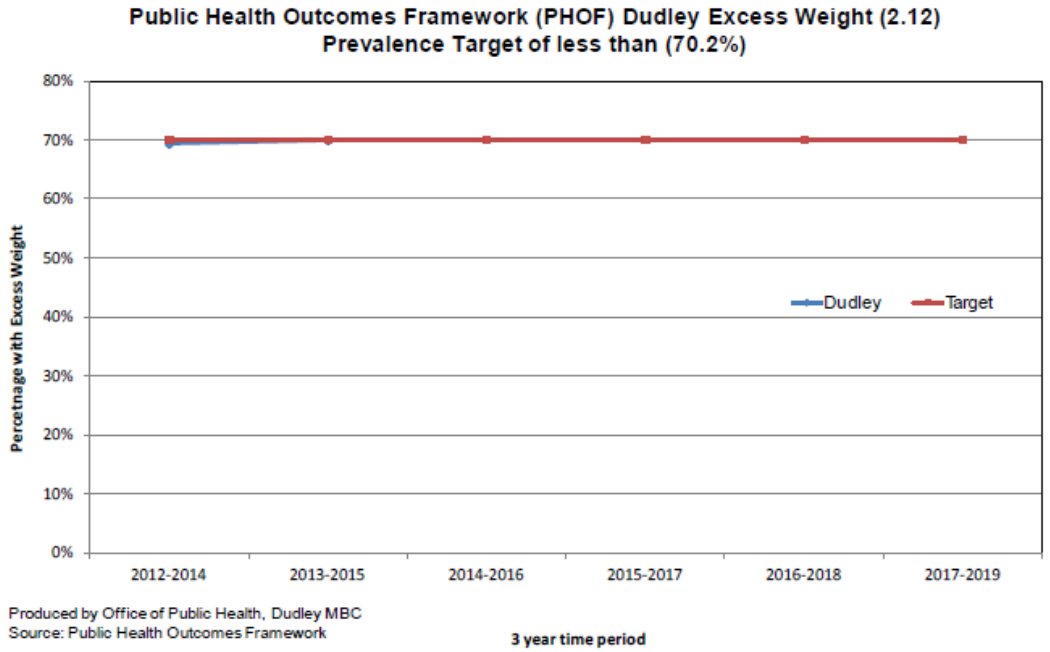
Year	Target %	Actual %	Actual Number of Children
2014-15	38.4%	39.1%	1327
2015-16	38.1%	37.9%	1334
2016-17	37.9%		
2017-18	37.6%		
2018-19	37.4%		

Source: National Child Measurement Programme (baseline year 2013/14)

Child Weight Management Referrals

Target referrals to the child weight management services are for 210 referrals, 245 referrals were actually received in 2015/16.

Adult Excess Weight Prevalence



Adult weight Loss Referrals

Locality	Obesity Register Size 2013/14	Target Referrals as % of Obesity Register	Target Number of Referrals	2014/15 Actual Referrals	2015/16 Actual Referrals
Dudley & Netherton	5,817	27.8%	1,615	543	1,318
Halesowen & Quarry Bank	5,207	25.0%	1,302	611	1,134
Kingswinford, Amblecote & Brierley Hill	8,788	25.0%	2,197	476	2,433
Sedgley, Coseley & Gornal	5,552	25.6%	1,422	362	1,324
Stourbridge, Wollescote & Lye	6,142	25.1%	1,540	247	1,417
Grand Total	**31,506**	**25.6%**	**8,076**	**2,239**	**7,626**

Key: **Actual number of referrals exceeds target**

Active Adults

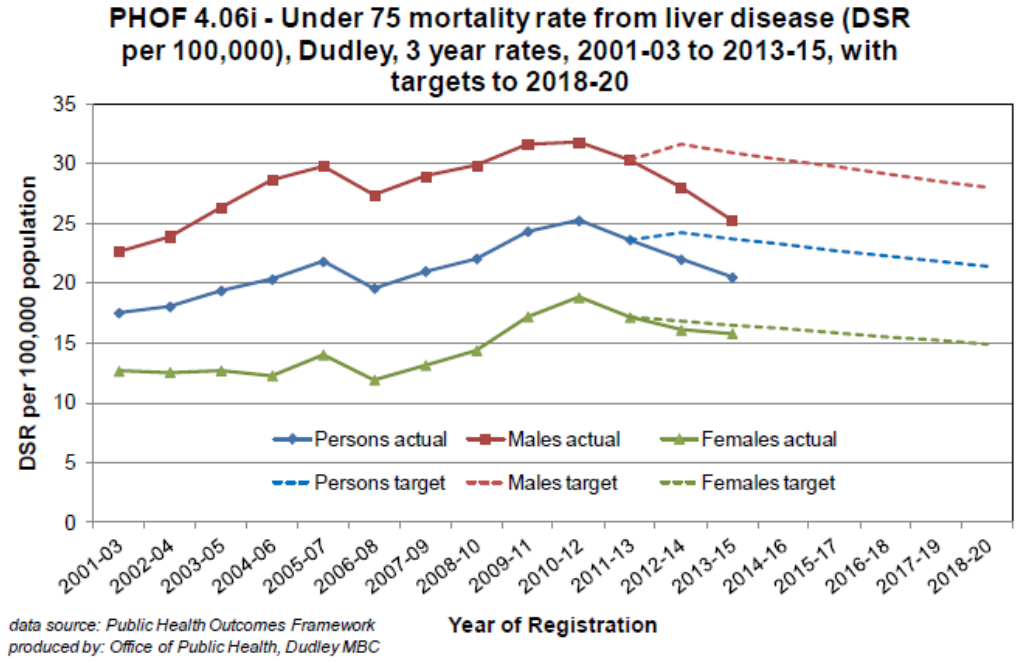
Active Adults Referrals:

Active Adults: Locality Targets: Number of Exercise Referrals (Target based on 4/1000 of 16+ practice population and 5/1000 for practices in areas of high CVD prevalence) (Numbers contribute to shared ambition in physical activity strategy to achieve 9663 more people more active in Dudley by 2019)						
Year	**Dudley CCG Overall**	**Dudley and Netherton**	**Halesowen and Quarry Bank**	**Kingswinford, Amblecote and Brierley Hill**	**Sedgley, Coseley, Gornal**	**Stourbrige, Wollescote, Lye**
2013-14	1,098	211	178	308	185	215
2014-15	1,098	211	178	308	185	215
2015-16	1,098	211	178	308	185	215
2016-17	1,098	211	178	308	185	215
2017-18	1,098	211	178	308	185	215
Totals	5,490	1,055	890	1,540	925	1,075

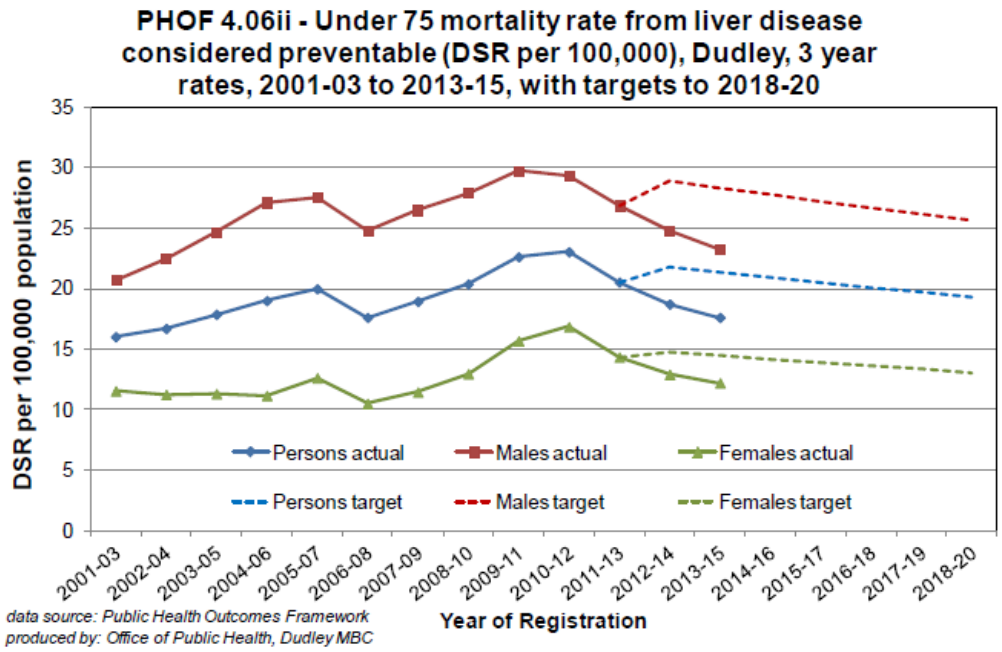
2013/14 to 2015/16 Outcomes

Year	**Dudley CCG Overall**	**Dudley & Netherton**	**Halesowen & Quarry Bank**	**Kingswinford, Amblecote & Brierley Hill**	**Sedgley, Coseley & Gornal**	**Stourbridge, Wollescote & Lye**
Annual Target	1,098	211	178	308	185	215
2013-14	544	117	46	183	79	119
2014-15	456	118	37	127	70	104
2015-16	421	101	69	134	49	68

Alcohol Mortality Targets



4.06i - Under 75 mortality rate from liver disease targets, 3 year rates, DSR per 100,000 (2011-13 baseline year)						
	Persons		Males		Females	
Year	Target	Actual	Target	Actual	Target	Actual
2011-13	23.6	23.6	30.3	30.3	17.2	17.2
2012-14	24.2	22.0	31.6	28.0	16.9	16.1
2013-15	23.7	20.5	31.0	25.3	16.5	15.8
2014-16	23.2		30.3		16.2	
2015-17	22.8		29.7		15.9	
2016-18	22.3		29.1		15.5	
2017-19	21.9		28.6		15.2	
2018-20	21.4		28.0		14.9	
data source: Public Health Outcomes Framework						
produced by: Office of Public Health, Dudley MBC						



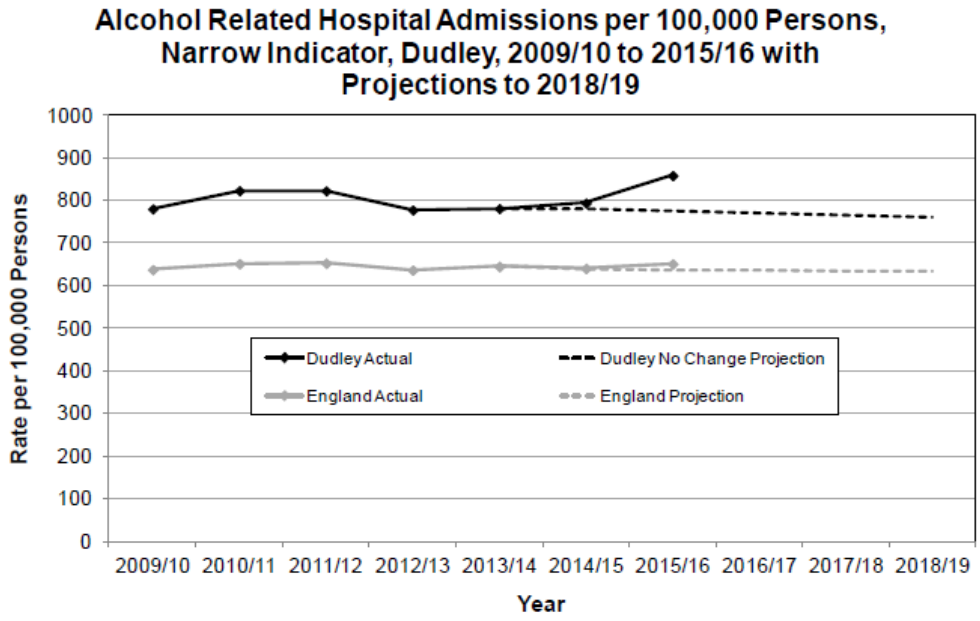
4.06ii - Under 75 mortality rate from liver disease considered preventable, targets, 3 year rates, DSR per 100,000 (2011-13 baseline year)

Year	Persons		Males		Females	
	Target	Actual	Target	Actual	Target	Actual
2011-13	20.5	20.5	26.8	26.8	14.3	14.3
2012-14	21.8	18.7	28.9	24.8	14.7	12.9
2013-15	21.3	17.6	28.3	23.2	14.4	12.2
2014-16	20.9		27.7		14.2	
2015-17	20.5		27.2		13.9	
2016-18	20.1		26.6		13.6	
2017-19	19.7		26.1		13.3	
2018-20	19.3		25.6		13.1	

data source: Public Health Outcomes Framework

produced by: Office of Public Health, Dudley MBC

Alcohol related hospital admissions - narrow indicator targets



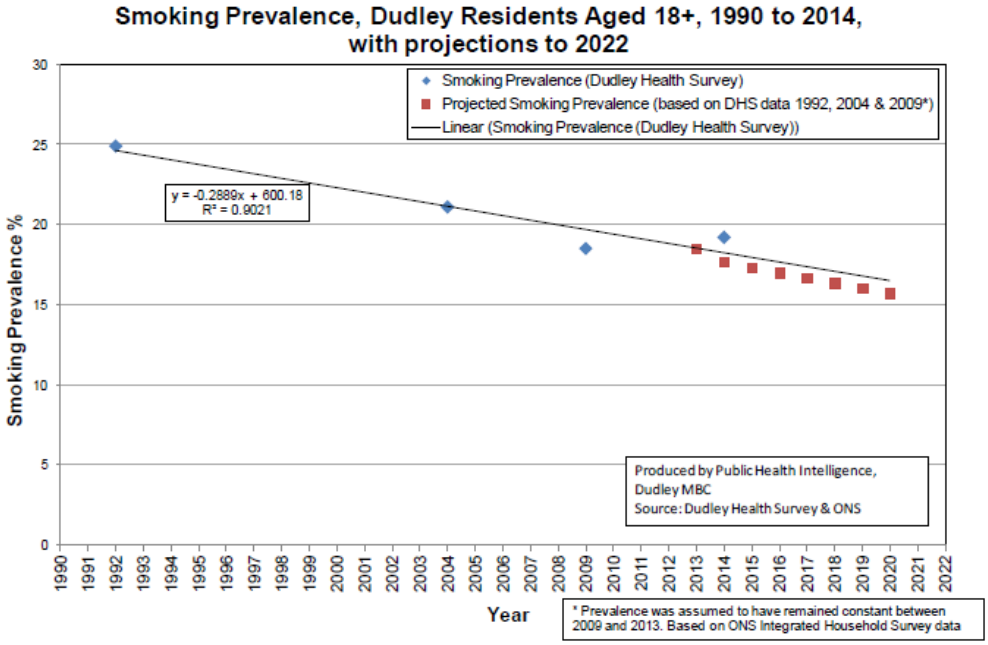
data source: Hospital Episode Statistics (HES)
produced by: Office of Public Health, Dudley MBC

Alcohol related hospital admissions per 100,000 persons, Narrow indicator, projections to 2018/19

	Dudley				England	
	Admissions rate (DSR/100,000)		Numbers		Admissions rate (DSR/100,000)	
Year	Actual	Projected	Actual	Projected	Actual	Projected
2009/10	780		2362		638	
2010/11	823		2499		652	
2011/12	823		2504		653	
2012/13	778		2381		637	
2013/14	781		2398		645	
2014/15	794	780	2449	2402	641	639
2015/16	859	775	2652	2394	651	637
2016/17		770		2386		636
2017/18		764		2378		634
2018/19		759		2370		633
data source: Hospital Episode Statistics (HES)						
Produced by Office of Public Health, Dudley MBC						

Tobacco Control

Smoking Prevalence



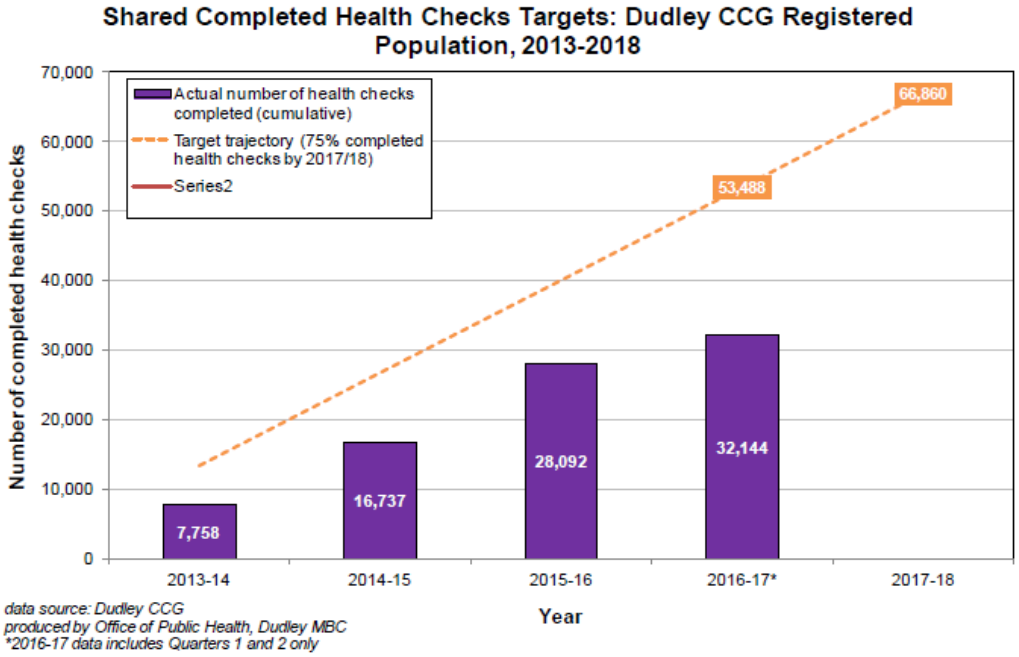
Tobacco Control (targets & outcomes)

Locality	Current Smokers[1]	Target Quits (4 Week) (3% of smokers)	Target Quits (4 Week) (4% of Smokers)	Actual Number Quits 2014/15	Actual Number Quits 2015/16
Dudley & Netherton	8,950	269	358	149	134
Halesowen & Quarry Bank	7,633	229	305	143	123
Kingswinford, Amblecote & Brierley Hill	13,234	397	529	249	198
Sedgley, Coseley & Gornal	8,452	254	338	155	121
Stourbridge, Wollescote & Lye	10,117	304	405	199	181
Grand Total	48,386	1452	1935	895	757

[1] Based on 2013/14 QOF Data

Health Checks Coverage

Targets for Health Checks have been amended since the original 5-year ambitions were set. The new target is the PHE "stretch" target of 75% cumulative uptake for the whole of Dudley by 31 March 2018.



data source: Dudley CCG
produced by Office of Public Health, Dudley MBC
**2016-17 data includes Quarters 1 and 2 only*

Shared Completed Healthchecks Targets, by Locality:

Locality	total eligible population (2013-2018)	Health Checks Completed (cumulative) 2013-14 actual	2013-14 target	2014-15 actual	2014-15 target	2015-16 actual	2015-16 target	2016-17 actual *	2016-17 target	2017-18 actual	2017-18 target
Dudley North	13,506	938	2,026	2,028	4,052	3,680	6,078	4,107	8,104		10,130
Halesowen & Quarry Bank	15,783	1,084	2,367	2,753	4,735	4,624	7,102	5,305	9,470		11,837
Kingswinford, Amblecote & Brierley Hill	24,965	2,804	3,745	5,806	7,490	9,730	11,234	10,935	14,979		18,724
Sedgley, Coseley & Gornal	15,385	1,201	2,308	2,632	4,616	4,865	6,923	5,744	9,231		11,539
Stourbridge, Wollescote & Lye	19,507	1,731	2,926	3,518	5,852	5,193	8,778	6,053	11,704		14,630
Dudley CCG Total	**89,146**	**7,758**	**13,372**	**16,737**	**26,744**	**28,092**	**40,116**	**32,144**	**53,488**		**66,860**

source: Office of Public Health, Dudley MBC
**(2016-17 includes Q1 & Q2 only)*

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

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

The aim is to improve health and wellbeing and reduce health inequalities by using surgery staff to promote healthy living, provide well-being advice, signposting and services, and support people to self-care and manage long-term conditions. The teams will make every contact count to provide relevant health information. Surgeries would be awarded the Healthy Living Surgery quality mark following a robust accreditation process.

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

Our new long term conditions framework making best use of the EMIS web system to support a systematised approach; case find; manage call and recall and extract data. The system will be implemented from 1 April 2016, replacing elements of the QOF and existing enhanced services.

In addition we will:-

- review the COPD pathway with a view to reducing emergency admissions;
- implement our diabetes model of care with a single point of access and triage for all referrals; the majority of care being provided in a primary care setting and the de-commissioning of routine type 2 diabetic reviews in secondary care;
- take part in the national Diabetes Prevention Programme;
- carry out further work on hypertension building on current performance in terms of increased recording on primary care disease registers by 1%;
- implement a new pathway for anticoagulation services;
- commission IV antibiotics and IV diuretics in the community;
- implement the agreed familial hyperlipidaemia screening process;
- support a systematic approach to self-care programmes using appropriate technology, particularly in relation to COPD and heart failure;
- implement an integrated heart failure pathway across acute and community services, 7 days a week.

f) Medicines Optimisation

The CCG has a strong record, in conjunction with public health colleagues, of leading innovative medicines optimisation initiatives, a number of which have received national accolades. From 1 April 2016, the Medicines Management Team, previously part of the Council's Office of Public Health, transferred to the CCG but create a closer alignment to the commissioning process.

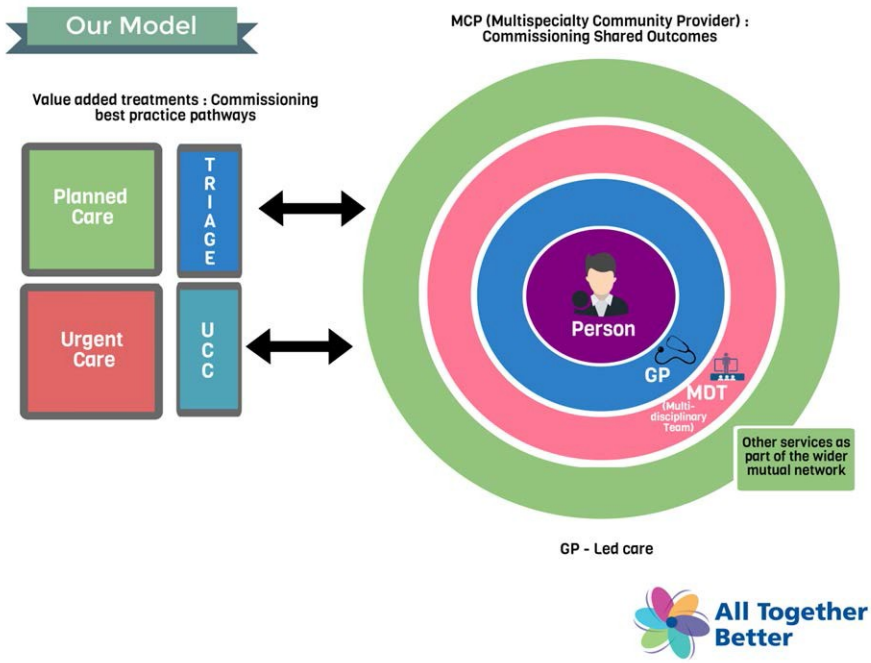
The CCG will be implementing a clear medicines optimisation plan as part of the QIPP programme. This will include:-

- development and roll out across all practices of our Prescription Ordering Direct (POD) designed to optimise repeat prescribing processes;
- increasing the level of practice based pharmacist support, working as part of the Multi-Disciplinary Teams and taking a population based approach to medicines optimisation;
- implementing with our Black Country STP colleagues, following consultation, a policy on medicines of limited clinical value.

g) Population Health Model

The case for the development of our MCP model has been well rehearsed in previous plans, our Value Proposition submissions and our submission for the "Early Engagement" phase of the Integrated Support and Assurance Process (ISAP).

A growing frail elderly population with increasing co-morbidities and a strained primary care system means that we need to create a new model of care that is preventative, joined up and focussed on the health of the population, centred on a re-energised, list based, primary care system



The MCP will provide:-

- community physical health services for adults and children;
- mental health and learning disability services;
- out-patient services, primarily for patients with long term conditions;
- emergency admissions over which the MCP has influence, including those relating to falls and those from care homes;
- public health commissioned services including sexual health, substance misuse and health visiting services;
- services for people assessed as having NHS Continuing Healthcare needs;
- adult social care;
- primary medical services;
- local improvement schemes;
- voluntary sector services;
- a number of activities currently carried out by the CCG.

It will be commissioned in line with the "MCP emergent care model and contract framework" as published by NHS England to include:-

- MDT working as the basic operating model;
- a long term, 15 year, contract;
- a defined set of outcomes linked to a payment framework;
- risk/gain share schemes with other parts of the system.

The CCG has now completed the Early Engagement phase of the ISAP. A Prior Information Notice will be published by late November 2016 and the full procurement process will begin in February/March 2017, with a view to a contract being in place by 1 April 2018, to be mobilised thereafter.

h) CHC Processes

Relative to other CCGs our expenditure on NHS Continuing Healthcare is low. We believe we have robust processes in place to manage the assessment and delivery process. We now have a clear policy in place for Children and Young People's Continuing Care.

We face particular challenges in terms of:-

- high cost placements for learning disability clients – these are being assertively reviewed;
- systematic requests from local authority colleagues, in the face of tight social care budgets, for assessments for patients clearly not meeting the criteria – we have developed a local "code of conduct".

We will continue to support patients with continuing healthcare needs wishing to have personal health budgets.

i) Primary Care

In partnership with our practices and primary care colleagues, Dudley CCG is driving a programme of innovation and investment in primary care to meet – and go beyond - the ambitions of the General Practice Forward View (GPFW) and the Operating Plan.

Our work to transform family doctor services across the borough has been given additional momentum by the CCG taking on fully delegated responsibilities for commissioning primary care.

The commissioning of a MCP has put us at the leading edge of reshaping primary and community care to improve outcomes, reduce inequalities and secure safe, high quality, sustainable services which are responsive to the changing needs of our patients.

Our detailed response to the GPFV, to be published in December, sets out how we will:-

- commission the MCP to deliver improved health outcomes for our registered practice population through a range of integrated, responsive and innovative primary and community health and care services;
- continue our clinically-led (through the Primary Care Collaborative and Primary Care Development Steering Group) programme of major investment in primary care transformation, to ensure that family doctor services are safe and sustainable, and able to play a leading role in the successful delivery of the MCP;
- offer expanded choice and enhanced access to primary care services for our population by expanding roles such as practice based pharmacists
- provide training and development to improve the working of community based multi-disciplinary teams, and widen the range of clinical and non-clinical input to those teams;
- ensure that we take full advantage of the opportunities offered by new technology to drive innovation, underpin integration of services, improve efficiency and empower patients;
- support and encourage practices in their ongoing efforts to work collaboratively, build effective support and development networks and manage growing demand safely and sustainably;
- invest in the infrastructure and estate needed to support and promote our ambitions;
- maximise the benefits and opportunities offered by the adoption of borough wide frameworks (such as Dudley Outcomes for Health) and initiatives – including our Enabling Practices to Improve and Change (EPIC) programme - while also embracing national best practice and evidence based innovations (such as those developed by other Vanguards);
- evaluate what we do through constant monitoring, challenge and peer review,

to ensure that we are securing the desired return on our investment;
- use these actions to reframe our conversations with local people to engage them as active health partners to build healthier neighbourhoods, promote healthy lifestyle choices and encourage local people to become proactive healthy citizens.

4. Urgent and Emergency Care

Dudley urgent and emergency care economy is currently seeing unprecedented levels of demand. There has been a rise of 5.4% (October year to date) in emergency attendances since 2015-16. E D attendances via ambulance is also running above the forecast plan (+3.1% October YTD) equating to an additional 1477 conveyances. This dynamic is shared across the Black Country and also at a national level.

In spite of these pressures, Dudley Group NHS Foundation Trust (DGNHSFT) are consistently within the top 10% performers in England for the four hour standard (UNIFY Type 1&3) and significantly one of only nine Trusts to achieve the emergency standard for 2015-16. The newly constituted A and E Delivery Board acknowledges that this performance is dependent on maintaining strong multi-agency collaboration and particularly improving acute patient discharge flow. The Board currently manage a work plan consisting of four key areas:-

- supporting the current structure and performance of Dudley urgent and emergency care economy;
- delivering the nationally mandated best practice guidance - the delivery of the 95% four hour wait emergency standard and the 75% standard for the 8 minute emergency ambulance response; and delivery of the national A&E Delivery Board five mandated areas:-
    - streaming and A&E;
    - NHS 111 calls transferred to clinicians;
    - Ambulance Response Programme;
    - improving patient flow; and
    - improving discharge.
- leading on assurance and oversight of plans in preparation for the winter period.

a) West Midlands Ambulance Service

West Midlands Ambulance Service (WMAS) is experiencing significant pressure across the West Midlands footprint. Dudley CCG is over plan YTD by 3% against the expected number of emergency ambulance conveyances. Despite this, when benchmarked regionally (using a rate of breaches per 100 handovers in 16/17 YTD), Dudley Group NHS Foundation Trust has one of the lowest 30 minute breach rates at 1.6 per 100 handovers (or 1.6%). 60 minute breach rates are also low at 0.16 per 100 handovers (or 0.16%).

WMAS acknowledge that they are currently very challenged in meeting this demand for the CCG commissioning collaborative and achieving their constitutional targets. WMAS are currently participating in the National Ambulance Response Programme (ARP) which has resulted in revised data collection, KPIs and monitoring reports. Dudley CCG is an active member of the WMAS commissioning Collaborative and currently support a number of in-year initiatives to improve ambulance performance. Measures to address current underperformance and agreement on the commissioning intentions for 2017-18 are on-going. Below is a summary of remedial actions and measures for inclusion in the 2017-18 contract negotiation:-

- support for a revised payment mechanism (e.g. 3-part: block, activity-based 'cap and collar' and incentive);
- WMAS joining the Integrated Urgent Care alliance agreement;
- 999 transfers to 111 at the earliest possible point that this can be technically possible;
- reducing ambulance conveyances through more see and treat episodes;
- implementation of Paramedic Pathfinder;
- complete roll-out of electronic Patient Record to all responders;
- contractual review of key targets (hear and treat, see and treat, see and convey);
- review of GP referral/planned and routine type activity;
- explore GP Visiting Service for crews (direct appointment bookings);
- review role of the Hospital Liaison Officer;
- continued review and refinement of Directory of Services ; and
- strengthen WMAS local engagement in Dudley A&E Delivery Board.

b) The New Integrated Urgent Care Service

NHS 111 plays a significant role within the urgent and emergency care pathway. This makes the commissioning of the new Integrated Urgent Care Service and its four year contract with Care UK all the more significant and welcome. Dudley CCG has played a pivotal role in the design, procurement and current mobilisation of the new service which went live in November 2016. The new provider will deliver a clinical hub and seamless service with the GP out-of-hours service. With significantly enhanced clinical cover within the new service, there will be a marked reduction in the number of patients being directed by NHS 111 to the Emergency Department and a reduction of emergency ambulance dispatches.

c) 7 Day Hospital Services

The four priority standards for 7 day hospital services: -

- timely consultant review
- improved diagnostics
- consultant directed interventions
- review of high dependency will be met in full by March 2017.

d) Dudley Urgent Care Centre

Dudley Urgent Care Centre (UCC) is now in its second year of operation. The design of this pathway has received regional and national praise, in spite of the service operating from interim premises on the Russells Hall Hospital site. Capital funding is being sought for a new and purpose built UCC/ED premises for 2017/18. In doing so the UCC will be able to realise its full service potential i.e. minor injuries assessment, non-urgent and social care patient navigation and ambulance streaming. Recent verbal feedback of inspections by the Care Quality Commission and West Midlands Quality Review Service of Dudley Urgent Care Centre also praised the model and patient outcomes.

5. RTT and Elective Care

The CCG is currently in a good position with regard to its attainment of the 92% Referral to Treatment position. At the end of Month 7, 96.13% of patients on the incomplete non-emergency care pathways were waiting less than 18 weeks. The Year to Date position is 96.79% and forecast outturn is 95.64%. The national standard has been achieved for over 18-months, with each of the main specialties also obtaining the standard. There are no reported concerns at present in achieving the standard, however, the CCG will maintain close contact with the provider over the winter months to ensure that the standard is continually delivered.

a) NHS e-Referrals

The increased use of the NHS e-Referral service is being actively encouraged across GP practices. While current utilisation is circa 64%, this is required to increase to 80% by March 2017. As a result, the CCG is seeking to cease paper referrals unless there is a good clinical reason not to do so in some smaller specialties. The CCG has been actively engaged with its main provider to ensure that the appropriate clinical response has been organised to receive such referrals, whether this be for consultant letter review or advice and guidance. The CCG is committed to delivering 100% of referrals electronically well in advance of the April 2018 deadline and is seeking ways to achieve this as soon as is practically possible.

A QIPP scheme has been developed for 2016/17 for DGFT to develop Advice and Guidance provision. For all appropriate specialties, these will be in place by March 2017. A number are already in place such as Haematology, Cardiology and Orthopaedic Assessment. As part of this programme, the Outpatient Booking Team within the Trust has been reorganised in order to better manage incoming referrals in a chronological systematic way.

There is a monthly joint e-Referral Performance meeting in place to move these issues forward.

b) Redesign of Outpatient Pathways and Reducing Follow-Ups

The CCG will be developing streamlined referral pathways that will take out the expected growth in next year's activity. This will be done through a QIPP scheme which will capitalise on the Demand Management Action Plan and the Menu of Opportunities.

For alternatives to outpatient referrals, the CCG will work with the Local Optometry Committee to develop new referral pathways which will take referrals from general practice into the community rather than into secondary care. This will reduce activity into DGFT relieving pressure on that service, give patients more choice of where to be referred and treated and improve waiting times.

For follow-ups, the intention is to develop a more systematic approach to how this activity is managed. At present follow-ups are largely 'unmanaged' in that there are few criteria or performance standards in this area. The CCG will work collaboratively with DGFT to reduce this activity by agreeing criteria for the number of follow-ups by specialty with the expressed intention to standardise clinical practice and reduce variation.

The Right Care Packs have highlighted a particular issue in Dudley with elective admissions in MSK. The data suggests that such admissions in Dudley are £2.25m adrift of its peer group of 10 CCGs. This issue is being investigated both statistically and clinically to identify the opportunities for change in order to address this position of being a significant outlier.

Outpatient management, follow-up improvements and MSK will now be led by the joint Clinical Strategy Board, with a local implementation group to ensure delivery of the improvements.

c) Maternity

Births overall have reduced marginally year on year since 2011. There are some concerns over the number of caesarean sections and the numbers of readmissions within 28 days which are currently being reviewed.
A new service specification has been agreed with DGFT which refers to the Better Births programme. An action plan is being developed to deliver the Better Birth programme.

A joint Maternity Performance and Assurance Group is now in place to oversee improvements in service delivery.

6. Cancer

1. 2-Week Waits – for outpatient appointments and outpatient appointments with breast symptoms, performance is well above the required standard in all three recorded categories at Month 7, Year to Date and forecast.
2. 31-day Waits – similarly across the reported performance indicators and timeframes waiting times are in excess of minimum performance standards,
3. 62-day Waits – Cancer Waits are contractually managed on a quarterly basis, with September's improved position meaning Q2 was achieved with performance of 85.41%. Despite the quarterly position being achieved, there remains concern in relation to long waits, particularly tertiary referrals between DGFT and Royal Wolverhampton. Quality Teams at Dudley CCG and Wolverhampton CCG are working collaboratively to support both providers in ensuring that tertiary referrals are made within the nationally mandated timescale of 38 days.

The following actions are being taken to reduce waiting times for cancer patients:-

- on-going review of shared breaches with tertiary centres to action potential options for streamlining shared Head and Neck pathway;
- Trust clinical collaboration with Strategic Clinical Network in agreeing timed clinical pathways through Expert Advisory Groups;
- adjustments to the escalation processes with surgical teams to be implemented;
- additional PTL (Patient Tracking List) 'trend' tool developed to help management team identify issues sooner and target resources;
- appointment of new MDT Coordinators to support escalation processes, with recruitment underway for 2 new cancer tracker support roles;
- cancer performance dashboard in use throughout governance process, with further development planned through the Cancer Performance Group.;
- cancer governance structure being improved with the introduction of a new Trust Cancer Steering Group and separate Cancer Performance Group currently embedding.

The CCG is reconstituting its local improvement group to oversee the delivery of these actions.

The new outcomes framework will make a significant contribution to the early diagnosis of cancer and our one year survival rate; as well as the early diagnosis of other long term conditions.

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

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

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

7. Mental Health

The CCG's innovative and progressive approach means that we are well on the way to achieving, or having in place the mechanisms for achieving national targets.

We are committed to improving access to psychological therapies for people experiencing anxiety and or depression regardless of cause (i.e. physical and or mental health problems) by commissioning an integrated service. We are supporting the use of technology and exploring alternative ways of delivering the service which facilitate easier access, are more flexible and ensure high quality outcomes.

Through the operation of the MDTs and our more specialised mental health MDTs, we will continue to develop, encourage and support people experiencing severe mental illness to ensure professionals involved in their care address both their physical and mental health needs in an effort to improve physical health, quality of life and longevity. The mental health MDTs will have a particular role in supporting practices to manage patients effectively in primary care and facilitate their discharge form secondary care.

To ensure services commissioned to provide Early Intervention in Psychosis are, as a minimum, meeting the national standards for access and treatment we will continue to monitor monthly through the contracting process. We plan to evaluate the service mid-year to ascertain if the measures put in place have been sufficient to meet the requirements for an expansion in capacity and capability to meet the needs of the local population. The CCG is committed to ensuring this group of people access services at the earliest opportunity, to maximise the chances of optimal recovery and reduce the social impact that might present.

A 24 hour nurse led psychiatric Liaison service is available for our local adult population based in the local acute hospital. Evaluation has demonstrated that there

was no benefit from having a psychiatrist always available on site. A consultant Psychiatrist was employed on a locum basis for a period of 6 months in 2015. Evaluation of the role during this time highlighted the following:-

- clinical functions of the role during this time were minimal with an average of only twice per week. There was no identifiable pattern in terms of the type of input required;
- all presenting cases during could be managed effectively by the nursing team consisting of Band 7, very experienced and skilled staff;
- given the stable nature of the ED team there were no educational needs identified.

As a result the psychiatrist spent much of the time supporting the crisis intervention team based outside ED. The psychiatrist is now available on-call. Whist this means that the service does not achieve NHS England's Core 24 standard, the evidence above suggests that this does not create a risk.

It is our intention to develop the service into an all age service to ensure the right service is available at the right time and in the right place. We will also continue to explore and evaluate more efficient and effective ways of service delivery.

The CCG will increase access to individual placement support for people with severe mental illness by enabling them to find meaningful occupation and have a sense of being worthwhile members of society. Having to live with an illness can be both physically and emotionally stressful, however, it is only one aspect of life which if accepted and controlled needn't stop purposeful living. The CCG wishes to support people with mental illness to enjoy their life to its full potential and this is part of that ambition.

Suicide, whether accidental or intentional, is devastating for everyone. As a health organisation, the CCG is committed not just to doing no harm to its patients, but also reducing preventable harm. Dudley's Crisis Care Concordat will be refreshed. As part of this it is the CCG's intention to take a zero tolerance approach to suicide. In this way we can work with all of our partners, our public and patients in an attempt to not just reduce suicide but to hopefully remove from the future agenda.

Currently perinatal mental health care is provided by a combination of services accessible through the CCG's mental health and midwifery providers, as well as NHS England specialist services. Due to the number of providers the service can be provided in various locations and might appear to be fragmented at times. In an attempt to ensure a more seamless pathway for this service, the CCG has joined with its partners across the Black Country seeking to commission a specialist service for this particular patient group.

In terms of child and adolescent mental health services, we have undertaken a comprehensive social, emotional and mental health needs assessment to further

understand the needs of our children to inform the refresh of our 2016/2020 CAMHS Transformation Plan, which has now been assured by NHS England.

Our existing investment plans have been reviewed to ensure that the key outcomes have been implemented and the refresh includes how additional funding has been allocated. The implementation of this plan and its associated outcomes continues to be overseen by the CAMHS Transformation Group, with representatives from the NHS, local government and voluntary sector partners.

Building on our achievements to date, additional resources will allow us to accelerate the transformation of our local mental health and emotional wellbeing service offer over the next five years through the implementation of 10 key strategic priorities:-

- ensure that the "voice of the child" is incorporated into all children's service developments;.
- enhance the universal offer to all children, young people and their families
- develop a Single Point of Early Access to services;
- expand the existing school based Emotional Health and Wellbeing Team;
- ensure that a systematic and consistent application of Children and Young People's Improving Access to Psychological Therapies programme (CY IAPT) principles takes place;
- integrate the current specialist 0-5 years provision within CAMHS with the Neurodevelopment Delay Service;
- implement a CAMHS Tier 3+ service as part of our home treatment service;
- implement a 0-18 year old Children and Young People's Community Eating Disorder Service in partnership with Walsall CCG;
- develop therapeutic pathways and provision for victims of child sexual exploitation and other vulnerable children and young people;
- develop the workforce.

We are looking to work in conjunction with both Walsall and Wolverhampton CCGs to implement IAPT for children and young people.

By April 2017 we will have reviewed our self harm audit and conducted a baseline audit of children and young people who present to CAMHS experiencing a first episode of psychosis to ensure that they receive treatment within two weeks of referral and receive a package of care that meets the NICE recommended guidance. An interim report has been requested on the access and treatment of children presenting with a psychotic episode. A pathway will be developed for such children should they present to other services.

8. Learning Disability

We are working with our Black Country Transforming Care Partnership partners to implement our plan for enhanced community based provision for people with disabilities. This will include:-

- a community based assessment and treatment service;
- a community based short breaks service.

These developments will be fundamental to the reduction in inpatient bed provision. Locally, the role of the Ridge Hill Centre is critical to this and we are entering into discussions with Black Country Partnership NHS FT about the future use of this facility and its site.

Our new primary care outcomes framework and the associated outcomes framework for the MCP are designed to ensure that patients are receiving appropriate health checks, preventative measure are being put in place as a means of reducing premature mortality.

We will look to support patients with Personal Health Budgets.

E. COMMISSIONING FOR QUALITY AND SAFETY

a) Holding providers to account

We will work with our providers to encourage the development of smart dashboards to illustrate the performance of their services and inform patient choice. Progress has been made in giving feedback to the public on quality metrics – e.g. safer staffing levels. This will continue in 2017/18.

We expect all providers to develop clear clinical quality standards for their services and measure their performance against these. In 2017/18 we will continue to focus on outcomes based quality standards for inclusion in contracts and will monitor providers against these, mapped to the NHS Outcomes Framework**.**

The CCG Board will use patient stories as a key mechanism for obtaining feedback from patients and build the lessons learned into the service design process.

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

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

In terms of meeting its responsibility for the commissioning of primary care, the CCG will put in place a comprehensive quality monitoring programme to ensure safe care. Our educational programmes for primary care practitioners and community services

will be used to share best practice and lessons learnt.

b) Staff satisfaction

We will use nationally reported staff surveys to focus efforts and engagement.

c) Patient safety

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

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

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

- develop locally sensitive quality indicators and metrics to continually improve the quality outcomes of services;
- provide the governing body with a clear, comprehensive summary on the user view, effectiveness, safety and outcomes of services commissioned;
- monitor the performance of service providers against outcomes of agreed CQUINs and to support the development of future CQUINs;
- ensure nationally agreed CQUINs are fully implemented and complied with;
- support the implementation of improvement plans put in place by service providers in relation to breaches in quality and safety standards, using outcome measures and appropriate time lines;
- review and act upon any notification, advice or instruction issued by the National Regulators or NHS England;
- review and act upon any notification, advice or whistleblowing issued by other agencies or individuals;
- review reports from service providers on progress and outcomes against existing Quality Account work plans, and to review the outcomes of any new work plans;
- monitor and receive reports on incident data (Serious Incidents, Never Events, unexpected deaths);
- quality exceptions reported (such as whistleblowing, serious case review, adverse media reports);
- review safeguarding issues;
- review a suite of key indicators including HCAI data; complaints; patient experience; safety thermometer; quality visits; reports on CQRMs that have taken place including any exceptions to be brought to the attention of the Quality and Safety Committee; and a quality dashboard.

d) Safe and effective prescribing

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

Antibiotic prescribing rates remain a national public health concern. While excellent progress has been made in Dudley in previous years to reduce the volume of broad spectrum antibiotics, our biggest challenge will be to achieve a further reduction in the overall number of antibiotic prescriptions issued. The CCG will be working with the Office of Public Health to support GPs and their patients, through awareness raising; education; use of technology such as our Antibiotic Guidelines app; implementation of our agreed guidelines for the prescribing of antibiotics in the community; and through our agreed Prescribing Incentive Scheme.

We will work in partnership with Dudley Group of Hospitals NHS FT on guidelines and the clinical management of patients.

e) Seven day services

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

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

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

f) Compassion in Practice (CIP) and the 6 Cs

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

g) Provider cost improvement programmes

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

Quality and Safety Committee and appropriate assurance given to the Board.

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

h) Ensuring Clinical Accountability

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

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

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

- based on the registered patients with their practice;
- working in partnership with other consultants / physicians providing long-term care;
- supported by integrated population-based teams with consultants as the lead co-ordinators of pathways of care:-

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

i) Safeguarding children

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

For the Local Safeguarding Children Board to maintain oversight of the effectiveness of safeguarding children practice across the borough, and of the extent to which it is continuously improving, the key Section 11 agencies are expected to provide information on the arrangements they have in place to protect and promote the welfare of children and young people. This includes Dudley CCG as a statutory member of the Safeguarding Children Board.

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

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

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

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

j) Safeguarding adults

i) Prevent agenda

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

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

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

ii) Care Act and NHS Accountability framework

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

iii) The Mental Capacity Act 2006 (MCA)

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

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

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

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

F. ENGAGEMENT

We have several mechanisms for engagement within Dudley CCG which are supported by a Communications and Engagement Strategy. These include:

- a quarterly public Healthcare Forum
- Patient Participation Groups (PPGs) in every practice – 46 in total
- Patient Opportunity Panel – made up of PPG members
- Vanguard Engagement Group

- Annual #mefestival aimed at younger people
- ‘Patient Representatives’ that sit on various groups and committees including
- our locality multi-disciplinary teams (MDT)

Over the last twelve months, we have undertaken extensive engagement and consultation with the local community.

Our regular quarterly public Healthcare Forum introduced the NHS Five Year Forward View and in subsequent meetings we engaged with patients, public and stakeholders about the development of our new care model.

Early January saw the start of our listening exercise - the ‘Biggest ever conversation on health and social care’. We wanted to explore the idea of new care models and gather feedback on how the health and social care system worked for them, focusing on 4 key issues that had been identified by patients, carers and the local community:-

- Communication
- Continuity
- Co-ordination
- Access

These are now key features of the care model. We also wanted to explore notions of responsibility for health and wellbeing, consistent with our move towards mutualism - did people perceive that it was their responsibility or that of health and social care organisations and professionals?

Over 50 groups took part in the listening exercise and the feedback was positive in agreeing that these were the main issues that affected people’s experiences. People also wanted to further understand how new care models and the development of a MCP would directly impact upon them. In addition, we worked with Healthwatch Dudley and Dudley Council for Voluntary Services (DCVS) to co-design and deliver ‘Activate’ sessions.

In July we launched a formal public consultation on a proposal for the development of a MCP. We wanted to hear views on the scope, outcomes and characteristics of a MCP and understand potential impacts upon different community groups. The reach of feedback was:

The strongest theme that arose from the consultation was in terms of accountability, transparency and further opportunities for strengthening patient involvement. A communications and engagement strategy for the MCP development has been developed in collaboration with partners

As the procurement and development of a MCP begins, we will ensure that we continue to engage widely with our communities and seek to understand how they wish to be involved and where they can have influence the MCP. As part of the procurement process, there will be opportunities for patient and public involvement in the competitive dialogue phases and before the final solution is submitted.

With the commissioning of an outcomes based service model, we will be shifting into a culture of true patient empowerment and we would anticipate that a full review of engagement mechanisms will take place. Patient and public involvement will be at 3 levels:-

- we will co-produce at a public engagement level – through the development or codesign of services and by having conversations about self-care and health and wellbeing. We will engage with a range of people that reflect our diverse community and work with our voluntary and community sector partners and groups to extend our reach;
- we will co-produce at a patient experience level – for example, surveys will be designed with patients and we will develop our understanding of real time issues by evaluating data, collected through surveys and complaints. We will develop roles for patients within Clinical Quality Review Meetings with providers to ensure that pathways are consistent, yet flexible to respond to individual needs;
- we will co-produce at an individual level - through care planning, goal setting, shared decision making, self-management and medicines optimisation. By working in partnership we will seek to support people to empower themselves to manage their own conditions and live healthier and happier lives. We will also share Activate packs with local people who want to create opportunities in their own communities and encourage them to appreciate asset based approaches.

We recognise that relationships take time to build and that a new way of working with patients and communities within the MCP requires a huge culture shift and system change as well as support and patience.

G. WORKFORCE

The MCP is intended to be an organisation that like the CCG is values based and considers its staff as one of its most important assets. Our aspiration is for the MCP in Dudley to become an employer of choice that will:-

- attract new workforce to Dudley;
- encourage existing workforce to stay and develop their careers;
- develop new types of workforce consistent with delivering an integrated model of care.

It will do this by working in partnership with our providers to develop local innovative and transformational workforce plans that are a key enabler to both financial and performance success.

Our plan describes a series of interventions that will deliver an improved patient experience for the population of Dudley, financial sustainability and high quality services. The impact of this plan on workforce is three fold:

a) System Workforce Development

Our commissioned MDTs are proving demonstrable benefits to the patients at the centre of their care. As “teams without walls” they actively remove the organisational barriers to improve the quality of care. These teams contribute to a reduction in emergency admissions by reviewing the top 2% of patients who are at highest risk of emergency admission. Plans are in place to expand their sphere of influence with a larger risk stratification pool. This will be developed throughout 2017/18.

Health Education England have been providing specific support in Dudley with regard to toolkits to aid the workforce planning process and also scenario planning which has confirmed that the most effective approach to system workforce planning is to plan on a small scale rather than system wide scale. This work will be taken forward specifically with our MDTs to scenario plan how wider services can be incorporated into the model of working.

The Black Country STP describes a cross black country approach to workforce development with regard to reviewing the existing skill mix and consider different approaches to high demand areas such as using paramedics to undertake primary care home visits, triage services to reduce demand on hospital based services and the split between generic and specialist roles. System workforce development plans developed will be shared with partners across the Black Country to enable spread and replication of good practice.

Our response to the GP Five Year Forward View outlines the developments we are planning including the continued commissioning of our excellence in primary care leadership programme, mentorship programmes to support GPs and nurse retention, specific training and development for reception staff and health care assistants and the continuation of our highly successful borough wide GP education and Practice Nurse development programmes.

b) New Forms of Workforce and changing the use of Skill Mix

Through the development of the MCP we are leading the implementation of new forms of workforce such as the following:-

i) "Integrated Plus"

A team of individuals who build the bridge between primary care and the voluntary sector, through a social prescribing approach. These teams work particularly with the most vulnerable people in our society who are often socially isolated and have an unnecessary dependence on health and social care.

ii) MDT Care Co-Ordinators

A team of individuals who will support the development of the MDT way of working. Employed by one organisation, they will serve the needs of all of the staff who participate in the MDT. These co-ordination roles will have an in depth knowledge of all community services and will play an import role as a conduit between the MDT and other community services available. They will support the timely discharge of patients by providing a link between the discharge co-ordinators and the MDTs.

iii) Telemedicine Support for Care Homes

The telemedicine service developed by the Vanguard site in Airedale is being commissioned with implementation planned for January 2016, to support care homes with the highest hospital admission rates. This service uses an advanced nurse triage service which reviews patients and offers advice on continued treatment in the home setting.

iv) Community Integrated Teams

Working closely with our continuing and intermediate care teams, this intensive support from advanced nurse practitioners working with rehabilitation and social services to provide timely input at appropriate capacity level to keep people in their own homes to avoid emergency admission or facilitate timely discharge.

v) Extended Scope Pharmacists

Nationally Pharmacists are an area of workforce that are currently underutilised which presents an opportunity for better use of the knowledge and skills that are available. Our Extended Scope Pharmacists will enhance the use of their skills by enabling medicine reviews of our patients with complex chronic care needs (eg people with dementia or with multiple long term conditions) and other tasks currently undertaken by our GPs where there is scope for safely shifting the provision of care.

vi) Paramedic Home Visiting Service

This service will see paramedics working in primary care and as part of the MDT to undertake home visits following urgent requests received either through primary care directly, 111, or 999.

vii) IAPT

We will be working in conjunction with our Black Country Partners to develop plans for the IAPT workforce. This will centre upon having an integrated service for people with mental health and physical health needs, as well as creating a workforce trained to deliver talking therapies for children and young people.

c) Being an employer of choice

The MCP will be commissioned to be a values- driven organisation with a strong ethical ethos and high levels of staff engagement. There is strong evidence that shows that the higher the morale in the workforce the better the patient experience and the better the outcomes will be. Providers will work together and in partnership with the CCG to break traditional boundaries and create an empowered workforce to deliver the level of transformation that is required.

Staff engagement processes have already begun to support the MCP development and will continue throughout the next twelve months as the new care model is procured. The Partnership Board overseeing the development of the MCP has approved the following approach:-

- collaborative engagement - system wide, collaborative and consistent messages delivered by the system's most senior leadership;
- employer engagement - when and if this is specifically required to both engage and consult with staff in any change process;
- procurement of the MCP - regular channels of communication including drop in sessions that take staff on the journey of the development of the MCP, leading to engagement with the new MCP provider.

MUST DO 1 - STPs						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
Local Place Based Models of Care	Multi-Specialty Community Provider (MCP) contract to be let by 1st April 2018 with mobilisation to take place in 2018/19	Consultation on characteristics, service scope and outcomes completed. "Early Engagement" Phase of Integrated Support and Assurance Process (ISAP) completed. Market Engagement Prior Information Notice (PIN) published. Primary Care Collaborative and Primary Care Development Group established.	1. Checkpoint 1 of ISAP completed 2. All appropriate documentation prepared in readiness for ITPD 3. Primary Care Development Group to lead GP involvement and engagement with potential bidders with appropriate supporting capacity 4. ITPD issued 5. PQQs assessed 6. Dialogue phase carried out and preferred bidder identified 7. ISAP Checkpoint 2 completed 8. Contract let 9. ISAP Checkpoint 3 completed 10. Learning shared with other sites as appropriate throughout	1. Contract implemented 2. Phased mobilisation of services as agreed 3. Revised commissioning and contract management arrangements within CCG to be established	STP Assurance **Better Health:** Reduction in LTC prevalence, % deaths in hospital & social isolation; increase in people with LTC feeling supported. **Better Care:** Improved access, coordination of care, and patient experience of GP, community and other placed-based services, such end of life care services Clinical outcomes will be improved via MDTs, LTC care pathways and standardising access to care Patient experience improves through co-production & patient activation; and by delivering more efficient care and preventative services to reduce the necessity for ongoing provision as time progresses Safety/quality of the service will be safeguarded through standardised access and pathways; improved communication and reducing variation **Sustainability:** Resource sustainability will be realised through changing culture and behaviours, increased efficiency and	**Potential Headline Statements** • Delivery of Rightcare opportunities will deliver a 15% reduction in Elective activity over a 4 year period • Delivery of Rightcare opportunities will deliver a 9% reduction in Non Elective activity over a 4 year period • Improved management of Ambulatory Care Sensitive Conditions at a Primary Care MDT level will reduce the annual number of admissions by approximately 1,700 • Multi-Disciplinary Team working will improve efficiency and increase community productivity will increase community contacts by approx. 25,000 • The development of the new front end of A&E will allow an additional 7,000 patients to be triaged and seen by a more appropriate

					improved staff retention Reduction in emergency bed days, admissions for ACSC, and use of acute beds, nursing and social care placements	primary care clinician
Efficiency at scale through extended hospital collaboration	At scale efficiencies beyond the reach of the reach of individual providers, through coordinated action to develop networked and/or consolidated models of secondary care provision.	Individual approaches to Trust CIPs. Existing collaboration through Black Country Alliance. Multi-site specialty provision.	1. Develop shared/single service plans for acute specialities with particular opportunities/ challenges	Complete MMH development	**Better Care** Reduced variation in care and improved outcomes **Sustainability** Delivery of >2% CIPs £189m net savings (excluding additional workforce and infrastructure savings)	Clinical Service Review Better Care, Better Value Consolidation of back office & pathology services and re-provision of unsustainable services
			2. Develop new models of care to support specialised services incl. cancer/vascular	Implement new models of care to support specialised services		
			3. Develop options for delivering efficiency in pathology services	Implement preferred option(s) for pathology		
			4. Commission for Quality in Care Homes	Commission for quality in care homes		
			5. Delivery of individual CIPs	Delivery of individual CIPs		
Improving Mental Health and Learning Disabilities	Become one commissioner	Multiple commissioning approaches Black Country Transforming Care Partnership established Significant out of area placements Transforming Care Together programme established MERIT vanguard established	1. Co-design, agree and deliver a pathway based suite of designed and specified services (CAMHS; Planned; Urgent; Functional Older Adults) common to all 4 areas of the STP footprint		**Better Health** Improved access to mental health and mental well-being initiatives, care pathways and services across the life span, reducing levels of complexity and chronicity including physical ill health and improving quality of life and life chances and opportunities. **Better Care** Improved access to health and social care driven initiatives across all statutory and non-statutory key stakeholder partners and agencies, aligned with WMCA MH Commission deliverables including focus on primary care and also mental well-being and the wider determinants of mental ill-health in individuals, families and communities.	Transforming Care Partnership Transforming Care Together MERIT vanguard
	Build the right support for Learning Disabilities		1. Review and re-design community pathways for supporting people 2. Review and redesign inpatient services in line with the national XXXXXXXX 3. Deliver targeted workforce, provider and family training to support new models of care	1. Develop the market to encourage robust provision and increase the uptake of personal budgets		
	Improve bed utilisation and stop out of area treatments		1. **I**mprove capacity management within CCG and provider functions 2. Review of urgent care pathway across Black Country and implementation of 5YFV recommendations	1. Explore the potential for bed reconfiguration as part of TCP		
	Deliver the Combined Authority Mental Health Challenges		1.Implement and deliver Mental Health Waiting Times and Access Standards			
			2.Develop and implement a targeted demand reduction plan (incl.			

			substance misuse/suicide & homicides; and addressing wider determinants e.g. MH supported housing)		**Sustainability** £20m net savings. Transformed outcomes and experience and reducing demand of high levels and types of need on mental and physical health secondary and tertiary services, optimising recovery and developing and delivering initiatives to increase capability in Primary Care and Third and Voluntary Sector services.	
	Deliver extended efficiencies through TCT Partnership		1.Implementation of approved projects			
Improving Maternal and Infant Health	To achieve a sustainable model of maternal and neonatal care, improving outcomes for mothers and babies across the Black Country	Multiple commissioning approaches Multi-site provision Capacity challenges	1.Implement the recommendation of the Cumberledge report		**Better Health** Improved maternal health and infant mortality outcomes **Better Care** Sustainable options for future delivery of standardised care; reflective of national direction – Better Births; access, choice and empowerment **Sustainability** Effective pre-conception care; Healthy pregnancy pathway; Neo-natal pathway; Normalisation agenda for delivery	Better Births Healthy Pregnancy Pathway Neo-natal care pathway Maternal mental health pathway
			2.Develop an STP wide network for sharing intelligence and best practice on maternal, neonatal and infant health			
			3.Develop a Black Country Healthy preconception and pregnancy pathway that addresses risk factors associated with poor maternal, infant and child health outcomes	Implement and embed Black Country Healthy preconception and pregnancy pathway		
			4. Identify opportunities for system wide action on the wider determinants of health	Implement actions linked to wider determinants of health		
			5. Model maternity capacity projections across the Black Country and develop options for delivery	Implement preferred option(s) for delivery		
			6. Ensure best practice arrangements for birth agenda, improving maternity safety outcome across the Black Country			

Must do 2 - Finance						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
Deliver CCG Control Total	Business rules, growth and inflation assumptions and running cost targets all met. QIPP plan delivered	Financial plan developed that meets all business rules and planning requirements.	Contracts agreed that include, where appropriate, QIPP schemes QIPP schemes implemented	Contracts agreed that include, where appropriate, QIPP schemes QIPP schemes implemented	NHS E requirements in relation to surplus, resource limit, running costs, underlying surplus and QIPP all met. QIPP plan delivered	Right Care Medicines Optimisation

Must do 2 - Finance						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
Implement demand management plan	Range of initiatives to be implemented as set out in agreed demand management plan to include Right Care initiatives.	Demand management plan agreed.	Roll out of NHS E referral and Advice and Guidance. Agreed protocol for consultant :consultant referral. Aim to reduce out-patient attendances for ENT, MSK, ophthalmology and urology. Peer review of referrals. Implementation of policy on medicines of limited clinical value. Promotion of social prescribing through Integrated Plus		eduction in first and follow up out-patient attendances.	Right Care Medicines Optimisation Population health models

Must do 2 - Finance						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
Support self care and prevention	Implementation of outcomes framework for primary care and the MCP	New outcomes framework established for primary care	Continue development of framework	Framework fully established		
			Framework to be included in MCP procurement	MCP contract operational with agreed outcomes framework		Population health models (see below)
	Sustain performance in relation to the National Audit Office "high impact interventions"		Maintain performance through activities of Practice Based Pharmacists in relation to appropriate prescribing (see below)		Increased prescribing of drugs to control blood pressure and cholesterol, blood sugar control for diabetes and anti-coagulation for atrial fibrillation.	
	Integrate early years services through the commissioning process for the MCP	Commissioning responsibility currently split between CCG and Office of Public Health	Public health services (health visiting, family nurse partnership and school health advisers) to be included in scope for MCP contract	MCP providing integrated services	Expectations set out in outcomes framework met.	
	Develop model of "health living	Model for healthy living	To be rolled out as part of MCP	Delivery of model		

Must do 2 - Finance						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
Progress population health models	Operational Multi-Specialty Community Provider (MCP)	Consultation taken place in 2016/17 on proposed characteristics, service scope and outcomes to be delivered by a MCP	Conduct procurement process beginning Spring 2016 and continuing through competitive dialogue phase Autumn 2017 to contract award	Contract awarded April 2018. Mobilisation plan agreed for mobilisation to take place during the course of 2018/19, phased as necessary.	MCP fully operational with appropriate integration arrangements with general practice	GP Forward View Right Care Demand management plan
Medicines Optimisation	Practice Based Pharmacists incorporated into MDT operating model across all practices. Prescription Ordering Direct (POD)	Practice based pharmacists funded through Value Proposition, linked to MDTs POD operational across 2 practices	Practice based pharmacists to be procured as part of MCP (see above) Phased roll out to 46 practices	Practice based pharmacists embedded in model. Roll out complete	Reduction in hospital admissions related to medicines. Delivery of QIPP targets Reduction in repeat prescribing spend	Population health models QIPP QIPP
NHS Continuing	Robust assessment	Nurse assessors	Ensure reviews are taking place on a 3	Continue with process	Containment/reduction in growth of	Personal Health Budgets

Must do 2 - Finance						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
Healthcare Processes	and review process.	expanded to create capacity for reviews and a 7 day per week operating model	monthly and 12 monthly basis in order to identify any reduction in need and consequential non-eligibility. Assertively review high cost cases previously commissioned by Dudley MBC and identify alternative placements/packages as necessary		expenditure for relevant client groups.	

Must do 3 - Primary care						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
Implement the General Practice Forward View	As set out in the CCG's plan for implementing the General Practice Forward View.	CCG already commissioning and implementing a range of support as set out in CCG General Practice Forward View implementation plan.	1. Workforce Expansion of the workforce supporting general practice including • Consultant outreach supporting each MDT • Extended scope pharmacists in each practice • Home visiting service operated by paramedics and nurse practitioners • Social prescribing practice and voluntary sector support to each practice in each locality • Expansion of care navigators to include training of reception staff in all practices • Increasing the number of Non Medical Prescribers by commissioning training places for staff in every practice	1. Workforce MCP becomes operational Further expansion and development of the MDT model to deliver outcomes commissioned from MCP including; Implementation and development of whole system workforce plan Workforce either employed by or commissioned through the MCP	NHSE assurance and reporting of outcomes through GP transformation board and New Care Models Team. CCG assurance and reporting of outcomes to public meetings of the Primary Care Commissioning Committee and Partnership Board. Increased number of doctors working in general practice Extra pharmacists working in general practice Expansion of Improving	MCP procurement A&E delivery plan Demand management good practice guide NICE guidance NHS Operational and Planning Guidance Dudley CCG 'Value Proposition' to New Care Models Team of NHS England General Practice Forward View Five Year Forward View

Must do 3 - Primary care						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
			• Participating in National pilot of new Nurse Associate role supporting the delivery of Dudley Quality for Health Outcomes Framework Commissioning of training, development and mentorship support programmes to support GP and nurse retention in Dudley Whole system workforce plan developed for the MCP (in collaboration with Health Education England)		Access to Psychological Therapies (IAPT) in general practice Increased investment in training practice staff and greater use of online consultation systems	
			2. Workload Continued commissioning of the Dudley Outcomes for Health Framework to support changes in the delivery model and skill mix in delivering primary care component of MCP outcomes framework. Evaluation of reduction in workload and	2. Workload Dudley Outcomes for Health Framework commissioned from MCP Commissioning arrangements for the delivery of primary care outcome measures		

Must do 3 - Primary care						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
			changes to skill mix delivered as a result of the Dudley Outcomes for Health Framework.	reviewed and revised in light of national guidance		
			3. Care Redesign Commissioning outcome measures required of primary care in the MCP as part of the Dudley Outcomes for Health Framework delivering: • national best practice and evidence based care for access, continuity and co-ordination outcome measures MCP outcome measures and MDT delivery model incorporated into commissioning arrangements with General Practice New roles in place and supporting delivery of primary care outcome measures i.e. extended scope pharmacists, paramedics, consultant outreach, mental health therapists,	3. Care Redesign Dudley Outcomes for Health Framework will be commissioned from the MCP. MDT model core part of MCP model with staff participating in MDTs employed or contracted through MCP. MDTs will have shared responsibility to deliver outcomes of MCP contract. Workforce redesign models will be embedded into MCP delivery.		

Must do 3 - Primary care						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
			social workers, voluntary sector.			
			4. Infrastructure Implementation of the Health Infrastructure Strategy (HIS) to increase occupancy and utilisation of current estate Complete Estates & Technology Transformation Fund (ETTF) project to reconfigure Health Centre allowing practice co-location in line with the HIS Implementation of the IT Strategy. Implementation of new core IT Service Management and technology infrastructure layers Development of the integrated patient record to support MCPs	4. Infrastructure Investment in ETTF Cohort 2 scheme to build Urgent Care Centre providing Primary Care Triage at front door of Emergency Department Continued implementation of HIS objectives Continued development of the integrated patient record platform	As above	• As above. Also: • CCG Estates Strategy • CCG IT Strategy • UECN
Investment plans meet or exceed required levels	• CCG produces an investment plan for	• CCG already investing in excess of £3 per head of	1. Investment plan produced and agreed by Primary Care Commissioning	1. Investment plan reviewed and revised in light of national	As above	As above

Must do 3 - Primary care						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
	implementing the General Practice Forward View	population on primary care development.	Committee meeting or exceeding the investment requirement.	guidance meeting or exceeding the investment requirement.		
Extend and improve access in line with requirements for new national funding	• Commission extended access outside of core hours including weekends i.e. Saturday and Sunday offering pre bookable and same day appointments • Commission access standards and outcomes as part of Dudley Outcomes for Health Framework	• CCG commissioning extended access over winter period • CCG commissioning best practice access outcomes as part of Dudley Outcomes for Health Framework	1. Commission extended access over the financial year accessible to all registered patients	1. Review and revise commissioning arrangements for extended access – taking into consideration establishment of MCP	As above	As above
			2. Commission best practice access outcomes as part of Dudley Outcomes for Health Framework	2. Review and revise best practice access outcomes commissioned from MCP		
			3. Invest in IT infrastructure and training to enable remote access to medical records of all patients, in all practices.			
Support general practice operating at scale the expansion of	• To ensure GP Practices across Dudley are properly	• Primary Care Collaborative of 40 practices in place	1. Primary Care Collaborative agrees partnership arrangement with provider in response to MCP procurement	1. MCP is established - primary care mobilises for the delivery of 15 year	• As above	• As above

Must do 3 - Primary care						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
the MCP	involved in the development of the CCG's plans to radically alter the way a raft of primary and community health and care services are commissioned. This transformation will be delivered though the development of a Multi-Specialty Community Provider (MCP) model.	• Primary Care Development Group supporting • Group supported by £1m of additional resource provided by the New Care Models Team • Group is overseeing wider integration with community and other services organised around General Practice		outcomes based contract having successfully partnered with provider organisation.		
			2. Primary Care Collaborative agrees the 'integration agreement' and updated Memorandum of Understanding between the Collaborative that enables the MCP to fulfil its commissioning responsibilities to the CCG in respect of primary care outcomes measures.	2. MCP is established – Primary Care Collaborative starts to operate and deliver MCP outcome measures at scale		
			3. Primary Care Development Group is able to develop and implement a range of projects with investment secured through the New Care Models team that demonstrate improved outcomes from operating at scale, and wider integration of community and other	3. MCP is established – Primary Care Development becomes core function of MCP, service delivery model and transformation begins.		

Must do 3 - Primary care						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
			services organised around General Practice.			
Commissioning of the 10 High Impact Changes in Primary Care	• As set out in the CCGs plan for implementing the General Practice Forward View.	• CCG already commissioning and implementing a range of support as set out in CCG General Practice Forward View implementation plan	1. Delivery of the 10 High Impact Changes achieved through the following programmes • MCP model of care • MDT working • Dudley Outcomes for Health Framework • Enabling Practices to Improve and Change Programme (EPIC)	1. Review and revise commissioning arrangements and implementation plans to improve the commissioning, and delivery, of the 10 High Impact Changes.	• As above	• As above
Enable and fund primary care to play its part fully implementing the forthcoming framework for improving health in care	Establish position in relation to the role of primary care within frailty pathways in general and care homes in particular	LIS in place to support practices providing input to care homes	1. Commence commissioning of 24/7 telemedicine service from Airedale NHS Trust – National Vanguard Care Home provider – available across all care homes and	1. MCP established – MCP provider reviews and establishes appropriate model based on Airedale	• As above	• As above

Must do 3 - Primary care						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
homes			General Practice in Dudley	pilot for delivering frail elderly pathway		
			2. Evaluate commissioning of Airedale scheme in context of enabling improved management of the frail elderly, reduced admission and reduced demand on primary care and ambulance service.			

Must do 4 - Urgent and Emergency Care						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
Ensuring more than 95 percent of patients wait no more than four hours in A&E	Acute Trust Emergency Department achieve and exceed national target.	95%	Maintain current trajectory and performance against four hour standard Modify streaming pathway of urgent care centre to reduce patients with minor injuries sent to ED. Ensure maximum benefits are realised from newly commissioned Integrated Urgent care Service (NHS 111).	Maintain current trajectory and performance against standard	Delivery of target as reported to Unify. Positive Friends and family feedback on experience of using emergency care and UCC.	Urgent & Emergency care Network New models of care and general practice. Health and social care Integration RightCare
Emergency Care Networks rolled out to 100 percent of the population	WM Urgent & Emergency Care Network (UECN) constituted and establish in 2016.	N/a UECN already in place	Continue membership and involvement in UECN Contribute to system mapping, developments and service changes led by UECN.	No plans to introduce a specific measurement.	Delivery of NHSE mandated requirements for UECN and its members. UECN standards adopted and met by all member CCGs and providers.	• STP

Must do 4 - Urgent and Emergency Care						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
75 Percent of Category Ambulance calls responded to within 8 minutes.	Red 1 response delivered above constitutional national target. Of note is that WMAS is currently a pilot site for the National Ambulance Response Programme (ARP) clinical coding trial. This trail currently exempts WMAS from the 75% target. The trail will conclude in February 2017.	75%	Maintain current trajectory and performance against the 75% standard.	Maintain current trajectory and performance against the 75% standard.	Delivery of target as reported to UNIFY.	Urgent & Emergency care Network .

Must do 4 - Urgent and Emergency Care						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
Meet the 4 priority standards for seven-day hospital services for all urgent network specialist services	RAG rate green against guidance key deliverables. Timely consultant review Improved diagnostics Consultant directed interventions Review of high dependency	Amber (Assured by NHSE)	Deliver four clinical standards by March 2017	Maintain 7 day offer and new service provision. To cover 100% of population nationally by 2020	Assured as blue and fully implemented by NHSE	Urgent & Emergency care Network STP

Must do 4 - Urgent and Emergency Care						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
Deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department	Warm Transfer of 999 calls to the Integrated Urgent Care Service is included in phase 2 of service mobilisation and the service specification for the newly commissioned service.	Amber (Assured by NHSE)	Develop operational and technical capability between IUSC and WMAS. Lead for this will be IUSC alliance and mobilisation group. Pilot developed 2017/18.	Full capability realised and developed into business as usual.	Assured as blue and fully implemented	Urgent & Emergency care Network STP
Initiation of cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis.	Surveillance and reporting of breaches captured for Dudley urgent and emergency care services. Ensured 24/7 MH provision is in place to meet target.	Amber (Assured by NHSE)	Ensure surveillance of target and delivery standard by March 2017	Maintain performance against the waiting time standard	Delivery of target as reported to UNIFY.	Urgent & Emergency care Network STP

Must do 5 - Urgent and Emergency Care						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
Ensuring more than 95 percent of patients wait no more than four hours in A&E	Acute Trust Emergency Department achieve and exceed national target.	95%	Maintain current trajectory and performance against four hour standard	Maintain current trajectory and performance against standard	Delivery of target as reported to Unify. Positive Friends and family feedback on experience of using emergency care and UCC.	Urgent & Emergency care Network New models of care and general practice. Health and social care Integration RightCare
			Modify streaming pathway of urgent care centre to reduce patients with minor injuries sent to ED.			
			Ensure maximum benefits are realised from newly commissioned Integrated Urgent care Service (NHS 111).			
Emergency Care Networks rolled out to 100 percent of the population	WM Urgent & Emergency Care Network (UECN) constituted and establish in 2016.	N/a UECN already in place	Continue membership and involvement in UECN	No plans to introduce a specific measurement.	Delivery of NHSE mandated requirements for UECN and its members.	• STP
			Contribute to system mapping, developments and service changes led by UECN.		UECN standards adopted and met by all member CCGs and providers.	

Must do 5 - Urgent and Emergency Care						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
75 Percent of Category Ambulance calls responded to within 8 minutes.	Red 1 response delivered above constitutional national target. Of note is that WMAS is currently a pilot site for the National Ambulance Response Programme (ARP) clinical coding trial. This trail currently exempts WMAS from the 75% target. The trail will conclude in February 2017.	75%	Maintain current trajectory and performance against the 75% standard.	Maintain current trajectory and performance against the 75% standard.	Delivery of target as reported to UNIFY.	Urgent & Emergency care Network .

7 day hospital services for urgent care						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
Meet the 4 priority standards for seven-day hospital services for all urgent network specialist services	RAG rate green against guidance key deliverables. Timely consultant review Improved diagnostics Consultant directed interventions Review of high dependency	Amber (Assured by NHSE)	Deliver four clinical standards by March 2017	Maintain 7 day offer and new service provision. To cover 100% of population nationally by 2020	Assured as blue and fully implemented by NHSE	Urgent & Emergency care Network STP

Must do 5 - RTT and elective care						
Priorities	Key deliverables	Baseline position	2017/18 actions / milestones (steps to delivery)	2018/19 actions/ milestones (steps to delivery)	Success measure (inc reference to plan trajectories)	Relationship to other plans/programmes, e.g. RightCare, UECN,
Deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT).	Delivery of Referral to Treatment constitutional standard	94%	Maintain implementation of CCG/Trust improvement plan	Maintain implementation of CCG/Trust improvement plan	Delivery of STF trajectory templates as on Unify.	Cancer improvement plan as agreed by NHSE/NHSI Agreed Inter trust Transfer Policy
Deliver patient choice of first outpatient appointment	Recording of patient choice	N/A – proxy recording of patient choice through outpatient referrals, either by e-referral or paper.	No plans to introduce a specific measurement. Choice options are rarely recorded in patient notes unless for specific reasons. Consider use of patient questionnaires to gain feedback.	No plans to introduce a specific measurement.	Patient feedback	Vanguard programme
Achieve 100% of use of e-referrals by no later than April	Increased use of electronic referral system	62%	Achieve 80% utilisation by March 2017 to deliver Quality Premium Engage with GPs to raise awareness of system and its benefits	Achieve 100% utilisation by March 2018 Engage with GPs to raise awareness of system and its benefits	Attainment of 80% utilisation in March 2017	Part of QIPP Plans for 2016/17 Part of Primary Care improvement plans for 2017/18

Must do 5 - RTT and elective care						
Priorities	Key deliverables	Baseline position	2017/18 actions / milestones (steps to delivery)	2018/19 actions/ milestones (steps to delivery)	Success measure (inc reference to plan trajectories)	Relationship to other plans/programmes, e.g. RightCare, UECN,
2018 in line with the 2017/18 CQUIN and payment changes from October 2018.			Engage with Providers to ensure they are ready to receive e-referrals	Engage with Providers to ensure they are ready to receive e-referrals		
Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups	Outpatient Redesign	N/A	1. As part of this programme, the CCG will implement a range of policies and procedures which are currently available but have not been fully utilised to date. These include the following: Management of Aesthetic Surgery & Procedures of Limited Clinical Priority; Advice & Guidance; Consultant Letter Review 2. This process will be overseen by the Clinical Strategy Board.	Development of QIPP and SDIP schemes to reduce unnecessary steps in patient pathways – to be determined	The main objective is to keep outpatient activity flat thereby negating growth. Key Deliverables: * Outpatient management at acute provider will be centralised and operating procedures standardised * Undertake a clinical audit to ensure compliance with policy in both primary and secondary care for Aesthetic Surgery & Procedures of Limited Clinical Priority (Q1) * Standardise the referral pathway for GPs using the e-Referral service (end paper	The CCG is seeking to build on the Demand Management Good Practice Guide by seeking practical alternatives to outpatient appointments. In so doing, this will reduce demand on outpatient services which will reduce outpatient waiting times. Additionally, more patients will be managed in the alternative settings such as in primary care or more appropriate community services. Utilising Rightcare packs to develop approaches to areas where spend/activity is not in line with similar CCGs – specifically these are: MSK; Genito-Urinary;

Must do 5 - RTT and elective care						
Priorities	Key deliverables	Baseline position	2017/18 actions / milestones (steps to delivery)	2018/19 actions/ milestones (steps to delivery)	Success measure (inc reference to plan trajectories)	Relationship to other plans/programmes, e.g. RightCare, UECN,
					referrals by March 2017) * Use of Advice & Guidance across all appropriate specialties (Q1)	Trauma and Injuries. The CCG is also utilising the Map of Opportunities and the Choosing Wisely guidance from the Academy of Royal Colleges.
	Reducing unnecessary follow-ups	Number of follow-ups is reported through SPQR	The streamlining of pathways will have a direct effect on the number of follow-ups as these will reduce in line with those changes.	Continuation of developments from 2017/18	* Reduce follow-ups by reviewing each specialty and considering criteria for appropriate follow-ups (Q1)	See above
			Discussions with the providers on limiting the number of follow-ups by specialty.			
			Consideration of the cost implications this will have in addressing overall funding gaps			
Implement the national maternity services review, Better Births, through local maternity systems.	Better Births embedded into local service delivery	Better Births has been included in the newly revised service specification	Monthly Performance & Assurance Group now in place to take forward this programme of work.	Better Births to be fully implemented by March 2019	Full implementation of Better Births with associated monitoring.	Black Country STP Group now in place Local and regional maternity networks Rightcare
			Develop action plan to begin implementation of Better Births			
			Consider implications of service changes			

Must do 6 - Cancer						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
Deliver the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity, and the other NHS Constitution cancer standards.	Delivery of 62 day constitutional standard	85%	Maintain implementation of CCG/Trust improvement plan Embed day 38 referral transfer guidance as part of main provider contract Increase diagnostic capacity to support continued delivery of standard	Maintain implementation of CCG/Trust improvement plan	Delivery of STF trajectory templates as on Unify.	• Cancer improvement plan as agreed by NHSE/NHSI • Agreed Inter trust Transfer Policy
Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report.	Spearhead a radical upgrade in **prevention and public health** Drive a national ambition to achieve **earlier diagnosis** Establish **patient experience** on par with clinical effectiveness and safety Transform our approach to support people **living with and beyond cancer** Make the necessary investments required to deliver a **modern, high-quality service** Ensure **commissioning, provision and accountability**	N/A	Relate current work programme to the cancer taskforce report Establish local programme of meetings Develop local action plan	To be determined In progress To be developed	To be determined	• Black Country STP will review acute pathways to improve cancer survival • Link in with cancer networks at local, regional and national levels

Must do 6 - Cancer						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
	processes are fit-for-purpose					
Make progress in Improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.	Improve one-year survival rates	67.3% (Cancer Research UN)	Standardisation of acute pathways will improve cancer survival	Embedding acute pathways into standard practice	Increase percentage of patients surviving at one year	• Black Country STP will review acute pathways to improve cancer survival • Link in with cancer networks at local, regional and national levels.
			Establish strategic group to consolidate current programmes of work	Strategic group to continue to lead on current and new programmes of work		
			Ensure participation screening programme	Continue participation screening programme		
			Improve proportion of cancers diagnosed through 2-week waits	Continuation of improvements into future years		
	Reduce cancers diagnosed following emergency admission	21% (Public Health England)	Standardisation of acute pathways will improve cancer survival	Embedding acute pathways into standard practice	Reduction in cancers diagnosed following emergency admissions	• Black Country STP will review acute pathways to improve cancer survival • Link in with cancer networks at local, regional and national levels.
			Establish strategic group to consolidate current programmes of work	Strategic group to continue to lead on current and new programmes of work		
			Ensure participation screening programme	Continue participation screening programme		
			Improve proportion of cancers diagnosed through 2-week waits	Continuation of improvements into future years		
Ensure stratified follow up	Development of stratified pathways	To be determined	Across the West Midlands no unified method for follow up	Continue to develop patient pathways and seek improvement into	To be determined	• Black Country STP will review acute pathways to improve

Must do 6 - Cancer						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types.			pathways; some nurse led, some Consultant led. There have been meetings, but not every team in agreement or near to agreement. Dudley could start working up independently, but this would mean they would non-compliant with West Midlands Guidelines for the Quality Surveillance programme etc. Develop local action plan Establish local programme of meetings	future years.		cancer survival • Link in with cancer networks at local, regional and national levels.
Ensure all elements of the Recovery Package are commissioned	1. all patients have a holistic needs assessment and care plan at the point of diagnosis; 2. a treatment summary is sent to the patient's GP at the end of treatment; and 3. A cancer care review is completed by the GP within six months of a cancer diagnosis.	To be determined	1. All Breast cancer patients have Holistic Needs Assessment at diagnosis; undertaken by Cancer Nurse Specialist. 2. Patients also receive a copy of the treatment plan letter that is sent from the Consultant to GP. This has been adjusted to ensure patient friendly language. 3. This is part of	Continue monitoring to ensure compliance.	To be determined	• Black Country STP will review acute pathways to improve cancer survival • Link in with cancer networks at local, regional and national levels.

Must do 6 - Cancer						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
			Quality Outcomes Framework and is part of the Long Term Conditions Framework also. In addition, the CCG is committed to annual reviews for 5 years.			
			Can run audits to demonstrate compliance rates			

Must do 7 - Mental Health						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
Provide additional psychological therapies so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with physical healthcare	Integrated physical and mental health service	Currently commission separate mental health and physical health IAPT services from Dudley and Walsall Mental Health Partnership NHS Trust and Black Country Partnerships NHS Foundation Trust	Share commissioning intentions with DWMHT and BCPFT Confirm and Include as SDIP item for 2017/18 contract. Scoping and business case development HR and Staff side engagement Management of organisational Change Launch of formal consultation	Implementation of change Evaluation and Analysis Respond to recommendations and implement required changes to model	Both providers signed up to commissioning intentions including access and recovery target trajectories 17/18 Q3 16.8% 18/19 Q2 19% Providers in full agreement and engaged with SDIP contract review and monitoring of SDIP Business case to DCCG CDC and DWMHT MEXT for signoff. HR and staff side engagement. Dates times venues and feedback from formal consultation Implementation plan. Evaluation report, conclusions and recommendations Implementation of recommendations	Population health models Population outcomes. MCP Other DWMHT services

Must do 7 - Mental Health						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
At least 32% of children with a diagnosable condition are able to access evidence based services by April 2019, including being part of CYIAPT by 2018	Increased access to NHS funded community MH service. All community mental health services will adopt the CYPIAPT way of working in place	Baseline to be generated using 2016/17 MHSDS data.	Trajectory will have been agreed. Developed model service specification for targeted and specialist children and young people's mental health services (T2/3) services using CYP IAPT principles and values. Integrated Tier 2 service commissioned and implemented. Work with Walsall CCG to sign up to West Midlands IAPT Collaborative. Identify the relevant staff that deliver emotional health, wellbeing and mental health that need to be trained in CYP IAPT. Arrange awareness training for all staff staff that deliver	Identified staff will be trained in CYP IAPT to ensure that IAPT is embedded across the whole pathway.	30%, in 2017/18 and 32%, in 2018/19, of CYP to be treated in a community service when they need it. Increased number of CYP treated over 2014/15 position. (Technical Definitions E.H.9)	MCP CAMHS Transformation Plan. Other DWMHT services Joint Technical Definitions for Performance and Activity 2017/18-2018/19.

Must do 7 - Mental Health						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
			emotional health, wellbeing and mental health services.			
Expand capacity so that more than 53% of people experiencing a first episode of psychosis begin NICE recommended treatment within two weeks of referral	EIP service will have sufficient capability and capacity to meet national standards	Currently meeting the existing standard requirement of 50% Outcome of self assessment awaited	Discuss commissioning intentions with provider. Evaluate resources Agreed training plan in place and on target Agree implementation plan and time frames Agree service specification with increased target	Will be meeting standards Regular monitoring through contract review meetings. Skills analysis Skill mix to deliver NICE compliant therapy	Intentions agreed Service developments informed by evaluation and recommendations Staff trained and able to deliver NICE compliant therapies Capacity able to meet demand	Population health models Population outcomes. MCP Other DWMHT services
Reduce suicide rate by 10% with all partners	Agreed strategy with partners	Current rate – 9.8/100,000 Crisis Care Concordat in place Existing strategy in place led by Office of Public Health	Identify stakeholders and convene series of meetings. Establish current baseline Bring borough stakeholders and suicide prevention plans together. Convene stakeholder meeting to Refresh Crisis Care Concordat Explore possibility	Gather provider and service user feedback Develop Joint Suicide Prevention Strategy and implement action plan Ensure embedding of lessons learnt User feedback to inform future developments and implement recommendations.	Joint strategy developed and published Refreshed Crisis Concordat submitted Developments in services resulting from user feedback/lessons learnt Consistent reduction on current base rate Development of a Zero tolerance	Population health models Population outcomes. MCP Other DWMHT services Dudley MBC Dudley Group of Hospitals West midlands Ambulance/111 West Mercia Police Fire Service

Must do 7 - Mental Health						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
			to develop a joint /integrated crisis care concordat Monitor SUIs and identify lessons learnt Monitor through CQRM		approach to suicide	
Increase access to individual placement support for people with SMI Commission community eating disorder services so that 95% of children and young people receive treatment within four weeks of referral for routine cases and one week for urgent cases	Create capacity within Out-Patients Clinics for psychiatry support, to enable the management of complex cases, physical health and prescribing; Provide dedicated sessions of Clinical psychology to support complex cases and the	Current service commissioned from Dudley and Walsall Mental Health Partnership NHS Trust. Baseline to be established. Number of CYP ED referrals evaluated to inform commission of new service. New service commissioned and recruitment completed.	Review existing service in terms of capacity and capability Service fully operational by February 2017 Evaluation after 6 months and report to CAMHS LTP/ CCG Commissioning Development Committee	Audit of service, including whether CYP IAPT principles have been adopted.	Access increased The CYP ED service will achieve by 2020 minimum of 95% of referrals waiting less than: • 1 week for urgent cases 4 weeks for routine cases	MCP CAMHS Transformation Plan. Other DWMHT services. Dudley Group of Hospitals FT Paediatric Services. Joint Technical Definitions for Performance and Activity 2017/18- 20.

Must do 7 - Mental Health						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
	provision of NICE recommended interventions; Provide a dedicated family therapy clinic for Eating Disorders in accordance with NICE guidance					
Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution and home treatment teams and mental health liaison services in acute hospitals	24 hour access to mental health services for all ages.	24/7 Psychiatric liaison in place not Core 24 standard. Street triage in place (Black Country joint venture) I CAMHS service commissioned to ensure extended 7 day access. Recruitment underway. Proposal for older adults crisis service being considered	Reconfiguration of services to ensure 24/7 MH assessment, response and intervention available. Support to the A&E delivery board to bid for funding to support implementation of core 24 standards for psychiatric Liaison Business case to CDC for assurance Public consultation Project and implementation plan for service development	Monitoring through contract review and CQRM Gathering of user feedback Evaluation of services Respond to recommendations and implement required changes to model	All age Psychiatric Liaison service meets Core 24 standard. Services configured to ensure all presentations of crisis/need have timely effective response (24/7) form appropriate mental health services without having to attend ED.	A and E Delivery Board Plan CAMHS Transformation Plan DWMHT DGoH Ambulance 111

Must do 7 - Mental Health						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
Maintain dementia diagnosis rate of at least two thirds of estimated local prevalence	Target met	Current performance c 58%. Target – 67%. Award winning "Dementia Gateways" available to provide post diagnosis support.	Concerted actions in conjunction with primary care to systematise the diagnosis process and facilitate access	Plan implemented and target met	Target met	Better Care Fund
Eliminate Out of Area Placements for non-specialist acute care by 2020/21	Process to minimise potential for acute and non acute out of area placements	Currently no out of area acute placements commissioned. Minimal specialist non acute placements commissioned only through prior approval. All PAT providers actively managed by CCG to ensure identified needs/care plan implemented and reviewed within agreed time periods	Review and refresh CCG process, procedures and policies for out of area placements CCG to continue to provide support, advice and guidance around most appropriate placements to meet identified needs Decisions made on a case by case basis. All providers monitored through quality, clinical outcomes and service user feedback for each patient All placements reviewed and	Evaluate Embed any lessons learnt Implement any recommendations Transfer from CCG to MCP	There will be no acute OAP beds commissioned The number of specialist OAP non acute beds will be reduced	
Mental Health Investment Standard	Increase baseline spend by 2%					

Must do 7 - Mental Health						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
		Achieved – increased by £964,000	recovered to local service provision within agreed time frame			

Must do 8 – People With Learning Disabilities						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN**
Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism	Agreed Black Country Plan in place.	CCG is a partner with local government in the Black Country Transforming Care Partnership.	Contribute to finalisation of Black Country Transforming Care Plan.	Implement plan.	Planned bed reductions and service changes completed in accordance with required timescale	
			Plan to identify appropriate bed reductions	Beds to be reduced by March 2019.		
Reduce inpatient bed capacity by March 2019 to 10 – 15 per million population	Bed reductions completed and appropriate alternative community based assessment and treatment services commissioned as an alternative to hospital admission.	Current local specialist health provision includes inpatient assessment and treatment facilities and short stay provision.	Develop plan in context of the Black Country Transforming Care Plan for the reduction and /or reconfiguration of local in patient provision.	Plan to be implemented by 1 April 2019.	New services in place and bed reductions implemented	
			Develop community based alternative to inpatient assessment and treatment service.	New service to be commissioned to support bed reduction process.		

Must do 8 – People With Learning Disabilities						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN**
			Develop community based alternative to short stay provision.	New service to be commissioned to support bed reduction process.		
Improve access to healthcare so that by 2020, 75% on a GP register are receiving an annual health check	Systematised health checks in place across all practices.	Currently commissioned from GPs through local primary care outcomes framework. 57% of people with learning disability receiving a health check.	Implement this element of the outcomes framework.	Monitor performance.	Health checks completed	
	Appropriate outcome measure reflected in primary care outcomes framework and outcome framework for MCP.	Outcome measures established for this to feature in MCP procurement.	Assess ability of bidders to achieve requirements as part of the procurement dialogue process.	Implement and monitor contract.	Health checks completed.	

Must do 8 – People With Learning Disabilities						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN**
Reduce premature mortability by improving access to health services, education and training of staff and by making reasonable adjustments	Access to primary care incentivised through GP outcomes framework with focus on long term conditions	57% of people with a learning disability receiving a health check	Improved access to services to be specified and tested in MCP procurement	Revised service specification in place as part of MCP contract	Reduced mortability rate	Primary care outcomes framework and access to primary care
	Health access service commissioned	Training for staff included in saving specification	Review spread of training delivery	Reflect specification in MCP contract	Reduced mortability rate	

Must Do 9 – Improving Quality in organisations						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones** **(steps to delivery)**	**2018/19 actions/ milestones** **(steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
Priority 1 Develop revised quality assurance framework	A re-defined format for Clinical Quality review Meetings (CQRMs) based on clinical	• Provider based CQRMs established for all providers (now) • Multi-provider Safeguarding review meeting established (from Dec 16) • Pathways identified and principles of new process discussed with main providers (end 16/17)	Early adopter processes for CQRM with single pathway Self auditing arrangements established and agreed Develop patient representation, refine structure and roll-out. Reference patient engagement FFT etc Review/ refine for MCP		Review of impact of services via audit, internal and external	Royal College, NICE Guidelines. Care closer to home and community engagement. (Ensure patients with identified health needs access the right advice in the right place in a timely manner).
	The development of a mechanism for provider self-assessment	Proposed self-assessment template drafter (end 16/17)	Agree self-assessment Template CQRM		Review of impact of services via audit, internal and external	
			Roll-out alongside CQRMs		.	

Must Do 9 – Improving Quality in organisations						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones** **(steps to delivery)**	**2018/19 actions/ milestones** **(steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
	The development of a comprehensive CCG inspection schedule that is aligned with both providers' own internal audits and inspections and those from external agencies		Deliver agreed schedule Review schedule and agree for remainder of year Deliver remainder of schedule			
Priority 2 Monitor our providers and gain robust assurance on the quality of the care they provide	. Establish Datix as the standard incident management system in primary care	Datix implemented in CCG, UCC, and identified practices	Implement Datix (incidents) in all practices Implement complaints module pathways involving patient representatives wherever possible Enhance incidents functionality from user feedback involving patient representatives wherever possible		Primary care, community services, acute health services and wider locality systems become effectively integrated to improve outcomes by working collaboratively	

Must Do 9 – Improving Quality in organisations						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones (steps to delivery)**	**2018/19 actions/ milestones (steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
Support and encourage the delivery and continuous improvement of patient pathway-focussed services through a collaborative approach to continuous improvement through support and facilitation			Enhance complaints functionality from user feedback			
			Review impact of MCP			
	Provide Root Cause Analysis (RCA) training to primary care	Training package agreed and session (s) scheduled	Deliver training to PM and GP reps for each locality		Improved quality of RCAs	
			'Mentor' newly-trained individuals	For identified actions from investigations are shared across the health economy		
			Agree and deliver training package for other primary care staff			
	Review Systems in place for quality oversight to manage the provider processes for Serious Incident reporting and	Principles agreed (end 16/17)	E.G Implement revised pressure ulcer (PU) SI reporting process		Smart Systems in place and effective across all	
	reviewing of incidents		Implement further improvements		services	

Must Do 9 – Improving Quality in organisations						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones** **(steps to delivery)**	**2018/19 actions/ milestones** **(steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
Ensure providers deliver assurance that guidelines & recommendations from publications in response to avoidable deaths remains an integral quality and safety priority	Following the publication of National, local reviews and recommendations to reduce avoidable deaths all providers to provide a written response Ensure there are mechanisms in place to sustain rigorous investigations once an avoidable death has been identified	Targets for achieving recommendations with Providers agreed with CCG. Where service development is required, dates for implementation agreed	For providers to benchmark activity to demonstrate required improvements For providers to demonstrate measures taken to respond to findings with clear and agreed targets Document to form an integral agenda item for each provider as appropriate	Records maintained and actions implemented by provider. Where required training to be agreed and delivered to time scale. Monitoring of progress	Information to be shared in a consistent way. Assurance gained and evidence recorded within quality review meetings. Follow up with, announced and unannounced visits by CCG quality and safety team For joint working to take place as a priority with all involved agencies to ensure wider learning takes place	Patient Feedback via Friends and Family PALS Patient Advisory Networks NHS Choices
Priority 3 Maximising the sharing from t eh STP workstream of learning and	Develop a standardised	Principles agreed	Review of quality assurance policies and procedures	1. Managing service change requirements to meet strategic vision	• All CCGs managing provider assurance in a consistent way • Positive	Royal College NICE Guidelines Care closer to home

Must Do 9 – Improving Quality in organisations						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones** **(steps to delivery)**	**2018/19 actions/ milestones** **(steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
best practice across the Black Country, agreeing standard practices where appropriate	approach to assurance and improvement across all four Black Country CCGs	with other CCG.	Review new process for one pathway in each CCG		feedback from other CCGs	
	Support the Clinical Reference Group element of the STP Programme?	CRG defined and established (end 16/17)			• Progress of planned deliverables • NHSE approval of QA process	Health economies and MCP collaborate to develop stronger integrated relationships reducing duplication.
Priority 4 Support a clear and sustained a process of admission avoidance for the frail elderly population	Evaluate existing Systems and processes to assess benefits to the frail and elderly population by introducing the prevention agenda. 'manage care homes like a virtual ward'	Health-economy wide forum established			Changes to practice implemented as a result of health economy wide discussions. Clear measures in place to maximise wellbeing and quality of life providing care closer to home	

Must Do 9 – Improving Quality in organisations						
Priorities	**Key deliverables**	**Baseline position**	**2017/18 actions / milestones** **(steps to delivery)**	**2018/19 actions/ milestones** **(steps to delivery)**	**Success measure (inc reference to plan trajectories)**	**Relationship to other plans/programmes, e.g. RightCare, UECN,**
		Airedale framework defined and agreed Promotion of the Prevention agenda by community geriatricians				
Priority 5 To provide staff within Care Homes with the training and development to enable patients to remain the community	Enhance the training and education options for staff which allow continuous proactive management of patients in care settings and avoid admission to acute trusts	Training provision agreed and date for roll out defined.			Reduction of frail elderly admissions to acute trusts. Best use of resources	Evidence of consistently high quality 'Care close to home'