Health and Wellbeing Board

Monday 27th April 2015

Walsall Clinical Commissioning Group (CCG) Refreshed Operational Plan: 2015/16-2016/17

1. Background

Walsall CCG's Operational Plan has been refreshed to take into full account new NHS planning guidance, issued at the end of 2015, including the Five Year Forward View, The Forward View into Action: Planning for 2015/16 and the NHS Mandate 2015/16. This report summarises key elements of the refresh and has attached as appendices the refreshed Operational plan and plan on a page.

Note: The appendices have been sent to members of the Board and are available on the Council's Committee Management Information System (CMIS): https://cmispublic.walsall.gov.uk/cmis/Home.aspx

2. Recommendation

That the report be received for information and discussion

3. Report Detail

3.1 Walsall CCG Refreshed Operational Plan: 2015/16-2016/17

Walsall's Clinical Commissioning Group's (WCCG) previous Operational Plan covering the 2 year period 2014-15 to 2015-16 was formulated prior to the CCG adopting its Strategic Plan in July 2014 which covers the period 2015-19. This Strategy is based on the CCG's Vision, "To improve the health and well-being of the people of Walsall" and four related strategic objectives, which as illustrated in Figure 1, lay a solid foundation on which to build the CCG's refreshed Operational Plan covering the period 2015-16 to 2016-17.

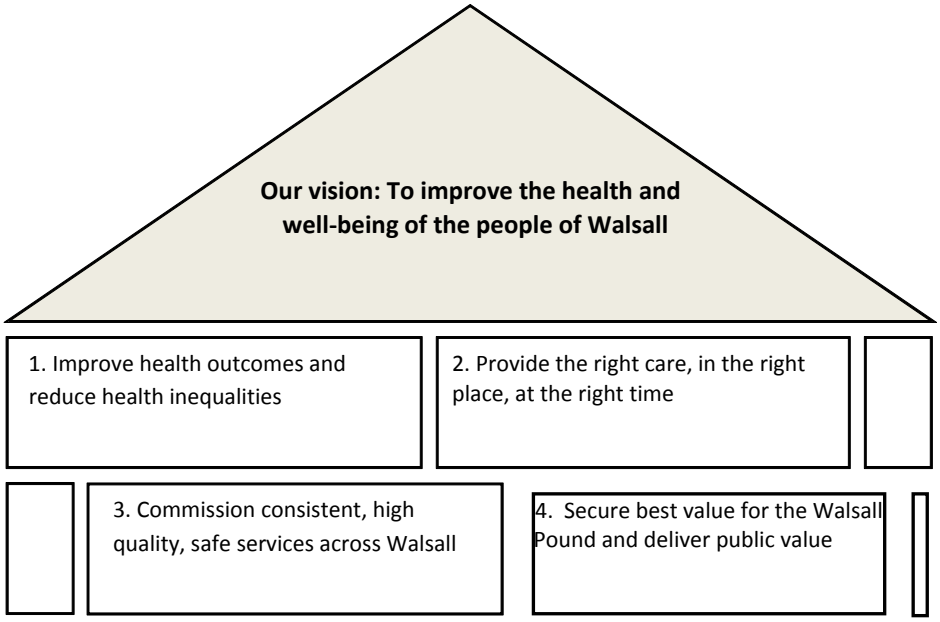

Figure 1 - Walsall CCG Vision and Strategic Objectives

As well as reflecting the Strategic Plan which itself was based on the refreshed Joint Strategic Needs Assessment (JSNA) for Walsall, the refreshed Operational Plan also seeks to demonstrate how the "Five Year Forward View" issued in October 2014, the "NHS Mandate 2015-16"and the related planning guidance, '"The Forward View into Action: Planning for 2015/16" will be delivered in Walsall through partnership working with other key organisations including the Local Authority, our key providers and the local third sector. Indeed, a further new key feature of this refreshed Plan is the Better Care Fund with its increased emphasis on integrated working.

Our engagement with member practices, with the public and patients through our "Call to Action", "Your Voice" events, and with Practice Patient Groups, identified a set of key priorities which remain in this Operational Plan period and that collectively seek to address the greatest challenges facing the Walsall Health economy:

I. Reducing emergency admissions to hospital with attention to improving the urgent care pathway as well as primary community and social care redesign;

II. Improving service quality and performance with a particular focus on improving and maintaining performance against Referral to Treatment standards (RTT)

III. Improving mental health and wellbeing and achieving parity of esteem

IV. Providing the right care, in the right place, at the right time with emphasis on improving primary care capacity to drive new models of care.

Further details on these priorities are given in **Section 2** of the Operational Plan which attached as an **Appendix**.

To support and give a rapid overview of the refreshed operational plan a plan on a page has been developed which describes the CCG's 4 key objectives in 2015/16, priorities for access , improved outcomes we expect to see, plans for improved quality and safety of NHS services commissioned, key transformation programmes in 2015/16 and our plans for delivering value. The Plan on page attached as an **Appendix**.

Please note at the time of drafting this report the refreshed Operational Plan and that of other CCGs nationally had not completed the NHS England assurance process but this is expected to have been completed by 14th April.

For information of members other sections of the Operational plan are as follows:

Section 3 sets out our detailed plans for improving services and patient experience through improved access, outcomes, quality, innovation and value.

Section 4 details how we will measure performance and monitor quality in order to ensure that our ambitions are achieved.

Section 5 summarises our Financial Plan which seeks to address the financial pressures and challenges which the Walsall Health economy will face in the next two years.

Section 6 describes the approach to Quality, Innovation, Productivity and Prevention (QIPP).

Section 7 provides the detailed Service Transformation and Redesign projects which are to be delivered by WCCG's revised planning structure which has been specifically redesigned to reflect the Strategic Objectives and Priorities set out in the Strategic Plan. This detailed work programme for 2015-17 will help WCCG make significant strides towards its end state ambitions described in the Strategic Plan 2015-19.

The final element of the Plan,

Section 8 describes our enabling plans and includes Information Technology, estates, workforce and commissioning support.

This all adds up to a bold and ambitious Operational Plan which will also be complex and challenging to deliver.

3.2 The National Context: Five Year Forward View

The NHS Five Year Forward View strategy document sets out the reasons why the NHS needs to change. These include an ageing population, rising patient expectations, quality and safety considerations, the rising costs of health care and the funding available to meet these, and others. These have given rise to a three-fold case for change:

1. The health and well-being gap – unless we change the health inequalities gap will widen.
2. The care and quality gap – unless models of care delivery change it could impact on quality and safety of services provided.

3. The funding gap – the need to match funding with wide ranging and sometimes controversial system efficiencies which may need us to decommission and/or recommission services in different and more cost effective or revising criteria on access to certain medications based on best practice.

The Five Year Forward View provides aspirations for a better future provided that the NHS and its partners ensure the right changes; right partnerships and right investments are made and support a radical upgrade in prevention:, new models of care and efficiency.

The CCG's refreshed Operational Plan is set in the context of the current WCCG strategic plan but takes full account of the 2015-16 planning guidance which sets out the first steps to realizing "The Forward View" demonstrating and evidencing what we will be doing to help move us forward from where we are now so as deliver improved outcomes for our population.

Key components of the "Five Year Forward View" include:

i. Getting serious about prevention;

ii. Empowering patients and engaging communities;

iii. Delivering the Better Care Fund and greater integration of services;

iv. New models of care including improved community and primary care services;

v. Local clinical leadership; workforce development;

vi. Embracing the information revolution and improved estate management

These are all essential ingredients to our approach so as to ensure that the conditions for successful transformation exist in Walsall and that the health economy is suitably equipped to respond well to the drivers for change described above.

WCCG is working closely with partners to develop a joined up approach to delivering transformation. The Boards of health and social care organisations have met and agreed the way forward. Our next steps include:

Reaching a shared view of the system challenges
- Taking stock of the initiatives we have already started
- Creating a case for change that meets all perspectives at a whole system level
- Defining how to communicate and take everyone on the journey

Agreeing how to arrive at a new model of care that meets the challenges above
- Designing in the avoidance of ready-made solutions
- Articulating a vision at a level that has depth and which is clinically owned

Developing the activity and finance implications up front
- Facing up to the difficult challenges as early as possible
- Using finance as one of the key design parameters (as well as activity and quality)

Developing an approach to ensure rapid transition from planning to doing

- Identifying and scaling the pump priming required
- Managing cost pressures and lead time to scale
- Prototype approach to replace pilots
- Agreeing the required set of behaviours to enable individuals to cope with scale and difficulty of changes

3.3 Walsall CCG planning footprint

Table 1 outlines the 'Unit of Planning' over the forthcoming operational planning cycle.

CCG	Unit of planning Operational Plan	Unit of planning Strategic Plan
Walsall	Walsall CCG coterminous with Walsall MBC.	• Walsall CCG • Walsall MBC • Walsall Healthcare NHS Trust (community and acute) • Dudley and Walsall Mental Health Partnership Trust.

Table 1 – Unit of Planning

WCCG recognises that it is working as part of a wider health and social care system and specifically with NHS England Area Team for Birmingham, Solihull and Black Country. WCCG will continue to work together with our partners including NHS England Area Team and other local CCGs.

WCCG will also be working very closely with partners on the local Health and Wellbeing Board to improve well-being in our community and positively impact on health outcomes. WCCG will continue to engage with work streams established to review on a cross CCG basis and in some cases led by NHS England, including Urgent Care, LTCs, Planned Care, Vascular Services, Trauma Care, Maternity, Stroke and Transient Ischemic Atrophy (TIA) services, Adult Mental Health, Pathology, right care right here, services for offenders and services for military veterans.

WCCG will also engage with local professional networks and accelerate transformational change programmes. For example, it will link with the local pharmaceutical network for the Black Country to learn and share best practice that can be used and/or adapted locally to speed up transformational change and improve the quality and value of services provided. WCCG recognises the value of engaging and working with other networks as a way of reducing duplication of effort by Clinical Commissioning Groups locally and optimising care pathways.

4. Relationship to Health and Wellbeing Board

The CCG is a key partner and an active contributor and leader of health care delivery in Walsall Borough.

Authors

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14 April 2015

NHS
Walsall Clinical Commissioning Group

Operational Plan

2015 - 2017

Version 2.9

Walsall CCG serves a population of 274,000 and is coterminous with Walsall MBC. This Operational Plan 2015/16 describes the actions we are planning to further deliver our strategic objectives as set out in our five year Strategic Plan.

Walsall currently faces many care challenges, including high levels of deprivation, a growing and ageing population, changing demographics with an increasing BME proportion, and a high level of unhealthy lifestyles. At the same time we have health and social services that are not well integrated, an over-reliance on A&E for out of hour's treatment and some services of insufficiently high quality. These factors contribute to the below average health of our population, including high infant mortality, low male life expectation, inequality of health across the borough and a growing number of people with long term conditions. Our task is to address these challenges especially the need to improve the performance of services we commission, whilst also needing to be more cost-effective through strong and robust annual operational plans.

Our vision is to transform this situation for the people of Walsall, and this plan will contribute by detailing actions that focus on improving health outcomes and reducing inequalities; providing the right care in the right place at the right time; commissioning consistent, high quality and safe services across Walsall; and securing best value for the Walsall pound and delivering public value. These are our four strategic objectives, and these include specific priorities around integrated care and mental health that are reflected in this Operational Plan. We have begun to work closely with partners to develop a system wide programme of transformation which delivers sustainable models of health and social care. This will enable us to exploit greater opportunities to provide more joined up care in ways that are more affordable and produce better outcomes for people.

Building on our Strategic Plan 2015-19 we have agreed as part of this Operational Plan local priorities, supported by a strong evidence base built on intelligence tools, national Commissioning for Value data packs and programme budgeting analysis. This analysis has also enabled us to define measurable ambitions and an improvement trajectory to monitor our progress towards our overall goal. These goals include reducing the level of emergency admissions in 2015/17 agreed as part of our BCF submission as a contribution to the target of 15% over 5 years and delivering savings in 2015/17 as part of our financial plan.

Cross-referencing to NHS Planning guidance – the "Five-Year Forward View, The Forward View into Action: Planning for 2015/16 including supplementary guidance" and the "NHS Mandate 2015/16", confirms that our resulting plan addresses the required characteristics, domains and ambitions for a robust and effective health economy.

We have developed strong governance processes to support and monitor delivery of this plan and will track performance against the improvement trajectories. We have also set out the enabling support strategies needed to enable delivery of these plans, including system leadership, finance, engagement, informatics, organisational development and estates.

Dr. Amrik Gill
Chair
Walsall Clinical Commissioning Group

Salma Ali
Accountable Officer
Walsall Clinical Commissioning Group

Table of Contents

Document reference information

Version:	2.9
Status	Draft
Director responsible	Strategic Lead for Service, Transformation and Redesign
Name of originator/authors:	Phil Griffin & Kelvin Edge
Date Ratified and by whom:	Health and Well Being Board CCG Improving Outcomes Committee CCG Governing Body
Date Effective From	1st April 2015
Review date:	This should be 6 months prior to expiry date
Expiry date:	31st March 2016
Date of Equality and Diversity Impact Assessment	Initial assessment 4th March 2014. Equality analyses to be conducted on commissioning decisions which are taken under this plan.
Target audience:	Stakeholders, NHS England Area Team, Public Health, General Public

Records Management: NHS Code of Practice

In accordance with the code of practice this document is classified as 'Business plans, including local delivery plans' with a minimum retention period of 20 years after which it will be destroyed.

Publish	Distribute and make available for distribution	From 10th April 2015
Archive	One calendar year from expiry date	31st March 2017
Destroy	Twenty years from expiry date	31st March 2037

Contribution List

Key individuals/committees involved in developing the document

Name	**Designation**
Phil Griffin	Strategic Lead – Service Transformation and Redesign
Kelvin Edge	Planning Manager
Anet Baker	Mental Health Programme Lead
Bharat Patel	Head of Primary Care & Medicines Management
Jane Hayman	Unscheduled Care Programme Lead
Wendy Godwin	Lead Commissioner for Planned Care
Kam Mavi	Head of Performance
Tony Gallagher	Chief Finance Officer
Paul Deeley-Brewer	Governance & PMO Manager
Alan Turrell	Strategic Lead for Planning, Contracting and Procurement (Interim)
Ian Staples	Lead Commissioner - Learning Disabilities, Physical Disabilities and Sensory Impairments, Autism, Carers and Employment Services
CCG Improving Outcomes Committee	Commissioning Sub-committee
CCG Clinical Operational Group	Operational Commissioning
CCG Programme Boards	Manage Project Portfolios
Member Practices	CCG Localities/GP Consultative Assembly
CCG staffing support Services	Staff Protected Learning Time
Salma Ali	CCG Accountable Officer
Yvette Sheward	Executive Lead for Integrated Governance and Organisational Development

Patients and public	Call to Action and Your Voice including Health watch and Voluntary Sector
Dr Paulette Myers and Martin Ewin	Department of Public Health Medicine, Walsall MBC
Health and well Being Board Members	Health and Well Being Board
CCG Governing Body	Accountable Body
Steve Corton	Head of Involvement and Inclusion

Circulated to all of the above for consultation

Version Control Summary

Significant or Substantive Changes from Previous Version

Version	Date	Comments on Changes	Author
0.1	12th Jan 2015	Initial draft – Format based on Walsall CCG 2014 - 16 Operational Plan.	Kelvin Edge
0.2	20th Jan 2015	Updated Section 7 projects as agreed by PG/AT & programme leads	Kelvin Edge
0.3	24th Jan 2015	Updates from programmes	Kelvin Edge
0.4	30th Jan 2015	Refreshed paragraphs 1.1 and 1.2	Phil Griffin
0.5	2nd Feb 2015	Refreshed paragraphs 1.3 to 1.6 inclusive	Phil Griffin
0.6	2nd Feb 2015	Further updates from programmes / formatting	Kelvin Edge
0.7	3rd Feb 2015	Steve Corton Amendments	Kelvin Edge
0.8	3rd Feb 2015	Read through and various amendments to Sections 1 to 5 inclusive	Phil Griffin
1.0	3rd Feb 2015	Version sent out to contributors and ratifiers to check	Kelvin Edge
1.1	4th Feb 2015	Amendments from Commissioning Leads	Kelvin Edge
1.2	9th Feb 2015	Update metrics in Section 7	Kelvin Edge
1.3	10th Feb 2015	Amendments from Paediatrics/Gynaecology/Maternity	Kelvin Edge
1.4	12th Feb 2015	Amendments from Mental Health and QIPP	Kelvin Edge
1.5	13th Feb 2015	Amendments from Learning Disabilities	Kelvin Edge
1.6	13th Feb 2015	Read through, amendments to UC sections	Phil Griffin
1.7	13th Feb 2015	Updated with current position on CQUIN development	Paul D-B
1.9	19th Feb 2015	Amendments from comments / 17th Feb meeting	Kelvin Edge
1.10	20th Feb 2015	General updates	Phil Griffin
1.11	20th Feb 2015	General updates	Phil Griffin
1.12	26th Feb 2015	Formatting Changes	Kelvin Edge
1.13	26th Feb 2015	Final Draft Formatting	PG/AT/KE
2.0	17th Mar 2015	Revised section 1.4.1.2 BCF and Integration to reflect joint work on integration with partners -reference Salma Ali	Phil Griffin
2.1	24th Mar 2015	Split Section 1 into 2 separate sections and add in MH comments	Kelvin Edge
2.2	25th Mar 2015	Paragraph 4.3 CQUIN updated	PDB & PG
2.3	26th Mar 2015	Section 2.2.1 Cancer and update Section 7 target figures	Kelvin Edge
2.4	30th Mar 2015	NHS England Assurance checklist requirements reflected	SMT
2.5	31st Mar 2015	Amendments to financial and Quality sections	PG, Tony Gallagher and Sally Roberts
2.6	31st Mar 2015	Amendments to Appendix Numbers and minor changes to text	Phil Griffin
2.7	2nd April 2015	Update Section 7 target figures & general tidy up	Kelvin Edge, PG and Alan Turrell
2.8	2nd April 2015	Additions to foreword, paragraphs 1.2 and 2.1.2	Salma Ali and Wayne Greenwood
2.9	7th April 2015	Final tidy up	Kelvin Edge

Section 1
Strategic Context

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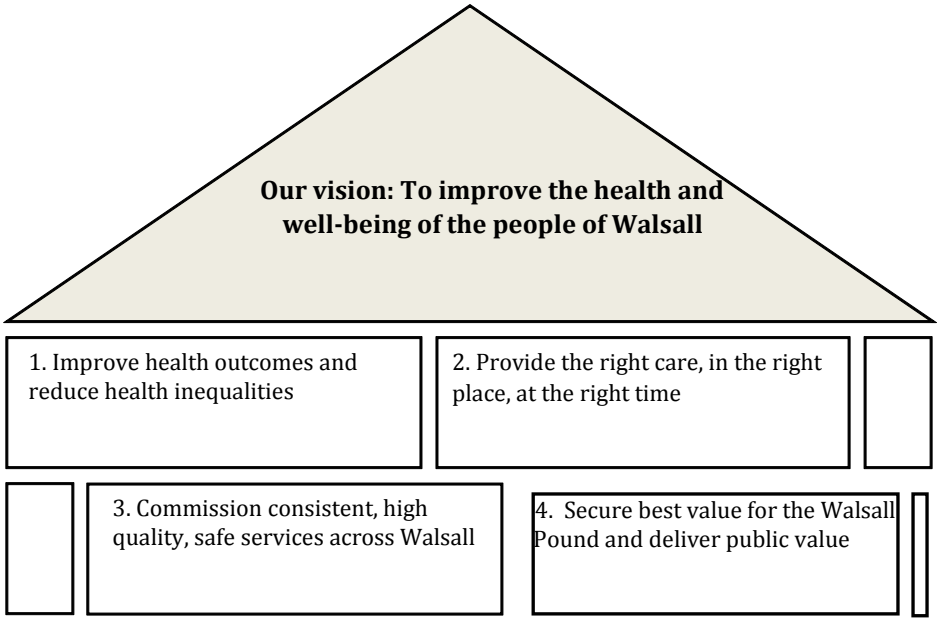

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Key components of the "Five Year Forward View" including: getting serious about prevention; empowering patients and engaging communities; delivering the Better Care Fund and greater integration of services; new models of care including improved community and primary care services; local clinical leadership; workforce development; embracing the information revolution and improved estate management and these are all essential ingredients to our approach so as to ensure that the conditions for successful transformation exist in Walsall and that the health economy is suitably equipped to respond well to the drivers for change described above.

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WCCG will also engage with local professional networks and accelerate transformational change programmes. For example, it will link with the local pharmaceutical network for the Black Country to learn and share best practice that can be used and/or adapted locally to speed up transformational change and improve the quality and value of services provided. WCCG recognises the value of engaging and working with other networks as a way of reducing duplication of effort by Clinical Commissioning Groups locally and optimising care pathways.

1.4 Walsall CCG Strategic Plan

In developing its Strategic Plan WCCG has responded to the requirements of national planning guidance, the key findings from the local JSNA and local WCCG commissioning priorities. The strategic plan provides the context within which this Operational Plan has been developed.

WCCG vision is to improve the health and well-being of the people of Walsall.

The vision is underpinned by the following values, which have been developed in consultation with our constituent members and key stakeholders:

Figure 2 – Organisational Values

- Respect and value people – Individuals are at the core of what we do.
- Listen to local people – We are committed to involving patients, clinicians and communities in the design and improvement of their services.
- Clinical leadership - We recognise and embrace the need for clinical leadership in service planning and redesign to ensure highest levels of quality, safety and efficiency.
- Clear accountability and transparency – We value feedback and a clear sense of personal accountability and responsibility.
- Innovation – We will make best use of all new technology, particularly striving to be at the forefront of innovation in exploitation of information technology.
- Prevention – We will prevent poor health starting early with families, children and young people.
- Partnership – We will work closely with our partners in health, local authority and voluntary sectors to ensure a holistic approach to promoting health and equality in the community.
- Public Value - Through our commissioning and procurement arrangements we will promote the creation of public value as measured by the social, economic and environmental impact on the community.
- Parity of esteem - Between physical health, mental health and learning disabilities. We will work to not only improve mental health and learning disability services, but also to change how people think about them, so that mental health and learning disabilities is truly 'on a par' with physical health.

These values are enshrined throughout our Strategy and set the standard for how WCCG conducts itself.

The CCG Strategic Plan identifies four Strategic Objectives:

- Improve health outcomes and reduce health inequalities.
- Provide the right care, in the right place, at the right time.
- Commission consistent, high quality, safe services across Walsall.
- Secure best value for the Walsall pound and deliver public value.

In order to deliver each of these Strategic Objectives, several Strategic Priorities have been identified as illustrated in Figure 3. Each of these priorities are supported by a number of trajectories for each of

the five years covered by the Plan together with a vision of where WCCG wants to be and the key interventions and delivery mechanisms.

Our Vision	Our Strategic Objectives	Our Priorities
Improve the health and well being for the people of Walsall.	Improve health outcomes and reduce health inequalities.	Reduce perinatal & infant mortality.
		Increase male life expectancy.
		Reduce the incidence of, and better manage LTCs.
		Improve mental health and well-being and ensure parity of esteem.
	Provide the right care, in the right place, at the right time.	Strengthen emotional health and wellbeing services for children and young people.
		Reduce emergency admissions to hospital..
		Bring Care Closer to Home
		Improve integration of primary, community and social care.
	Commission consistent, high quality, safe services across Walsall.	Enhance the public and patient experience.
		Eliminate recurring significant incidents.
		Improve service quality and performance.
	Secure best value for the Walsall pound and deliver public value.	Deliver cost efficiency programmes (including QIPP)
		Ensure the delivery of provider cost improvement plans.
		Ensure that services are provided by the most capable providers.
		Providers deliver benefits to the Walsall community.

Figure 3 - Walsall CCG Vision, Strategic Objectives and Strategic Priorities

These interventions have been identified through communications and engagement with our key stakeholders, specifically the public, service providers and public health. We have focused on interventions which have a strong evidence base in delivering better outcomes and value for money and best match the needs of our local population.

Section 2
Operational Plan Priorities

In developing this Operational Plan for 2015-2017, WCCG has reviewed the objectives, priorities and interventions within the Strategic Plan, which remain in place, but by taking into account the particular pressures and challenges facing the healthcare system in Walsall and the views of our stakeholders though our engagement activities, we have identified four areas for priority attention during this period:

1. To reduce emergency admissions to hospital: In 2015/17 Urgent care pathways will continue to be reviewed, transformed, and designed to produce better outcomes. The BCF will drive the integration of commissioning and provision to reduce emergency admissions to hospital of people aged 65 years and over. This will include primary, community and social care services redesign.
2. To improve service quality and performance: In 2015/17 we will continue to work with our main acute provider to maintain and assure quality and safety of planned care services including recovery of RTT standards. We will be working to ensure that demand management around elective care pathways is robust and focus on these areas: an agreed high level milestone plan for recovery; a single regular reporting system ; and have developed & agreed specialty level recovery plans.
3. To improve mental health and wellbeing and parity of esteem: In 2015/17 we will achieve dementia diagnosis, IAPT and additional access standards.
4. To provide the right care, in the right place, at the right time: In 2015/17 development of primary care (PC) provider capacity to support new models of delivery and PC co commissioning will be a key priority.

By concentrating on these areas, we will respond to the requirements stipulated within national planning guidance, the outcome of the joint strategic needs assessment, priorities agreed in the Health and Well Being strategy and local intelligence from the Call to Action work (where patient and stakeholder views were gathered).

As Illustrated in Section 4, our Operational Plan 2015/17 and local priorities align to:

- The six characteristics of high quality, sustainable health and care systems expected by NHS England in five years' time
- The five domains of better outcomes mandated through the NHS Outcomes Framework
- The seven critical ambitions that these systems must deliver, within the five domains.

Details of how we will address these areas through the Operational Plan are as follows:

2.1 Reduce emergency admissions to hospital

WCCG has achieved a level of success in reducing the increase in emergency admissions in 2014/15 keeping this to 2% compared to the previous year. This has been possible through the investment WCCG has made over the last 2 years in redesigning community services and other health system schemes including investing in social care, WMAS, Mental Health, NHS 111, GP, community based Discharge to Assess beds, enhanced GP medical support to Private Nursing Homes and voluntary sector schemes. Additionally we also commissioned additional winter capacity schemes from the local acute provider including an additional 29 bed Ward and enhanced medical and nursing staff. As part of the acute contract going forwards into 2015/16 we have agreed a further reduction in acute admissions of 2% from outturn with savings from this reduction being put back into WHNHST to further enhance the capacity of community services.

As illustrated in Figure 3, the reduction of emergency admissions is a strategic priority within the Strategic Plan and the 2.0% reduction target in 2015-16 is agreed with our local provider as part of the 2015/16 contract. It is a specific focus for the Operational Plan for 2015-17 and key components of WCCG's approach to achieving this are detailed below.

2.1.1 Urgent and emergency care

Reducing unplanned demand on acute services will remain a high priority given the recent performance of the health system. There are several elements to our local improvement programme of change as follows:

Urgent care review

The review and consultation was completed and reported in November 2014. The drivers behind the review include growth in urgent care attendances across the Borough, growth in emergency admissions, the local acute trust struggling to achieve the 95% 4 hour wait target, over performance on unscheduled admissions, the need to reduce emergency admissions over the next 5 years by 15% and patients being confused about which services they should access for their urgent care needs.

It concluded that WCCG should maintain the elements of the longer term plan described in the consultation document with a commitment going forward to resolve the issues identified by respondents including an assessment of urgent care cases in the North of the Borough.

The vision and therefore strategic direction approved by the Governing Body and assured by NHS England is:

To develop an Urgent Care Centre Hub - A unified Urgent and Emergency Care System in one building over 5 years. Some urgent care services will be provided together in one building. People would be able to 'walk' into the service at any time of the day for urgent care or be brought to the service by ambulance if they have an emergency need 24/7. The new centre will benefit patients in the following ways:

- There will be easy to access, open 24/7, providing the right care, in the right place, at the right time
- The new service would be based at Walsall Manor Hospital's A&E department and would be open 24 hours per day, 7 days per week for people who need urgent or emergency care.
- High quality services

Patients would go through one door and would be directed to the best service to deal with their problem. This could be 'expertise' provided by a GP, a hospital doctor or a nurse who will all have fast access to diagnostics and can route patients through appropriate pathways of care.

We believe that by bringing services together in one place we will be able to make it easier for patients to know where to go for help at any time of the day or night. We will also be able to improve the quality of care provided to patients, and services will be able to make the best use of resources such as staffing and have immediate access to diagnostics and community support services, so that patients receive the right care, in the right place and at the right time.

In pursuing this 5 year vision, the UC strategy will address the important issues raised as part of the UC consultation concerning:

- GP out of hour's access.
- WHNHST Emergency Department infrastructure.
- The perceived risk to business as usual services on the Manor site through implementing this vision.
- Public transport access to WHNHST.
- Car parking at WHNHST.

- A review of Urgent care access in the North of the Borough.

The priority in 2015/16 is delivery of the transitional model of UC to be operational from October 2015 which is dependent of 2 key projects- replacement premises for the current Walk in centre which is in area of redevelopment in Walsall Town centre and the procurement of a new provider who will offer UC services under a hub and spoke arrangement and work with WCCG to transition to the new model of UC access described above.

Systems Resilience Plan 2015/16

The evaluation of this year's winter plan schemes will inform the actions WCCG will be taking in the coming months as well as shaping the System Resilience Plan for this coming year. WCCG has increased the proportion of winter resilience funding available to the WHNHST from £1.1 million in 2014/15 to £1.6 million in 2015/16. The opportunity to increase this investment has arisen as a consequence of targeted recurrent funding from the BCF to enhance social worker and reablement services to contribute to the effective discharge process which was previously supported through the winter resilience allocation in 2014/15.

All current winter schemes have been carried forward into 2015/16 pending a review and assessment of their impact and to inform a decision if they should be commissioned again for a full year. This assessment is planned and the outcomes will be shared with SRG who will make the decision on what schemes (existing and new) should be commissioned in 2015/16.

WCCG has identified an additional £1.9 million in non-recurrent support for WHNHST to enable the creation of the infrastructure to deliver a planned reduction in emergency admissions of 2%. It is acknowledged that this support is a reduction on the £4 million made available in 2014/15 but of this total, £2 million represented the final contribution from WCCG to support the reconfiguration of A & E Services which will result in a new capital development at the hospital.

The WCCG and WHNHST urgent care demand and capacity modelling work will be refreshed in the summer of 2015 and assurance of robustness of the plans that emerge from this exercise and risk mitigation will be though the System Resilience Group (SRG).

Our demand and capacity modelling is based on an assumption that a 2.0% reduction in avoidable emergency admissions will be delivered by March 2016 as a result of WCCG plans for greater integration of community based services as set out in the Better Care Fund submission. This includes more effective integration of community health, social care, mental health and primary care services with the development of local multi-disciplinary teams linked to risk stratification and case management, co-location and joint assessment.

In addition, part of the BCF objectives is to swiftly and safely transfer people back to their own homes following an acute episode of care, and requires a coherent and efficient joint intermediate care service which will be made up of the current separate health and social care services. This service will have the skills of hospital discharge and social care reablement, linking with the wider multi-disciplinary locality teams, to agree with people the packages of care they most need at home. Through the Single Point of Access, there will be a menu of packages of services ranging from at the most intense, our specialist intermediate care beds in the Hollybank Unit, through to at the least intense, 'reablement ' which is available within 24 hours of request and provided for a specified duration of days/weeks depending upon the recovery time needed.

All risks to this programme will be captured in the Urgent Care risk register and will be reviewed by and assured by WCCGs Urgent Care programme and SRG.

Taking forward Keogh Report stage 1 recommendations

WCCG has an established System Resilience Group (SRG) and will address the requirements of the Keogh report through this forum although recommendations relating to the establishment of urgent and emergency care networks need to be addressed on a larger planning footprint involving other CCGs and providers. WCCG will work collaboratively with Black Country CCGs initially and then with Birmingham and Solihull CCGs concerning implementation of the report's recommendations.

Recovery of Urgent Care Performance

WCCG is working with local providers to ensure recovery and sustainable achievement of the 4 hour wait 95% target. This part of the Operational Plan provides an update on urgent care performance and the latest improvement actions designed to recover the 4 hour standard as follows.

- Context - Performance against the 4 hour standard has consistently failed to achieve the target – the Trust has failed to achieve the standard for 19 consecutive months (August 2013 – February 2015 inclusive). During the 2014/15 reporting year so far, there has only been 1 week where the 95% standard has been achieved on a weekly basis. This was w/e 28/09/14. At the same stage last year, the 95% target had been achieved in 21 of the 49 weeks

- Recent performance**-** Prior to Christmas there had been some progress where the scope of improvement was to go from 90% to 95%. However following the dip in performance in early January where the Trust experienced prolonged periods of escalation, we have not seen performance return to pre-Christmas levels as expected. The scope in February and March has been to recover and build but from a lower base of 85% to 90%, with a committed trajectory to achieve 95% at the end of March.

- Improvement actions- Walsall's SRG believe that the existing agreed set of actions are the right ones and that continued effort and greater implementation focus are required to fully embed the changes that drive the improvement impact. A recent Length of Stay (LOS) review conducted by Emergency Care Intensive Support Team (ECIST) with participation from across health and social care partners confirmed the need to press ahead with embedding improved ward round processes and better co-ordination of care for elderly patients. The plan to recover 4 hour wait performance remains based upon consistently delivering a co-ordinated set of priorities at pace under the following themes:–

  Reducing pressure on admissions:-

  - Primary Care admissions avoidance schemes targeting over 75s and at risk patients (WCCG).
  - Arrangements are now in place for an independent review by a public health specialist to review acuity and admission thresholds to better understand admissions during February and March 2015 (WCCG/ WHNHST).
  - Case management and support from Community Matrons in place and working to avoid admissions (WHNHST).
  - In-reach into nursing homes by community matrons in place and directly impacting on admissions from those homes (WHNHST).
  - Extended Urgent and Emergency Care Centre (UECC) service to include triage and manage patients away from Emergency Department (ED) (WCCG).

  Improving hospital flow and discharge management processes:-

- Recent ECIST review reconfirmed current action plan. This includes a concerted campaign to embed improved ward and board rounds; discharge summaries and checklists; assessment capacity; review and re-balancing of staff e.g. therapies support (WHNHST) as well as to accelerate progress on flow through Discharge to Assess beds (DTA) beds (WMBC).
- Critical friends now supporting key wards with their Board and Ward round processes to ensure that improvements are embedded and functioning.
- A Board to Board meeting between WCCG and WHNHST has led to agreement on key actions including introducing joint Geriatrician/GP clinical assessment in Ambulatory Care Unit (AMU) to avoid unnecessary admissions of Frail Elderly people (WHNHST /WCCG).
- Additional focus is being given as a system to strengthen weekend discharge arrangements leading to the ambition to have consistent 7 day discharge levels. (WHNHST to lead).
- Additional Community Matron input to AMU used in times of escalation (WHNHST).
- Input from rapid response into AMU to proactively manage patients out of hospital and back home (WHNHST).
- WCCG working with WHNHST to accelerate further training of Ward staff to enable a more rapid throughput of Continuing Health Care and Discharge Support Team CHC/DST assessments (WHNHST/WCCG).
- There has been agreement from all key stakeholders to undertake a further Breaking the Cycle initiative across health and social care (All).
- Easter plans are being confirmed to ensure that there is sufficient capacity over the bank holiday period, although this remains a risk. WCCG have also approved to fund the extension of winter schemes to cover Easter (All/ WCCG).

Improving flow through Discharge to Assess (DTA) beds:-

- Maintained funding for SWIFT ward following implementation of DTA model off site (WCCG).
- A joint weekly review of DTA beds is in place, with structured reporting and escalation. The team are working to agreed targets in terms of throughput and turnover. (WCCG/WHNHST/WMBC).
- Equivalent processes used to manage acute beds are being implemented with the step down beds, i.e. Expected Date of Discharge (EDD), care plans, patient choice policy, regular Multi-Disciplinary Team (MDT) review etc. (WMBC).

Smoothing the transition for patients from acute to social care

- Continuing to embed closer integration of processes between the acute hospital and social care to improve patient flow through step down and intermediate care capacity, including reducing readmissions to hospital (WHNHST/WMBC)
- Key actions include: improving the quality and rate of section 5s and subsequent turnaround of assessments; on-going frequent review of medically fit patients to expedite discharge; additional social worker & Occupational Therapy (OT) input into SWIFT ward (WHNHST/ WMBC)
- Reduction in the Medically Fit for Discharge (MFFD) list is being given special focus to ensure that there is a consistent pace and focus to helping patients transfer to the most appropriate care setting as quickly as possible
- Further work has commenced to extend the existing Frail Elderly Team towards stepping down frail elderly back in community (WHNHST/WCCG).

- Recovery planning **-** A revised recovery trajectory was proposed to the NHS Local Area Team at the beginning of February 2015, to achieve the standard in the last week of March. However performance has remained flat through February, beginning to rise in the first two weeks of March. Therefore further work was done to better understand the timing and impact of key actions in reducing breaches to the level required to meet the standard. An

analysis of improvement assumptions has been developed which sets out a number of scenarios based on three levels of risk. Initial discussions with NHSE and the Trust Development Authority (TDA) have begun with the expectation that the trajectory for recovery will be finalised at the end of March for subsequent agreement.

- Urgent Care summary & next steps - Pressure on all parts of the urgent care system has continued to constrain efforts to implement actions which will improve performance. The system has seen a step back in performance after Christmas which requires consistent and co-ordinated effort to address this deterioration in performance.

- System leaders have agreed a set of monitoring and escalation arrangements to maximise the progress and impact of planned improvements. These include a weekly follow up by Chief Officers on the key actions, and detailed review of issues as required, unblocking any delays.

Additionally a number of measures are being put in place to assure the overall improvement plan including;

- Additional oversight and assurance of improvement actions by SRG.
- ECIST/ independent review of plans.
- Added capacity and expertise to bolster operational leadership within Medical Division.
- Adding project support to the ward improvement project already underway.

2.1.2 Better Care Fund and integrated care

This is an important programme of change which WCCG has commenced with agreement of the BCF application and the establishment of an Integration Board. In summary it will involve new models of providing integrated care and develop further the joint commissioning approaches WCCG have successfully operated in Walsall over the past 5 years.

Walsall's Better Care Fund will initially aim to develop the integration of health and social care services in Walsall over the period 2015/16 from the current shape of service provision.

The vision for BCF as set out in our Health and Well Being Strategy and based upon our Joint Strategic Needs Assessment (see Walsall Metropolitan Borough Council (WMBC) website) is to maintain and where possible improve the independence, health and well-being of the people of Walsall. In doing so we aim to reduce the prevalence of emergency admissions to hospital, the number of older people who are receiving on-going social care services, especially admissions to care homes, from 2015/16 onwards as set out in our trajectories.

During 2014/15, working with key partners, we have further developed the vision to bring into focus the things we need to do in 2015/16 and beyond to get to where we want to be. Our Shared Vision is of a system commissioning and providing integrated care closer to home, together with a joined up public health, prevention, self-help agenda to enable us to respond to the challenges and pressures described in the 5 Year Forward View .

In order to respond to these pressures and ensure we are able to build sustainable health and social care services for our population, the four organisations providing health and social care in Walsall have committed to work together to deliver integrated care for our area.

Our commitment to working together is designed to support a shift away from reliance on the hospital and institutional bed-based care towards early detection, prevention and intervention and the provision of more care and support for patients in their own homes or an ambulatory or outpatient basis. This approach will also see us working more closely with community and third sector organisations to support a more community focussed approach to care.

We have begun to make changes that will support us in the delivery of this vision through the following initiatives:

- Integrated Locality Teams - Walsall Healthcare and adult social care have organised both adult community nursing services, social work and reablement into five locality teams each serving a population of c. 50,000 people. The teams are aligned to clusters of GP practices to support early identification and preventative care. Joint investment from WCCG and the Council in 2014/15 and in 2015/16 through the Better Care Fund has enabled us to expand the capacity of these teams. WCCG is also working with local GP practices on models that will bring practices together to collaborate to improve primary care services as part of this model.

- Intermediate Care - We have expanded our intermediate care provision through extending the capacity of our Rapid Response Team (providing a 2 hour response to prevent admission to hospital). The Rapid Response Team sees 200 patients a month and ensures that over 80% can be cared for without hospital admission. Other intermediate care developments include the joint commissioning of 40 Discharge to Assess beds in local nursing homes to support early discharge from hospital, an integrated reablement residential unit and a social care reablement service, working with primary and community health partners to deliver 24/7 step up and down service to prevent hospital and care admissions.

- Reduced use of nursing home and residential home placements - The council has maintained a very low level of admission to placements (in regional and national comparators) in nursing and residential homes supporting people at home instead.

- Case management and Targeted Support - All patients admitted to hospital as an emergency more than 4 times in 12 months are systematically reviewed by community matrons – 2/3rds of these have not been admitted since or only been admitted once. This approach is now being expanded with social and primary care partners in local multi-disciplinary teams with pro-active case finding of those most at risk of hospital and care home admissions. We have also provided community matron support to nursing homes and from April 2015 to residential homes to help avoid hospital admissions.

- Dementia Strategy - We have developed an integrated dementia strategy that includes work to increase early diagnosis by GPs (Walsall reached the national 67% target in 2014 ahead of target), dementia cafes and community support pathways, and support for older people with mental health difficulties admitted to the hospital.

- Our Plan in 2015/16 and beyond is committing WCCG to work with partners to develop a more integrated, community-facing model of care for our population - We have a set of broadly coterminous organisations with a shared vision of how WCCG and partners can create a more sustainable system and our current experience makes clear the scale of the challenge we face if we do not deliver change. We are developing joint leadership and board arrangements such as H&WB Board, with integrated commissioning well established between the Council and WCCG, and integrated service models with NHS and other providers under development.

- Making the most of our developing locality team model - Linking primary care, social care, community health services and mental health services to serve locality populations of c. 50,000 provides the building block for a system that can identify those at risk of needing admission to hospital or other institutional care and intervene early with packages of care and support at home.

- Improving the assessment and care of frail older people - Developing different approaches to the assessment or frail older people than avoid the need for attendance at A&E, or care home admissions, and provide a multi-disciplinary response at times of potential crisis provides the

potential to care for more people at home (including physical and mental health services). Linking the NHS Rapid Response Team and the Council reablement provision will extend the range of options available to us. This could also include "step-up" intermediate care capacity for patients who need extra support but do not need acute care.

- Extending our Intermediate Care Provision - Continuing to develop the range of care that we can provide for older people who have been admitted to hospital but who no longer need acute care is another priority for our system. This could include better working together on discharge planning as well as ensuring that we have high quality step-down and discharge to assess capacity (potentially in newly built accommodation to ensure we have services that fully fit for purpose). Building in effective support for older people with mental health difficulties to help them return home will be critical to this.

A set of potential enabling arrangements will help us deliver this vision successfully and include:

- Closer working between health and social care partners to define and agree a coherent journey of transformation which delivers sustainable models of care.

- Further development of joint leadership across the health and social care system, with both integrated commissioning and new models of service delivery in the community.

- Flexibility to use resources across organisations and across health and social care to support the development of the right services in the right place.

- Flexibility of institutional arrangements to enable us to develop partnerships / joint ventures to commit resources and jointly invest in services provided across a number of organisations e.g. an Older People's Hub providing multi-disciplinary assessment across health and social care organisations.

- Flexibility of health and social care funding - to enable us to share risk and develop incentives to provide care at home wherever possible.

2.1.3 Community Services Redesign

This is covered in more detail later in the plan however WCCG expects that this priority will be directed towards both adults and children including those people with mental health issues problems, to ensure the swift return of all people to their own homes, places of work and educational establishments, whilst supporting and promoting and maintaining their independence. This will include the redesign of current provision, and delivery of a community services commissioning strategy that ensures services deliver against national outcome measures as well as embracing the following elements of provision:

- Intermediate care.
- Re-ablement.
- Primary care.
- Acute care management.
- Rapid response.
- Hospital at Home (Paediatrics).
- Continuing Health Care (where necessary).
- Admission avoidance.

2.1.4 Improved Self-care & Management of Long Term Conditions

As a priority WCCG will be focusing on diabetes and respiratory as follows:

- Respiratory - To prevent people from smoking and to support those who do smoke to stop. In addition, robust approaches to managing the condition, monitoring and aggressive treatment of flare-ups will prevent or shorten hospital stays and reduce days lost from work. This will include redesign of respiratory care pathways and specialist roles within it to support primary care management of exacerbations of Chronic Obstructive Pulmonary Disease and Asthma.
- Diabetes - To continue to develop approaches to improving patients feeling that they are better equipped to manage the disease by enrolling and taking part in structured educational programmes. To undertake more awareness raising work in schools, temples, community groups, patients and carer networks and workplaces.
- Develop the use of technology especially around LTC's in general practice like Sycamore House Medical Centre where patients can:
  - Access information on self-help.
  - Health apps.
  - Request medication.
  - Review their medical records.
  - Have web consultations.
  - Book an appointment online.
- Prevention and diagnosis through early identification of risk through PRIMIS searches leading to referrals to lifestyle services, education etc.

2.2 Improve Service Quality and Performance

It should be noted that at the time of developing both the 2014-16 Operational Plan and the Strategic Plan, adherence to the 18 week RTT standard was not an issue for WHNHST and therefore, in itself, was not identified as a key area of priority. However, given the poor performance during 2014-15, this is now a key priority for the Walsall health economy.

2.2.1 Recovery of Referral to Treatment times (RTT)

The position of WHNHST in relation to its elective care compliance to national reporting standards is given below. The Trust has a significant backlog of elective activity which has grown for a number of reasons, including but not limited to problems with the accuracy and validity of data within its patient waiting list system following the implementation of Lorenzo.

Considerable focus has been given to restoring confidence in the accuracy of data and the Trust is participating in a national validation exercise. In the meantime the Trust's Board has chosen to withdraw from national reporting with the expectation of being ready to restart at the end of Q1 2015-16.

The following factors have driven RTT performance:

- The introduction of a new patient management system in February 2014 led to difficulties in accurately identifying the number of patients waiting for elective care.
- Considerable focus has been given to validating the output from Lorenzo to arrive at numbers which could reliably inform activity planning.
- Growth in elective demand across a number of specialties.
- Potential underlying mismatches between existing capacity and the growth in demand may also have been surfaced through the validation process.

Actions taken to support recovery include:

- Capacity within NHS and Independent Sector (IS) market sought and provided to support reduction in breaches/waits.
- Primary Care clinical expertise offered to triage waiting lists and support appropriate patient choice.

- Funding of additional administrative support to the hospital's operational team.
- Senior support provided to help with the development of recovery planning.

Further agreed actions are grouped as follows:

- Primary Care:
  - Campaign with GPs to help manage patient expectations with referrals to alternative treatment provision and reduce pressure on the most challenged specialties.
  - Communicate advice at locality meetings, share info on private sector providers, specialties, locations and referral criteria, noting that WCCG will fund patient transport costs.
  - Given the relatively low use of Choose and Book, WCCG will consider a short term practice incentive scheme to encourage greater use at Walsall GP practices.
  - Visit practices where there are low referral rates through Choose and Book as these are the practices that are primarily referring to WHNHST before alternatives.
  - Accelerate and help place work with other hospitals and with the independent sector. The purpose is to explore options to secure capacity contractually.
  - Seek opportunities to source WCCG funded consultant sessions to look at Patient Treatment List (PTL) and identify the appropriate patients for treatment.
  - Continue to provide additional capacity and expertise from WCCG.

- WHNHST Trust Plan - Reporting & Data Quality:
  Progress to date includes:
  - Combined internal and external validation exercise checking and correcting data issues.
  - PTL reduced from over 40,000 to 32,000 (10,150 over 18 weeks).
  - Work with the Elective Access Team to improve data accuracy at source. Weekly difference between clock starts and clock stops reducing from c. +900 to c. +300.
  - Participating in national validation exercise.

  Next Steps include:
  - Estimate that "correct" PTL will be c. 23,000 patients. Compares to c. 14,000 before Lorenzo "go live".
  - Continue trust validation effort and continue to work with Elective Access Team to eliminate data errors at source.
  - Data accuracy to be tested by national validation exercise.
  - Current expectation that Trust will be ready to seek approval to start reporting by end of Q1.

- WHNHST Trust Plan - Booking & Scheduling:
  Progress to date includes:
  - New operational arrangements for outpatient booking and scheduling – clinics booked six weeks in advance. Weekly Outpatient Improvement Group led by the Chief Operating Officer (COO) to ensure delivery.
  - Trust Patient Access Policy in process of updating based on ECIST advice.
  - Additional staff recruited to boost capacity in the Elective Access Team.
  - Outpatient activity returning to levels pre-Lorenzo.

  Next Steps include:
  - Address continued operational difficulties with outpatient clinic booking and medical records. Final "big push" to address this in Q1.
  - Ensure clinical directors and consultants have greater input into and ownership of booking process.
  - Review clinic utilisation to ensure maximum value from all extra clinics and especially additional activity.

- WHNHST Trust Plan - RTT Recovery:
  Progress to date includes:
  - Focus on Longest Waits.

- Maintaining 52 week maximum wait.
- Polling ranges in Choose & Book to be reduced to c. 6 weeks to provide increased scope for focussing on longest waiting patients.
- Weekly PTL meeting to ensure specialities are focussing on treating longest waits to bring down maximum wait.

Next Steps include:

- Continuing to operate a high level of internal waiting list activity.
- Steady flow of orthopaedic patients to the Royal Orthopaedic Hospital (ROH), appointment of locum spinal surgeon, appointment of urology locum consultant.
- Working with independent sector re RTT access and protocols.

- Specialty Recovery Planning:
  - Specialty by specialty recovery planning process based on engagement with clinical team and review of demand and capacity is being delivered by external consultant.
  - Recovery trajectories set of 14 specialties with smaller backlogs to be achieved by end September 2015.
  - Work in progress for end of March on 7 specialties with largest backlog (65% of PTL) including orthopaedics, gastroenterology, cardiology, general surgery and gynaecology.
  - Will set out monthly activity levels delivered through mainstream capacity. Internal waiting List Initiatives (WLIs), use of other Trusts and independent sector capacity and expected impact on over 18 week PTL.
  - Will also need to consider backlog of follow-up patients waiting longer than indicated.
  - Exploring impact of temporary restriction on referrals from outside Walsall – will assess scale of impact versus level of disruption to non-Walsall commissioners.
  - Focus on ensuring delivery of max 6 week wait for diagnostics. Remaining issue with endoscopy capacity is now being addressed. Radiology team undertaking additional work to reduce waiting times for reporting of tests once undertaken

- Assurance and Governance arrangements of the RTT Recovery Action plan above are through:
  - RTT recovery Board.
  - Elective access working group.
  - Monitored through SRG.
  - WCCG Governing Body.
  - High degree of focus through NHS England Area Team (AT) and TDA.

  The plans for recovery of the NHS constitutional RTT targets for admitted, non-admitted and intermediate has been included in WCCGs UNIFY submission and has been discussed at length and in detail with NHS England AT and TDA. The recovery plan is robust and WCCG is assured that the actions planned are the right ones; however recovery of the RTT standards represents an area of risk for this Operational Plan.

2.2.2 Cancer

WCCG has a relatively poor outcome and spend position in relation to its statistical peers in the following areas:

- Alcohol attributable admissions (breast and lower GI cancer).
- % breast cancer detected at an early stage.
- Bowel cancer screening.
- Non-elective spend (lower GI).
- % of colorectal cancers detected at an early stage.

WCCG has plans to improve early diagnosis for cancer and to track one-year cancer survival rates by:

- Working with WHNHST to produce new 2 Week Wait referral forms for different cancer sites based on the new NICE Cancer guideline which is due to be published soon. This will help to guide GP on appropriate 2WW referrals.
- Delivering a series of educational updates for GPs with the support of WHNHST and Macmillan to improve early diagnosis of cancer and appropriate use of local pathways.
- Reviewing the referral pathways with the relevant specialist consultant's, starting with Gastroenterology.
- Walsall Feel Good, Move More programme, sponsored by Macmillan, is a new physical activity pathway for cancer patients to encourage uptake of physical activity in order to improve survival, health and wellbeing which is due to start in April 2015.
- Reviewing data of Bowel Screening Uptake for Walsall and work with Public Health to increase uptake of bowel screening especially in BME group and deprived areas. This will lead to earlier diagnosis of bowel cancer and improve 1 year survival rates.
- Wider public communications programme with regard to bowel screening take up which we will be doing over the next 6 months to better improve take up.
- More local work via the Pharmacy Campaigns.

In relation to cancer waiting time standards , 2 week wait (all cancers), 2 week wait (breast symptoms) and 62 day first treatment , WCCG is working with WHNHST though agreed remedial action plans, to ensure these standards are recovered and sustained during 2015/16. However while WHNHST has identified the main causes of not meeting the standards which include patient choice and DNAs, WCCG will be working with the provider to learn and understand the underlying causes of not meeting these standards in more granular detail and with a view to developing a clearer plan to sustain performance of these standards through 2015/16.

2.3 Improve mental health and wellbeing and parity of esteem

Improve Dementia diagnosis rates and Improving Access to Psychological Therapies support remains as priorities to ensure equalities within mental health services and also with physical health are improved.

WCCG will be looking to strengthen its response at the front end of the Mental Health Crisis Intervention pathway. This is referred to as part of the Urgent Care pathway review but specifically it will involve the merger and housing of the of the two mental health nursing teams who work out of the A & E department at WHNHST, Psychiatric Liaison Team and Older Peoples Mental Health; review of the Mental Health Crisis Car; crisis teams and also enhancing as resources permit the Crisis Response and Home Treatment Team's capacity.

WCCG is committed to a key NHS Mandate for 2015/16 to achieving better access and waiting time standards for patients under Mental Health Services. This includes specific standards for Improving Access to Psychological Therapies (IAPT) services that not only ensure at least 15% of adults with relevant disorders will have timely access to IAPT, with a recovery rate of 50%, but also that by March 2016 75% of people referred to the IAPT programme will begin treatment within 6 weeks of referral, and 95% will begin treatment within 18 weeks of referral. The NHS Mandate also sets out a standard that more than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral.

WCCG has agreed specific service development and improvement plans (SDIPs) within the 2015/16 contract with the prime mental health provider which will enable us to effectively monitor delivery of these standards, and in doing so ensure that no person waits longer than is necessary for a course of treatment, thus improving longer term mental health, physical health and recovery-focused outcomes and reducing the distress experienced by individuals and their families.

2.4 Provide the Right Care, in the Right Place, at the Right Time

As illustrated in Figure 3, this is a strategic objective within the Strategic Plan 2014-19 and a key component to address this is improved primary care. However, since the Strategic Plan was agreed WCCG has significantly sharpened its vision for the development of future primary care services and therefore it is appropriate for this to be highlighted within this Operational Plan as it will be a key focus over the next two years. Key components of this approach are as follows:

2.4.1 Developing primary care at scale

WCCG has been on a programme of transformation which began with scoping the development of primary care services in early January 2014 to identify why there is a need to change, barriers to change and how WCCG could support/enable that change to happen. This has led to a programme of transformation which has been successful in achieving behavioural change; with GP practices exploring how they can work differently to improve their productivity, improve patient care and deliver services at scale. There a number of key reasons why general practice needs to change in terms of:

- Meeting the changing needs and expectations of the population.
- Improve outcomes and tackle inequalities.
- Maximise limited resources across the system.
- Secure a sustainable service for the next decade.

WCCG is considering options for supporting general practice to take the journey to the next level so they themselves are in a position to take the development of new organisations forward. The formation of new primary care organisations will support WCCG to achieve its strategic objectives and support development of the primary care infrastructure for more integrated care to be delivered in community settings. This will also reduce the transactional aspects of commissioning by contracting with larger primary medical providers rather than 61 individual providers.

2.4.2 Co-commissioning of Primary Medical Services

CCGs have been given the opportunity to expand and strengthen primary care provider with greater influence over the wider NHS budget. WCCG made a submission for joint commissioning of primary medical services with the Area Team from 1 April 2015 moving to full delegated responsibility from 1 April 2016. A task and finish group was established to take this work forward and a formal submission was made on 26 January 2015. The Joint Commissioning Committee will be the vehicle to manage the transition of primary care commissioning from NHS England to WCCG.

The role of the committee shall be to carry out the functions relating to the commissioning functions of primary medical services which includes GMS, PMS, APMS contracts, newly designed enhanced services, design of local incentive schemes, etc. There are a large amount of operational aspects that still need to be worked through in detail and WCCG has agreed to work with the Area Team to develop an open, transparent and consistent approach through the transition to joint commissioning and beyond. There are resource implications for WCCG which are also being worked through: a range of issues have been feedback to the national team.

2.5 Engagement

The plan has been informed by local engagement with patients, service users, WCCG member practices, staff and the public. In response to Call for Action there has been an on-going programme of public and stakeholder engagement branded as “Your Voice”. A specific, wide ranging stakeholder event was held in November 2012 and further events in 2013 that have been used in setting planning priorities for 2014 - 2016. The input from the public, providers, clinicians and other stakeholders informed the decision making and the planning process.

As part of our strategy development further engagement is planned, this will also involve Healthwatch Walsall and Walsall Voluntary Action – the voice of Walsall's Voluntary Sector.

There is a programme of engagement events for the year ahead which will include events involving staff and the Carers Partnership Board. Particular emphasis on the scope of this plan will be given to the co-commissioning of primary medical services where only limited patient and public engagement has so far been possible. The implementation phases of the priorities identified in this plan will themselves necessarily include engagement and involvement for people affected by service reconfiguration, pathway design or re-design, or other changes.

WCCG is working with its local commissioning and provider partners to ensure that the engagement we all undertake is proportionate, and as far as possible offers complementary activities between organisations. In this way we seek to maximise the effectiveness of public and service user engagement; reduce duplication of effort across linked and overlapping programmes; and to avoid the risk of 'consultation fatigue' in our local population.

2.6 Operational Plan Sign Off

As part of the process involved in issuing commissioning intentions, contract preparations and negotiations, WCCG has formalised and agreed plans for 2015/16 with its main providers WHNHST and Dudley & Walsall Mental Health Partnership NHS Trust (DWMHPT). The formal agreement and signed contracts, which incorporate agreed priorities, were completed in accordance with national timescales. In addition there has been a process to seek agreement of the priorities reflected in WCCG's commissioning intentions and the QIPP priorities, with GP Localities actively engaged in this process. WCCG has additionally sought and been given assurance by the local Health and Wellbeing Board. The Health and Wellbeing Board have endorsed the priorities reflected in Strategic Plan and this Operational Plan.

The following chapters' sets out WCCGs delivery processes for the priorities summarised above.

Section 3

Improving Services and Patient Experience

This section describes the initiatives that will be used by WCCG to improve services and the patient experience through the delivery of improved outcomes, ensuring good access to services, applying innovation and delivering improved value.

3.1 Outcomes

3.1.1 Delivery across the five domains and seven outcome measures

As described in Section 1, WCCG wants to work in partnership to improve the health and well-being of the people of Walsall. WCCG will use the measures set out in NHS Outcomes Framework, other national planning guidance. Section 5 of this Operational Plan sets out the improvement trajectories WCCG have agreed for the national outcome framework measures.

3.1.2 Improving Health

The Health and Wellbeing Strategy recognises the need to foster personal responsibility for wellbeing within an environment that facilitates good health and wellbeing for all. All residents and organisations within the Borough have a part to play in this. Promotion of good health and wellbeing is complex and requires wide engagement with communities and strong, coordinated partnerships across organisations. The Health and Wellbeing Board (HWB) has recognised this and signalled its intent to work towards this. It should be recognised that some determinants of wellbeing cannot be influenced by local action alone and require strategic action on a national level.

The life course approach (The Marmot Review) recognises the significant relationship between early intervention and outcomes in later life. For this reason the local JSNA recommends that the core of the Health and Wellbeing Strategy comprises action to:

- Support families and parents to promote development of strong, resilient and healthy children and young people.
- Promote engagement in education and attainment across the life course.
- Promote employability and 'good' employment for all residents.
- Reduce the personal, social and economic burden of preventable disease and disability at all ages by tackling the BIG FOUR:
    1. Reduce the uptake and duration of smoking.
    2. Make healthy eating easier.
    3. Identify harmful drinking and intervene early on.
    4. Promote active lifestyle choices.
- Extend healthy and independent living in old age by maintaining active lifestyles, identifying memory problems early and supporting recovery from episodes of illness.
- To continue to improve flu uptake rates for the at risk groups.

Key recurring priorities for action from the Health and Wellbeing Strategy include:

- Embed health and wellbeing into all local planning activity – including good housing, access to good food, leisure and the promotion of active travel.
- Ensure focus on the promotion of environments that support wellbeing and healthy lifestyles, maximising opportunities in:
    - Workplaces.
    - Schools.
    - Communities via Area Partnerships.
- Ensure focus on prevention and early intervention through:
    - Making Every Contact Count.
    - Encouraging participation in National Screening Programmes and NHS Health Checks.
    - Ensure robust pathways of care for all long term conditions across the healthcare economy.

3.1.3 Reducing health inequalities

WCCG will continue to use its commissioning resources as part of a partnership approach to address health inequalities in the Borough. Particular priorities derived from our JSNA are male life expectancy and infant mortality

3.1.3.1 Improving and closing the gap in life expectancy including people with severe mental health needs

Our improvement ambitions for 2015/16 are for male life expectancy of 78.42 years and to close the gap in Life Expectancy and increase life expectancy for mentally ill patients within the Borough. The gap between the most deprived and affluent areas of Walsall (years) and between men (currently 10.36) and women (currently 7.62) through coordinated HWBB interventions and prevention programmes

WCCG will be working with partners to deliver a range of initiatives to improve male life expectancy including:

- Partnership action to reduce the impact of smoking and obesity in the borough.
- Robust response to the main causes of death in the borough with a focus on prevention and early detection.
- Maximise opportunities to influence lifestyle choices through the Making Every Contact Counts initiative.
- Encourage participation in NHS Health Checks and national screening programmes.
- Robust pathways of care across all health care providers.
- Improve the access to physical health checks for adults with psychosis and schizophrenia.

In relation to infant mortality our improvement ambition for 2015/16 is to reduce the Infant mortality rate per 1000 live births to 7.2, WCCG will be working with partners to deliver the following range of initiatives over the strategy period to reduce infant mortality:-

- Improving antenatal care through encouraging early booking for antenatal care, continuity of care through pregnancy and improved detection of intrauterine growth restriction (IUGR).
- Reducing levels of maternal obesity and smoking in pregnancy through projects such as Maternal and Early Years, Smoke-Free Homes, improving smoking cessation in pregnancy and working with ethnic communities to reduce the use of ethnic tobacco products.
- Maintaining an effective antenatal and new-born screening programme.
- Reducing sudden unexpected death in infancy (SUDI) and improving breastfeeding initiation and continuation rates.
- Target vulnerable groups through specialised programmes such as the Enhanced Community Genetics service and the Family Nurse Partnership.
- Develop and improve access to psychological support for perinatal mental health.

In relation to the 20 year gap in life expectancy for people with severe mental illness WCCG needs analysis predicts that by 2018 we will have 1049 people with a severe mental illness such as schizophrenia and that this number will continue to grow unless early interventions to address symptoms are developed and commissioned. It is recognised that providing support from as early as possible can build resilience from early childhood experiences and influence lifestyle choices into adulthood. It is identified that people who have a severe mental illness also have physical co morbidities that have influence on the life expectancy and can result in this cohort having a life expectancy of 15 – 20 year less than their counterparts who do not have a mental health issue. To reduce the morbidly in this group will be a long term strategy and will be multi-faceted in its approach. Particular service challenges are as follows:

- Childrens' Mental Health
  - No mental health support for pre, anti and post natal care.
  - Lack of access to talking therapies for children and adolescents.
  - CAMHs provision ends at age 17.

- Adult Mental Health
  - 80% of GP provision in surgeries has links to mental health.
  - Most of the adults with SMI (Serious Mental Illness) who are stable still remain in secondary care.
  - Limited provision for CBT, DBT and talking therapies for personality disorder services.
  - Physical health associated with Mental Health is not always addressed in line with parity of esteem.

WCCG needs to address these challenges if life expectancy of people with severe mental health needs is to improve. Therefore, priorities for this Operational Plan period that addresses early years and adult mental health needs are as follows:

- Developing the pathway for perinatal mental health to ensure those who have and identified and those who develop a psychosis during and post-delivery have the most appropriate access to mental health support for at least 12 months post natal.
- Further develop access to talking therapies for children and adolescents.
- Work in partnership with the Liaison and Diversion team to support emerging personality and behaviour interventions to prevent escalation and entering the criminal justice pathway.
- Review and develop a CAMHS service that will provide support from 0 – 25 years.
- Continue to deliver a series of educational updates for GPs with the support of DWMHPT to improve mental health knowledge and access to appropriate use of local pathways.
- Improve and develop the early intervention in psychosis to ensure a 2 week from referral to treatment time.
- Further integration of physical and mental health checks (at least yearly).
- Reviewing the referral pathways with the relevant specialist consultant's, and the use of crisis support.
- Review to actions for the NSA2 (National Schizophrenia Audit) 4 areas:
  - Provision and experience.
  - Physical health.
  - Prescribing practices.
  - Demographic makeup.

- By focusing on the areas of physical health needs and the appropriate use of drugs and lifestyles in the longer term we should be able to reduce the levels of obesity, diabetes and smoking in this client group by monitoring:
  - Smoking cessation.
  - BMI checks.
  - Abnormal glucose control.
  - Blood pressure.
  - Alcohol misuse.
  - Substance misuse.

3.1.3.2 High Impact Interventions

The National Audit Office (NAO) Report "Tackling Inequalities in life expectancy in areas of worst health and deprivation" 2010 recommends widespread, systematic adoption of the most cost-effective high impact interventions i.e.

- Increased prescribing of drugs to control blood pressure.
- Increased prescribing of drugs to reduce cholesterol.
- Increase smoking cessation services.
- Increased anticoagulant therapy in atrial fibrillation.
- Improved blood sugar control in diabetes.

The report recommends:

- Targeted approaches to case finding in hypertension, Chronic Obstructive Pulmonary Disease (COPD), lung cancer, cardiovascular risk and harmful drinking will improve outcomes and reduce health inequalities.
- Integration of care and services, so that they are commissioned around the needs of the patient and community rather than the needs of the professional or the service.
- Implementing Making Every Contact Count initiative, which systematically puts the prevention, protection and promotion of health and wellbeing at the heart of every patient contact in the NHS.

These approaches are being pursued by WCCG and it will continue to take into full account (in this and future Operational Plans) the findings and recommendations of the NAO report.

Lifestyle services commissioned through Public Health, Walsall MBC, help to tackle health risk factors, and are inbuilt to care pathways and accessible through "one telephone call". WCCG will continue to work with Health and Well-Being partners to tackle the wider determinants of health and health inequalities in the Borough. Recognising that it is not just WCCG that can make all the difference, the contributions of other partners reflected in the recommendations of the HWB strategy and JSNA, and for which partner organisations are individually responsible for progressing, are also very important in addressing the needs of the more vulnerable groups in our community including the homeless, migrants, Black Minority Ethnic (BME) communities and Travelling Communities. WCCG for its part will continue to develop Primary Care quality and access for these groups as well as the wider population and continue to ensure that NHS contracts with acute, mental health and learning disability providers are sensitive to the needs of these communities.

3.1.3.3 Parity of esteem

WCCG will be working to improve services to those suffering from dementia, needing access to psychological therapies and mental health crisis resolution. Section 7.5 of this plan describes how mental health is a high level priority for WCCG and its work programme is fully engaged to bring mental health to the same prominence as physical health by putting people on a par with patients with physical health needs.

3.1.3.4 Equality and Diversity Strategy

Equality considerations are central to WCCG's vision of providing a personal, fair and diverse health service and it has a strong commitment to integrating equality and celebrating diversity within all that it does. WCCG's equality objectives were published as part of its Equality Strategy and Action Plan in October 2013 and will continue for the duration of this plan. WCCG has decided to make use of the Equality Delivery System (EDS2) to look in detail at particular pathways including urgent care, dementia and rehabilitation for adult mental health and to consider how these pathways serve people from different protected characteristic groups. WCCG's strategy and action plan, and its most recent Equality Information Summary (January 2015) can be accessed at this **link**.

WCCG has stayed up to date with the development of the NHS Workforce Race Equality Standard and two briefings have been considered by the Safety Quality and Performance Committee in September

2014 and in January 2015. Our Head of Involvement and Inclusion has attended two workshop sessions held by NHS England to develop the metrics which will be used to assess progress. WCCG has also discussed with its provider organisations their state of preparedness for implementation of the WRES. At the time of writing we are awaiting answers to some specific questions raised by WCCG in relation to definitions and the implementation timetable and we are planning, with support from our HR partners in Midlands and Lancashire CSU, to collect data for each of the 9 metrics.

3.1.3.5 Outcome measures

WCCG has embedded equality and diversity considerations into its commissioning processes (such as business planning; policy review; service design; procurement, service specifications, and contracting) so that potential health inequalities for different protected characteristic groups are identified at an early stage, and appropriate mitigating actions built in to address them (Section 2.1.1.5).

3.1.4 Patient involvement and engagement

3.1.4.1 Citizens participation in service design

The themes that have emerged from the local call to action events are detailed in the WCCG report "Call to Action, Feedback from engagement workshops – September to November 2013" and the views received have been grouped under the theme areas in the Table 2 and continue to inform this plan:

Theme	Comments
Self-management	• Health Education • More on prevention • Self-management
Information Technology	• Better IT systems
Communications	• Simple terminology and avoid using jargon • Promote more awareness of services • More information on Mental Health services (Young People) • Urgent Care – promote greater understanding of the different access points available for meeting urgent care needs
Acute services	• More nurses • Stop Health Tourism • Penalties on patients abusing the system (missed appointments) • Appropriate discharge from hospital
Primary care	• Penalties on patients abusing the system (missed appointments) • Access to GP appointments
System wide	• Commitment to an NHS free at the point of delivery • Joined up and integrated care • Care in the community – closer to home

Table 2 – Call to Action Feedback

WCCG will continue to act on these theme areas in 2015/17 where they are within its power. For example the current reviews of Urgent Care and Community services are using this intelligence to inform the future shape and service specification of these services. The work around the BCF and integration will respond to comments and suggestions made regarding the need for joined up integrated care.

The Urgent Care Review was completed in November 2014. This successfully involved and engaged local people and many other stakeholders in shaping and informing the longer term plan for urgent care and the shorter term options available for getting us there. This work informed the options which WCCG publicly consulted on. The outcome of this process was reported to the Governing Body at the November 2014 meeting where the Board agreed that the longer term plan should be to work toward co-location of UC access with A & E at WHNHST offering a single point of access. It also agreed that in the interim and working towards 2020, WCCG would commission a Hub and Spoke model of UC access with the Hub at the hospital and the spoke in the Saddlers Centre in Walsall Town centre. In making its

decision the Governing Body agreed that the issues and concerns that people raised as part of the consultation would need to be worked through and addressed as part of the project and planning processes needed to achieve the longer term plan which included the redevelopment of the A & E department at WHNHST.

3.1.4.2 Patients empowered in their own care

The management of long term conditions through improved self-care is a key priority with particular focus on dementia, diabetes, mental health and respiratory as a follows:-

- Improve Dementia diagnosis rates – an important step in development treatment plans with the patient and carers
- Improving Access to psychological Therapies support (IAPT)
- Diabetes - To continue to commission approaches to empowering patients to self-manage their condition including increasing uptake to structured educational programmes and more awareness raising work concerning risk factors and prevention in schools, temples, community groups , patients and carer networks and workplaces
- Respiratory – To commission services that prevent people from smoking and to support those who do smoke to stop. In addition, robust approaches to managing the condition, monitoring and aggressive treatment of flare-ups will prevent or shorten hospital stays and reduce days lost from work. This will include redesign of respiratory care pathways and specialist roles within it to support primary care management of exacerbations of COPD and Asthma
- Review and assess the use of telehealth / assistive technology in respiratory, heart failure and mental health.
- Develop the use of technology in general practice for example where patients can choose to
    - Access information on self-help.
    - Health apps.
    - Request medication.
    - Review their medical records.
    - Have web consultations.
    - Book an appointment online.
- Increased use of personal budgets, self-directed care and recovery tool especially around mental health patients.

All of the above are part of WCCG's approach to improving the quality of care, preventing avoidable admissions and unnecessary attendances at A&E.

3.1.5 Access

3.1.5.1 Convenient access for everyone

Our community services redesign initiative will be particularly directed towards adults including the mentally ill to ensure the swift return of people to their own homes to help maintain their independence. This will include delivery of a community services commissioning strategy that embraces the following elements of provision:

- Intermediate care.
- Re-ablement.
- Primary care.
- Acute care management.
- Rapid response.

3.1.5.2 Meeting the NHS Constitutional standards

Planning guidance sets out further expectations in addition to the NHS Constitution requirements for ensuring that patients have appropriate access to care. This area is covered in more detail in Section 7 of this plan. A part of 2015/16 contractual arrangements will agree plans with providers to deliver NHS Constitution requirements including the new mental health access standards. This is shown in Section 4 of this plan.

3.1.6 Quality

3.1.6.1 Response to High Level Quality Reports

WCCG's quality strategy sets out five key aims and our approach to commissioning high quality healthcare. These aims incorporate the learning from the Francis, Berwick and Keogh reports.

Keogh/*Francis/Berwick*	WCCG Quality Strategy Aims
Patient Experience	**Patient Experience** WCCG will promise to use patient experience intelligence to deliver its commissioning responsibilities in terms of service improvement, innovation and service redesign. This involves setting out the central role that patients and service users must play in the oversight and scrutiny, design and measurement of high quality services
Safety *Preventing problems* *Detecting Problems quickly* *Taking action promptly*	**Early Warning Systems** To establish and maintain an early warning system that is sensitive, timely and responsive to small variances in quality of services. This includes setting out a system wide procedure to enable WCCG to respond in a rapid coordinated and collaborative manner to failings in quality whilst safeguarding patients and service users.
Workforce *Ensuring staff are trained and motivated*	**Contract management** It is through contract management that WCCG can assure itself of the quality of care being provided
Clinical and operational effectiveness	**Contract management** The management of the national contract is key to enabling commissioners to performance manage the provider, describe the quality metrics and standards required, drive continuous quality improvements and hold the providers to account.
Leadership and governance *Ensuring robust accountability*	**Values** To create an environment that supports and encourages a culture where the values and behaviours enable robust systems and processes to monitor, manage performance and regulate quality of care in a transparent and open manner.
Partnership	**Partnership working** This brings opportunities to strengthen and create new working relationships with local partners including the public to combine resources and tackle quality issues with a holistic approach.
Care Quality Commission (CQC)	**CQC** WCCG work closely with the CQC and hold a monthly information sharing meeting. WCCG share their Quality Risk Profiles with CQC and are in attendance at their inspections as appropriate for example representation on the review team for local acute CQC visit(s). The CQC are also a member of the Quality Improvement Sub Group for Primary Care established to act on any concerns / issues about primary care practitioners. The sub group ensure that WCCG takes necessary action when responding to concerns / issues in relation to primary care.

Table 3 – High Level Quality Reports

A detailed plan is in place to support WCCG's Quality Strategy; this has a named lead for each action with agreed timescales for delivery. The Governing Body have endorsed the Quality Strategy and its supporting plan, responsibility for monitoring the delivery has been delegated to the Safety, Quality and Performance (SQP)Committee, who will provide assurance to the Governing Body as part of its regular reports.

WCCG's lead for Nursing and Partnerships is also a full member of the Borough Safety Partnership.

This includes preventing problems, detecting problems quickly and taking action promptly. As the table above reflects WCCG has established and will continue to maintain an early warning system that is sensitive, timely and responsive to small variances in quality of services. This includes setting out a system wide procedure to enable WCCG to respond in a rapid, coordinated and collaborative manner to failings in quality whilst safeguarding patients and service users. WCCG is committed to an open and transparent approach to patient safety, ensuring patient experience is captured and informs commissioning activity at every opportunity. Duty of candour is expected and reviewed for every incident reported and, where necessary, challenged through WCCG safety arrangements.

In order to discharge its responsibility for acting on any concerns / issues relating to primary care, the Safety, Quality and Performance Committee agreed to establish a Sub-Committee with a role to ensuring that WCCG takes necessary action when responding to concerns / issues. Our Quality Improvement Sub Committee (in effect a patient safety collaborative) has representatives from WCCG, NHS England, Care Quality Commission, Local Medical Committee and General Practice Management. The role of the committee is to share intelligence and work with our practices to support quality improvements. A quality matrix has been developed which includes a range KPIs, acting as a high level early warning system and assisting in the identification of those practices requiring support. Where such cases are identified WCCG agrees improvement plans and trajectories against which improvement can be measured. Also working with our general practices, including GPs and Practice Nurses, we encourage the identification and reporting of incidents through our regular forums and training sessions and where applicable practice visits.

WCCG is committed to the highest standards of patient safety and is in the process of registering with the “sign up to safety” and developing our 3 year plan to save lives and reduce harm for patients.

Better management of chronic kidney disease management through the use of eGFR surveillance system is anticipated to ‘Improve patients’ understanding of their chronic kidney condition leading to better self-management’

The implementation of the eGFR surveillance system is part of WHNHST plans and objectives for 2015, and in line with the majority of other labs in the West Midlands. This initially will be a pilot for at least 12 months and will take into account if the system can be proven to be successful in what it aims to do (act as an eGFR early warning system, prevent earlier progress to dialysis in these patients). The system is based on the current model in place at Birmingham Heartlands under Dr Hugh Rayner, and is being developed / championed in collaboration with NHS England through the West Midlands Strategic Clinical Network & Senate (which will feed into the national programme for monitoring eGFR).

Data from the system and renal clinics can already be obtained through the renal registry, but at present WHNHST lab will keep a database of those patients flagged by the system leading to a warning chart being sent, the numbers being seen in Outpatients/appointments being made as a consequence of the charts, and the numbers requiring dialysis.

- Antibiotic prescribing - Antibiotic prescribing has been assessed from 2012 where we have worked closely with WHNHST using the University Hospitals of South Manchester antimicrobial self-assessment tool to continually improve their self-assessment score which is audited quarterly. This is in the form of Antimicrobial Stewardship with a monthly antibiotic snapshot. WHNHST have continually improved showing that it is one of the best performing trusts in the region and WCCG will expect this to continue.
- Secondary care prescribing - The Joint Medicines Management Committee oversees data received from WHNHST including and ensures that action plans are implemented to ensure rational use of antibiotics and adherence to formulary. The health economy also utilises benchmarking data using the DEFINE software tool as a collaborative approach.

- Primary care - The Local Improvement Scheme for prescribing includes a specific indicator to encourage appropriate use of antibiotics in primary care. Monthly benchmarking data is commissioned from Keele University on volume of antibiotics prescribed at practice level and "high-risk" antibiotics are monitored on a monthly basis. Support is provided by the Medicines Management Team to all practices and audit is undertaken for the WIC also on antibiotic prescribing.

3.1.6.3 Patient Experience

In addition to the above Sections relating to patient involvement and engagement, in 2015/17 WCCG will be reviewing its patient engagement strategy and refreshing existing arrangements to ensure a strengthened approach and revising and developing the roles of Patient representative groups.

WCCG has been working with residents in Rough Hay Ward on a community centred approach to health and well-being using the 'C2' (Connecting Communities) asset based model. This model seeks to reverse the deficit approach to community development where the focus is on 'what is wrong with the area' towards a more positive consideration asking 'what is right?' and 'what do people value here?' Working alongside organisational partners in Public Health and other Local Authority services, and with the main registered social landlord in the area, Walsall Housing Group, we are mapping assets in the local area and using the learning outcomes from Rough Hay to inform similar approaches in other parts of the Borough. By building capacity and resilience in local communities we hope to be able to have more productive conversations about shared approaches to tackling health inequalities with genuine organisational commitments to co-design, and co-production.'

3.1.6.4 Tackling Health Care Acquired Infections (HCAIs)

The HCAI steering group is a Borough wide group that is chaired by WCCG Clinical Lead for Quality and Safety. It has worked hard to ensure that the changes in how the NHS delivers its service have not affected the health economy approach to preventing infections in Walsall.

Infection prevention and control remains high on WCCG's agenda and as such it has a high profile across the Borough. It is essential that infection prevention is embedded in the new structures and is part of a robust governance framework. This is recognised in the new structures as described in the following assurance framework for Infection prevention and control (figure 4).

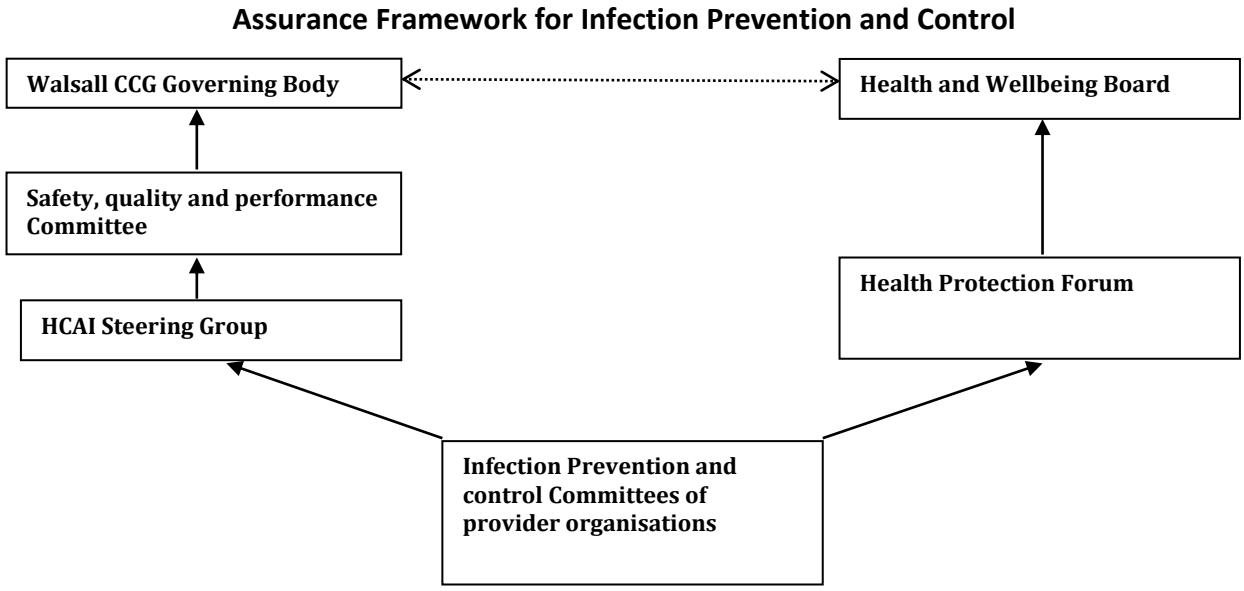


Figure 4 – Assurance Framework for Infection Prevention and Control

A monthly report is sent from the Public Health Service to the Safety, Quality and Performance Committee which is chaired by WCCG. In addition a report is received from each health care provider at the monthly Clinical Quality Review meetings.

Methicillin Resistant Staphylococcus aureus (MRSA)

The MRSA policy provides clear guidance for the management of Methicillin Resistant *Staphylococcus aureus* and facilitates the prevention of spread, thereby reducing risk to other patients, staff and visitors of WHNHST. The policy is also used to advise other health care providers in Walsall, including Primary Care and Nursing / Care Homes. Every case of MRSA bacteraemia MUST be reported as a Serious Incident (SI) and be investigated via post infection review process.

Clostridium difficile (Cdiff)

Actions to minimise the incidence of Cdiff will continue into 2014-15. WHNHST continues to review the Cdiff action plan to identify further interventions that can be implemented to prevent patients from acquiring this infection. Root Cause Analysis (RCA) continues to be undertaken after each case and lessons learned are shared amongst divisions. A round table discussion takes place between WCCG, WHNHST and Public Health Medicine to identify patients with Cdiff where it is deemed that the acquisition of the infection could not have been prevented by any actions taken by WHNHST. It is possible that these cases may then be removed from the total number of cases allocated to the Trust so that WCCG will impose financial penalties only in cases where the Trust had the potential to avoid the patient becoming infected.

3.1.6.5 Compassion in practice & 6 C's

The Department of Health published "Compassion in practice" in December 2012 which includes the future vision for nurses, midwives and care staff. To make Compassion in Practice happen, nurses across all services (including practice nursing) will take the lead on implementing this and this forms part of contracts agreed with providers with the 6 priority areas being:

- Maximising Health and Wellbeing. Helping people to stay independent.
- Working with people to provide a positive experience.
- Delivering care and measuring impact.
- Building and strengthening leadership.
- Ensuring providers have the right staff, with the right skills in place.
- Supporting positive staff experience.

WCCG has gained assurance on the implementation of these priorities and the 6 C's through the Contract Quality Review and Safety Quality and Performance processes. Within WCCG our Practice Nurse Strategy is in line with the 6 C's through a competence framework with Introductory, Intermediate and Comprehensive levels.

3.1.6.6 Special Educational Needs and Disability (SEND)

In April 2014 the Children's and Families Act 2014 received Royal Assent. The Act outlines significant reforms to improve services for children and young people with SEND.

The duties placed upon Local Authorities and NHS bodies are outlined in the Act, the SEND Code of Practice issued in June 2014, and the Special Educational Needs and Disability Regulations 2014.

The joint duties for WMBC and WCCG are to:

- Collaborate in the development, publication & delivery of a Local Offer.

- Have joint arrangements in place to agree outcomes of the integrated Education, Health & Care assessment and Plans (EHC Plans).
- Have joint commissioning arrangements in place to enable the delivery of Education, Health and Care plan (EHC Plans) for children and young people (aged 0-25 years).
- Clearly identify what will be offered as a personal budget.

WCCG is responsible for:

- Securing health services that are specified in EHC Plans.
- Setting out local arrangements and responsibilities for implementing the reforms.
- Contribute to co-producing the Local Offer.
- The provision and procedure for assessing the potential health element within an EHC Assessment / Plan.
- Joint commissioning with WMBC in the procurement of short breaks and PHBs (direct payments). There is consistent CCG representation on the Complex Needs Panel where resources / budget expenditure (case-by-case) is determined.
- Appointing a SEND Designated Medical Officer (DMO).
- Offering CHC personal health budgets to eligible families is relatively positive, however, future provision of PHBs to children with a wider range of illness / disability (April 2015) requires in-depth clinical consideration of eligibility criteria, budget allocation and range of NHS provided services that can be transferable into a direct payment to purchase an alternative non-NHS provision.

3.1.6.7 Staff satisfaction

WCCG is committed to being a great place to work where staff have a feeling of being valued and there is a real sense of continual improvement. A highly motivated, trained, and continually developed work force will provide consistent and quality service to the people whom WCCG serve. WCCG can only create this environment by providing opportunities to learn and develop and by listening and acting on staff views. To this end, WCCG continues to support and create learning opportunities for its staff and has carried out staff surveys to provide an opportunity for staff to tell us what is working well in the organisation and which areas need further improvement. The Staff Council meets regularly and its members act as communication champions for the departments they represent.

National staff satisfaction survey results are tabled for discussion with providers at Clinical Quality Review Meetings and action plans for improvement will be agreed as part of the quality schedule going forward.

3.1.6.8 Seven day working

WCCG is working with providers so that services provided are 7/7. This is a huge challenge but current working patterns will not support WCCG's aim to reduce emergency admissions. Therefore there is discussion with our main acute provider regarding the availability of consultant cover, diagnostic services and therapy services at weekends. Similar working arrangements need to be reflected in primary care and during this planning period efforts will be directed to supporting new primary care at scale models that can also support 7/7 working. The contract with our acute provider will include the provider's plans to meet 5 of the 10 - 7 day working standards in 2015/16 are included within the provider Service Development and Improvement Plans (SDIP).

3.1.6.9 Safeguarding

WCCG continues to place strong emphasis on collaborative practice with partner agencies in the interests of safeguarding vulnerable children and adults as preventative and protective measures and as both strategic and operational concerns.

The business of Walsall Safeguarding Children Board and its associated Committees serves to direct and influence local priorities having focus upon learning and improvement from a programme of multi-agency enquiry and audit and the specific activities associated with review of serious cases and childhood deaths. Identification and reduction of child sexual exploitation remains a key priority across the partnership. On-going engagement by healthcare services in the programme of work to establish a local Multi-Agency Safeguarding Hub (MASH) that will serve to support service provision to children and their families across a broad range of needs and vulnerabilities is fundamental and well-recognised by local corporate sites. Healthcare services maintain focus on strengthening care provision to children looked after and via strong commitment and delivery regarding the business of the Corporate Parenting Board.

The enactment of The Care Act 2014 has brought about significant changes in respect of protecting adults from abuse or neglect, embedding the new statutory framework across health and partner agencies will be a key priority for WCCG and will include:

- Further development of the safeguarding performance framework to support implementation of the statutory guidance across our NHS acute and mental health providers.
- Support partner agencies in safeguarding reviews.
- Strengthen mechanisms for sharing lessons learnt from reviews across health partners.
- Contribute towards the work of the adult safeguarding board through the Lead Nurse.

There is continued emphasis on work to support the Transforming Care agenda and to assure transformation across Learning Disability in-patient services, there is a programme of care and treatment reviews in line with national requirements.

Focus remains in place in respect of the PREVENT agenda, with joint working across health to ensure that this work stream is a priority during 2015/16 in line with new guidance and responsibilities for all agencies.

The designated and named professional's roles are fully embedded within the WCCG safeguarding Assurance Strategy. The governance structure within which these professionals work is evidenced in Appendix 9.

WCCG's Accountability Framework references our approach to the PREVENT agenda and in addition Provider contracts have been strengthened to ensure more formal arrangements around PREVENT are embedded. WCCG are active members of the local CONTEST steering Group. The Annual report which is attached as Appendix 9 to the Plan describes Safeguarding ambitions in 2015/16.

Progress and feedback from these key work streams is monitored through Clinical Quality Reviews and WCCG Safety, Quality and Performance Committee.

3.1.7 Constitutional commitments

WCCG has a good track record of achieving the NHS constitutional measures and plans to continue to meet the national standards. However, performance against the 95% 4 hour wait and RTT standards have been very challenging in 2014/15. We are working with our main acute provider to ensure that performance against these standards is recovered and maintained at the required level in 2015/16. The planned trajectories are shown in Section 4 of this plan.

3.1.8 Research and Innovation

WCCG's work in relation to medicines management and partnership with Local Government has been recognised nationally. These areas have been very successful in reducing future health care costs through a medicines optimisation approach and proactively supporting private nursing homes.

WCCG continues to be at the forefront of the development of healthcare procurement in the NHS with WCCG contributing to several national forums (such as the National Working Group for Commissioning Support Services and a member of the Health Care Supply Association Council as the representative for commissioning), presenting at procurement conferences and writing articles on procurement topics. WCCG is also a member of the national group developing the E-contract system.

In particular, and as illustrated in Section 3.1.6, WCCG's Contracting and Procurement Strategy is based on a published academic study conducted by WCCG's Head of Contracting and Procurement of the application of public value management to procurement which emphases the creation of public value through procurement. This has resulted in WCCG being at the forefront of the application of the Public Services (Social Value) Act which obliges all public sector commissioners to consider social, economic, and environmental issues when procuring services. As can be seen this public value approach has also influenced WCCG's overall Strategic Plan and this Operational Plan.

In addition during 2014-15 WCCG has participated in formal research studies relating to contracting and procurement conducted by the London School of Hygiene and Tropical Medicine and the University of Birmingham respectively and intends to maintain these academic links in 2015-17.

In our commissioning intentions to our main contract providers WCCG has expressed that innovative ideas/ways of working should be used to improve patients' quality of care. As part of our QIPP initiatives on going benchmarking is used, this is explained further in Section 6, which highlights which CCG's have better outcomes than WCCG. Programme leads are then challenged to investigate why and whether any innovative ideas can be introduced to improve our outcomes. Also the Innovation Scorecard produced by Health & Social Care Information Centre (HSCIC) is triangulated between the National Prescribing QIPP agenda and our commissioned medicine management advisors reports from Keele University.

GP Clinical Research lead has now been employed on a sessional basis by WCCG and is an active member of the local Primary Care Research Group (PCRG).

WCCG is working with Patient Representation Groups to develop arrangements for Patient Participation and awareness in Research and Development going forward.

3.1.9 Delivering value

3.1.9.1 Financial resilience; delivering value for money for taxpayers, patients and procurement

WCCG financial strategy accompanies this submission of the Operational Plan. In summary our assessment is that this addresses the areas required by the latest planning guidance. Section 5 of the plan contains a brief summary of the strategy but the technical detail is not reproduced in full.

3.1.9.2 Productivity of elective care

WCCG has used a range of benchmarking tools (see references Appendix 3) to assess the productivity of services it commissions and identified a range of QIPP improvement opportunities (see Appendix 2).

This confirms that the strategic change programmes and their focus are in the right direction. For example referral management for MSK, Urology, Gastroenterology and look at primary care demand management and patient flows are areas where WCCG can make significant savings and these are already included in WCCG's plans. Also investigate whether the Blueteq system can be used for prior approvals.

WCCG has also incorporated as part of contracts with providers QIPP priorities and these will be monitored through our PMO arrangements. Appendix 2 gives the detail of QIPP schemes for 2015/16 and 2016/17.

3.1.9.3 Delivering Public Value

As well as its ambition to commission high quality services providing the best health outcomes for the people of Walsall at the best possible value, WCCG is also committed to deliver broader public value for the people of Walsall by maximising the contribution that WCCG and our providers make to the local community through social, economic and environmental improvements.

This public value approach forms the basis for WCCG's Contracting and Procurement Strategy as illustrated in Figure 5. This identifies that key ingredients to delivering public value to the people of Walsall through contracting and procurement activity are: having a clear set of values; developing outcome-based specification; having a high level of public, patient and clinical engagement; embracing suppler relationship management; and having appropriate skills and competence.

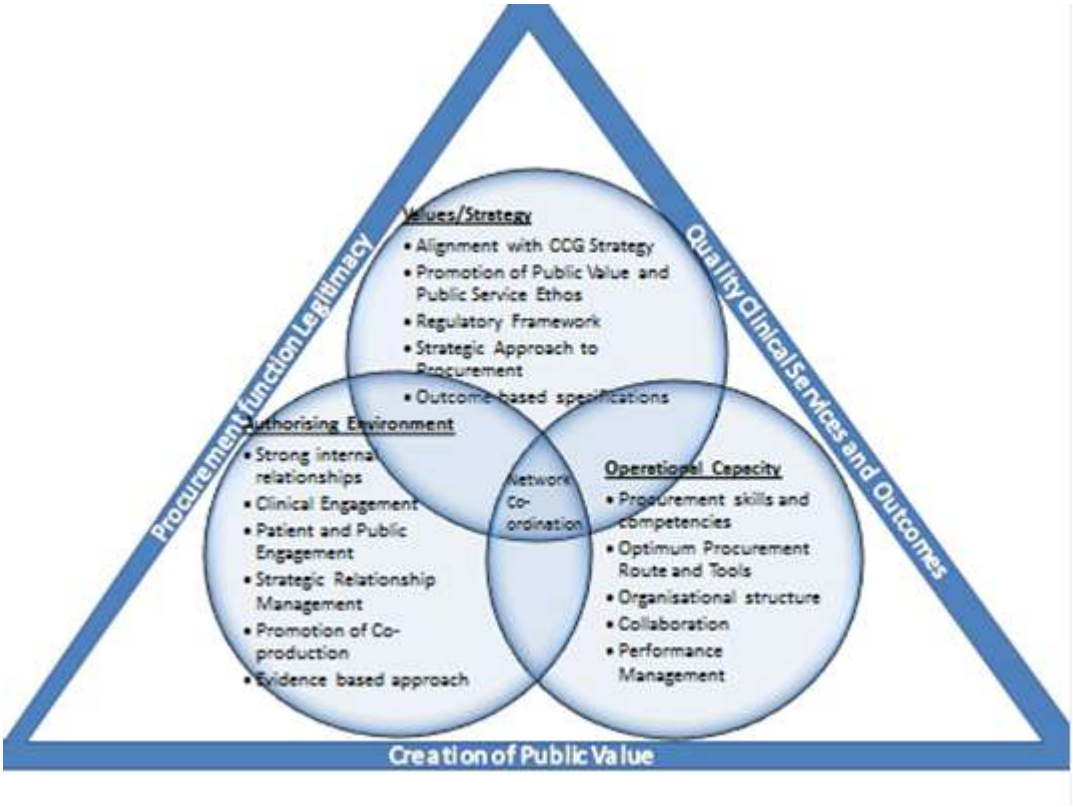


Figure 5– Walsall CCG Contracting and Procurement Strategy

This approach, which was recognized as a shortlisted project at the 2014 CIPS (Chartered Institute of Purchasing and Supply) Awards and "highly commended" in the 2014 HSJ Awards, is beginning to bear fruit in that, as set out in the Strategic Plan, providers are being required to produce public value accounts to demonstrate how they have delivered these broader benefits to the community and it is intended to publish the initial accounts, which are currently being piloted with a couple of providers, in the next few months. As the number of these accounts increases as set out in the trajectory within the Strategic Plan, WCCG will be able to demonstrate that it has not only commissioned high quality and cost effective healthcare services but, in doing so, its providers have contributed positively to the social, economic and environmental fabric of the local community.

Section 4
Performance Management

4.1 Review of previous year and Governance arrangements

From 2012/13, there has been a robust performance management framework in place which has included review of the following:

- NHS Constitution KPIs.
- NHS outcomes indicators (where it was possible to date).
- Performance against CQUIN schemes.
- Performance against contractual requirements.
- Progress against the QIPP schemes and key performance indicators.

An exception report highlights areas where performance has been of concern in 2014/15 and the actions being taken to improve performance at year end.

Reports are provided to the Safety, Quality and Performance Committee and WCCG Governing Body at agreed intervals throughout the year. In addition, a number of quality assurance processes are in place including:

- Contract Monitoring Review (CMR) and Contract Quality Review (CQR) - Contract management, with a significant number of locally agreed indicators for additional assurance e.g. workforce, safeguarding, end of life care.
- Performance review of provider patient safety metrics.
- Quality assurance visits to providers.
- Agreed quality scorecard with all providers.
- Internal processes for reviewing local intelligence and concerns.
- Primary Care Quality Review.
- Review of staff and patient surveys from WCCG and all providers.
- Commissioning Support Unit (CSU) data analysis.

The Improving Outcomes Committee (IOC) is the Commissioning sub-committee to the Governing Body and this oversees the work of WCCG planning system as shown in figure 6. There are 7 Programmes covering Mental Health, Elective Care, Urgent Care, Disabilities and Carers, Systems Resilience Group, Paediatrics & Maternity and Primary and Community care. Task and finish groups are accountable to these Programmes. This structure has been in place from January 2015 following a review after the first year of WCCG. Performance of transformational programmes is monitored through the Programme Management Office (PMO) and reports presented and discussed at the IOC.

Joint Commissioning Unit which is part of WCCGs planning structure reports through the Joint Commissioning Committee.

4.2 Plans for Performance Management & Quality

WCCG is in the process of reviewing the Performance Management Framework for 2015/16. The proposed approach comprises:

- Review and update the outcome indicators to show the planned improvements to outcomes for 2015/16 including:
  - "Five Year Forward View" & "The Forward View into Action: Planning for 2015/16".
  - QIPP outcome indicators showing the planned changes for 2015/16 and 2016/17.
  - CQUIN objectives, following agreement through the 2015/16 contracting process, including innovation and length of stay improvements.
- Use the outcome indicators as the basic building blocks for measuring improvement in WCCG Health outcomes.

- The outputs from the above actions will then feed into the appropriate Committees, Boards and the WCCG Board at agreed intervals.
- Provider participation will be critical to the delivery of the performance and quality assurance regime. WCCG will use the 2015/6 contract provisions to ensure that providers:
  - Participate in and publish results of national clinical audits.
  - Participate in West Midlands Quality Reviews (WMQR).
  - Complete central returns on incidents, never events and complaints.
  - Use the national patient experience surveys and ensure the results are acted upon. In addition, WCCG expects each local organisation to carry out more frequent local patient surveys, publish the results and to respond appropriately where improvements need to be made.
  - Share their staff survey results, in particular, whether staff would recommend their hospital.

4.3 Commissioning for Quality and Innovation (CQUINs)

The 2015/16 CQUINS agreed with our Acute Provider are in Table 4:

Scheme Name	National or Local	Proposed Overall %
Acute Kidney Injury	National	10%
Sepsis (Identification & Early Treatment)	National	10%
Dementia & Delirium Care	National	10%
Reducing the Proportion of Avoidable Emergency Admissions	National	10%
Improving Diagnosis & Re-attendance Rates of People with Mental Health Needs at A&E	National	10%
Discharge	Local	20%
Medication Safety Thermometer	Local	5%
Medicines Management (Blueteq)	Local	5%
Catheters / UTI	Local	20%
Total		**100%**

Table 4 – Acute CQUINS

The 2015/16 CQUINS agreed with our Mental Health Provider are in Table 5:

Scheme Name	National or Local	Proposed Overall %
Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness	National	10%
Improving Diagnosis & Re-attendance Rates of People with Mental Health Needs at A&E	National	20%
Dementia Pain Management	Local	20%
Medicines Safety Thermometer	Local	10%
Enhanced Carers Support	Local	20%
Dudley & Walsall recovery Outcome Measure	Local	20%
Total		**100%**

Table 5 – Mental Health CQUINS

In relation to the Sepsis and Acute Kidney Injury CQUINs these are national schemes developed by NHS England and will be implemented as per the national guidance. We have agreed the implementation of these with our acute provider as part of the contract process. Out of the overall CQUIN value, percentages for both acute kidney and sepsis are 10%.

CQUINs in smaller value contracts (e.g. hospices, non NHS providers) will also prioritise QIPP delivery, include gateways and work to the same objectives as the nationally mandated CQUINS.

The following section sets out our overall approach to meeting a number of key patient safety and quality measures in 2015/16.

4.4 Outcomes Measures

Improvement against NHS Outcomes Framework ambitions are in Table 6:

Outcome Ambition	Measure Used	CCG Ambition	
		2015/16	2016/17
Securing additional years of life for the people of England with treatable mental and physical health conditions	Potential years of life lost from conditions considered amenable to healthcare per 100,000 population.	2,181	2,145
Improving the health related quality of life of the 15 million+ people with one or more long term condition, including mental health conditions	Health related quality of life for people with long term conditions (measured using the EQ5D tool in the GP patient survey) average health score out of 100	0.744	0.760
	Dementia diagnosis rate per 100 population	67%	67%
	IAPT access proportion per quarter	TBC	TBC
	IAPT recovery rate per 100 people	50.4%	50.4%
	The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	TBC	TBC
	The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	75.1%	75.1%
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	Unplanned hospitalisation for chronic ambulatory care sensitive conditions per 100,000 population.	967.5	975.8
	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s per 100,000 population.	311.2	293.4
	Emergency admissions for acute conditions that should not usually require hospital admission per 100,000 population.	1,245	1,169
	Emergency admissions for children with lower respiratory tract infections per 100,000 population.	355.5	338.5
Increasing the number of people having a positive experience of hospital care	Patient experience of inpatient care per 100 patients	150.6	150.6
Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community	GP services per 100 patients.	7.1	7.1
	GP out of hours per 100 patients.		
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	MRSA	Zero Tolerance	
	CDiff for WCCG	56	N/A
	CDiff for WHNHST	18	N/A
Improving the health related quality of life of the 15 million+ people with one or more long term condition, including mental health conditions	The proportion of people that wait 18 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period	Currently no trajectory required	
	The proportion of people that wait 6 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period		
	Number of ended referrals in the reporting period that received a course of treatment against the number of ended referrals in the reporting period that received a single treatment appointment		
	Average number of treatment sessions		
	Re-focusing service provision on less severe cases (in development)		
	More than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral (in development)		
	% of acute trusts with an effective model of liaison psychiatry (all ages, appropriate to the size, acuity and specialty of the hospital) (in development)		
	Total number of patients in in-patient beds for mental and/or behavioural healthcare who have either learning disabilities and/or autistic spectrum disorder (including Asperger's syndrome)		
	Numbers of admissions to in-patient beds for mental and/or behavioural healthcare who have either learning disabilities and/or autistic spectrum disorder (including Asperger's syndrome).		
	Numbers of patients discharged to community settings		
	Patients without a care coordinator		
	Patients not on the register		
	Patients without a review in the last 26 weeks		

Table 6 – Outcome Ambitions

The outcomes indicators in Table 7 contribute to the overarching aims of the five domains in the NHS Outcomes Framework. The indicators demonstrate progress that the local health system is making on outcomes.

Domain	Measure Used	CCG Ambition	
		2015/16	2016/17
Domain 1 – Preventing people from dying prematurely	Potential years of life lost (PYLL) from causes considered amenable to healthcare per 100,000 population.	2,181	2,145
	Under 75 mortality rate from cardiovascular disease per 100,000 population.	70.4	68.4
	Under 75 mortality rate from respiratory disease per 100,000 population.	26.4	25.4
	(Proxy indicator) Emergency admissions for alcohol related liver disease per 100,000 population.	28.0	26.5
	Under 75 mortality rate from cancer per 100,000 population.	128.7	124.5
Domain 2 – Enhancing quality of life for people with long-term conditions	Health related quality of life for people with long term conditions average health score out of 100	0.744	0.760
	Proportion of people feeling supported to manage their condition	66%	66%
	Unplanned hospitalisation for chronic ambulatory sensitive conditions (adults)	967.5	975.8
	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	311.2	293.4
Domain 3 – Helping people to recover from episodes of ill health or following injury	Emergency admissions for acute conditions that should not usually require hospital admission per 100,000 population.	1245	1169
	Emergency readmissions within 30 days of discharge from hospital Percentage of emergency admissions to any hospital in England occurring within 30 days of the last, previous discharge from hospital after admission	11.4	11.2
	Emergency admissions for children with lower respiratory tract infections per 100,000 population.	355.5	338.5
Domain 4 – Ensuring that people have a positive experience of care	Patient experience of GP services per 100 patients.	97%	97%
	Patient experience of GP out of hours services per 100 patients.	70%	72%
Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm	MRSA	Zero Tolerance	
	CDiff for WCCG	56	
	CDiff for WHNHST	18	

Table 7 – Domain Measures

Direct commissioning – Primary Care Measures are in Table 8:

Domain	Measure Used	Ambition	
		2015/16	2016/17
Patient Satisfaction	Satisfaction with the quality of consultation at the GP practice	TBC	
	Satisfaction with the overall care received at the surgery.	TBC	
	Satisfaction with accessing primary care	TBC	

Table 8 – Primary Care Measures

NHS Constitution measures are in Table 9:

Constitution Measure	Measure Used	Ambition	
		2015/16	2016/17
Referral To Treatment waiting times for non-urgent consultant-led treatment	Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%	90%	90%
	Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%	95%	95%
	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%	92%	92%
Diagnostic test waiting times	Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99%	99%	99%
A&E waits	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department – 95%	95%	95%
Cancer waits – 2 week wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%	93%	93%
	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%	93.3%	93.3%
Cancer waits – 31 days	Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96%	96.2%	96.2%
	Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%	95.9%	95.9%
	Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%	98.2%	98.2%
	Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%	94.1%	94.1%
Cancer waits – 62 days	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%	85.5%	85.5%
	Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%	92.6%	92.6%
	Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set	91.6%	91.6%
Category A ambulance calls	Category A calls resulting in an emergency response arriving within 8 minutes – 75% (standard to be met for both Red 1 and Red 2 calls separately)	75%	75%
	Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%	95%	95%
Mixed Sex Accommodation Breaches	Minimise breaches	Zero Tolerance	
Cancelled Operations	All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.	No Measure	
	No urgent operation to be cancelled for a 2nd time	Zero Tolerance	
Mental health	Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%	95%	95%
Referral To Treatment waiting times for non-urgent consultant-led treatment	Zero tolerance of over 52 week waiters	Zero Tolerance	
A&E waits	No waits from decision to admit to admission (trolley waits) over 12 hours	Zero Tolerance	
Ambulance Handovers	All handovers between ambulance and A & E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. Financial penalties, in both cases, for delays over 30 minutes and over an hour.	0	0

Table 9 – NHS Constitution Measures

BCF measures are in Table 10:

Measure	Measure Used	Ambition 2015/16
Transfers	Delayed transfers of care	319.6
Admissions	Reduction in emergency admissions	2481
		2.0%
	Admissions to residential and nursing care	232
Reablement	Effectiveness of reablement	80%
	Reduction in expenditure on social care packages and residential placements for older people	No Measure
Experience	Patient / service user experience	90%
	Bed Days	
Local Measure	Dementia Diagnosis Rate	67%

Table 10 – Better Care Fund Measures

In relation to the measures in Section 4.4 to 4.6 these will be achieved via the interventions shown in Section 7 of the Operational Plan, Better Care Fund (Appendix 6) and also through the contractual arrangements WCCG has with its providers.

Complete definitions of all the above indicators can be found at the Health and Social Care Information Centre (HSCIC) website.

Section 5
Financial Plan

The Financial Strategy takes the 2015/16 recurrent forecast position for WCCG and reflects the changes to resources as a consequence of the adoption of the revised allocation formula, and the creation of the Better Care Fund. In support of this, three financial models have been constructed, a base case financial model, a best case model and a worst case model. In setting the parameters for the formulation of the financial models the following relevant statutory duties must be adhered to:

- To ensure expenditure within a financial year does not exceed the allocated budget.
- To ensure that revenue resource use and capital resource use do not exceed the identified limits.
- To ensure that the running cost budget remains within the limits set by NHS England.

The key variables in determining the impact on CCG resources are listed below:

- Growth funding.
- Tariff deflator (applies to both Payment by Results (PBR) and non-PBR services) based upon detailed tariff guidance contained within the 2015/16 National Tariff Payment System document. This includes an uplift of 0.3% in 2015/16 to support seven day working in the secondary care sector.
- QIPP savings.
- Allocation formula.
- Pace of Change in reaching target allocation.
- 1% of allocation used non-recurrently in 2015/16.
- Demand growth based upon work undertaken by Public Health outlining the demand for health services as a consequence of projected changes in the population profile and the impact of technological advancement upon the delivery of health services.
- Requirement to maintain 0.5% contingency to contribute to the overall management of financial risk.
- Requirement to meet a target surplus of either 1% or the value achieved in 2014/15 in each of the financial years of the plan.

The assumptions in our financial plan are based upon guidance received in the "Five Year Forward View" & "The Forward View into Action: Planning for 2015/16" document in conjunction with the draft rules for the adoption of the tariff as outlined in the 2015/16 National Tariff Payment System document. Further guidance has subsequently been received and providers have been given an option to either remain with the 2014/15 national tariff with the exclusion of any CQUIN known as the Default Rollover Tariff (DTR), or to adopt an enhanced tariff option (ETO) which combines the draft 15/16 national tariff payment system with some amendments around tariff efficiency requirements and enhancements to the emergency threshold. Both of our main providers WHNHST and DWMHPT have chosen the ETO option. WCCG has now received confirmation that the increased costs associated with the adoption of the revised tariff, will be met from the national allocation identified for this purpose. WCCG has been notified of an additional allocation of £1.1 million.

Our financial plan details the modelling work and QIPP plans for 2015/16. A summary of QIPP plans is given in Section 6 of the Operational Plan; this plan shows the effect of our proposed QIPP programme on main providers.

WCCG will need to assure itself that the transformation changes are not detrimental to Quality including access to services, Safety and service continuity. This work will be part of the commissioning cycle WCCG works through and will be reflected in operational plans

Section 6

Quality, Innovation, Productivity and Prevention (QIPP)

Overview

Plans agreed by Walsall CCG to deliver the QIPP challenge are summarised in the Table 11 below:

Programme	2015/16 CCG Savings £000
Mental Health and Learning disabilities	528
Unscheduled Care & Planned Care	3,000
Cross Cutting	3,193
Grand Total	**6,193**

Table 11 – High Level QIPP

The QIPP challenge will see WCCG deliver savings of approximately £6.2 million in 2015/16. The detailed programme by QIPP scheme is shown in Appendix 2.

Contractual arrangements with the main provider of acute services have seen savings of approximately £3.0 million agreed in the contract for 2015/16.

Assurance of QIPP delivery will continue to operate via a centrally coordinated Programme Management Office (PMO) and the planning of future QIPP programmes will build upon best practice adopted across the BCC Cluster.

The PMO will report on the delivery of QIPP schemes to the Finance, Contracting & QIPP Committee through a robust challenge and support process. This will build upon the approach adopted in 2014/15 which saw the successful delivery of QIPP targets.

Process behind developing the QIPP programme

WCCG QIPP 2 year plans have been reviewed and developed with the support of our Clinical Leads.

QIPP saving requirements have been based on a review of benchmarked spend by programme areas and through a review of a range of bench marking indicators shown in Table 12:

Category	Tool / Document / Group
Documents and Groups	The West Midlands and National QIPP work streams
	Walsall JSNA
	Programme Boards (Clinical & GP Led)
	Task & Finish Groups (new)
	GP Localities
	NICE QIPP Evidence
	NHS Benchmarking
	Better Care, Better Value Indicators
	NHS Comparators
Programme Budgets	Programme Budgeting (Spend and Outcome Tool) (SPOT)
	Atlas of Variation
	Commissioning for Value
Similar Metrics	West Midlands Estimated Potential Savings (WMEPS)
	CSU Report - Identifying Potential QIPP Opportunities for 2014/15
	CCG Outcome Indicators
	Primary Care Web Tool

Table 12 – Benchmark Indicators

This is an on-going process and will continue to be a significant feature of the work and development programme over the coming months and years.

The key transformational QIPP programmes are set out in the QIPP milestones template and this document will be used to carry out an assessment of our progress and challenge providers through

contract meetings. Further internal mechanisms (PMO) will be used to programme manage the delivery of QIPP initiatives. From the recently published SPOT analysis and revision of the WMEPS highlighted as areas of concern shown in Table 13 below.

Source	Reason	Metric
SPOT	Significant outlier	Diabetes and Cholesterol 5.0 or less (DM17)
		Register of diabetes with type (DM19/32)
		Diabetes register with adjusted denominator (age 17 and over)
		Neonatal infant mortality per 1,000 births (aged<28 days)
	Lower outcomes	Av health status (EQ-5DTM) for adults with a long-term condition
		Mortality from infectious / parasitic diseases. All ages, Persons
	Higher spend	Mental Health
		Musculo Skeletal
		Learning Disabilities
		Maternity
WMEPS	Rise above demographic growth	Falls related admissions
		Para-suicide and self-harm admissions
		Medicines related admissions
		Wholly attributable alcohol related admissions
		Emergency admissions for screening identifiable conditions
		Surgical interventions resulting from the poor management of diabetes
		Complications following surgery
		Excess bed days
		Admissions with a stay longer than 14 days
		Avoidable (acute conditions) emergency admissions
		Zero length of stay A&E admission
		Pre Op length of stay emergency admission
		Emergency admissions of people aged 75+ with no intervention
		Zero length of stay emergency admissions without procedure and discharged home

Table 13 – Areas of Concern

Section 7
Transformation and Redesign

The Improving Outcomes Committee (IOC) will have responsibility for the delivery of the Operational Plan including the QIPP plans supported by the PMO. It is charged with ensuring that, as part of the planning process, WCCG can demonstrate improved health outcomes. The commissioning programme boards report to the IOC and have the responsibility for identifying the key quality issues within its programme portfolio to be addressed as part of the QIPP planning process.

The Programme Management Office (PMO) provides the support, the definition and delivery of a portfolio of change across an organisation. It also provides the structure, governance, functions and services required for defining a balanced portfolio of change and ensuring consistent delivery of programmes and projects.

The following Programmes have been established to support the implementation of key service transformation / redesign initiatives also see figure 6:

- Elective Care.
- Urgent Care.
- Mental Health.
- Disabilities and Carers.
- Primary Care & Community Care.
- Systems Resilience Group.
- Paediatrics & Maternity.

The programmes are supported by Task and Finish Groups (T&F). These groups meet when necessary and are responsible for driving forward agreed commissioning priorities. The T&F's are focussed on specific clinical pathways. These priorities are established by using the documents and tools as mentioned in 'Section 6 QIPP'.

With regards to elective productivity as described above the T&F's concentrate on specific clinical pathways looking at access to services, maximising quality and streamlining to remove unnecessary steps. Currently the pathways being looked at are described in 'Our Plans' throughout this section.

In terms of outcomes for 2015/16 and 2016/17 WCCG expects that the transformation programmes will impact positively on the measures as detailed in Section 4 of this plan.

The table on the next page explains the content of the change programme described in the templates that appear in Section 7 for Elective Care, Urgent Care, Mental Health, Disabilities and Carers, Primary Care & Community Care, Systems Resilience Group and Paediatrics & Maternity. The investment figures in the 'Our Plans' sections of the template are activity based/derived but only the financial values are shown.

CCG Planning structure follows on the next page, Figure 6.

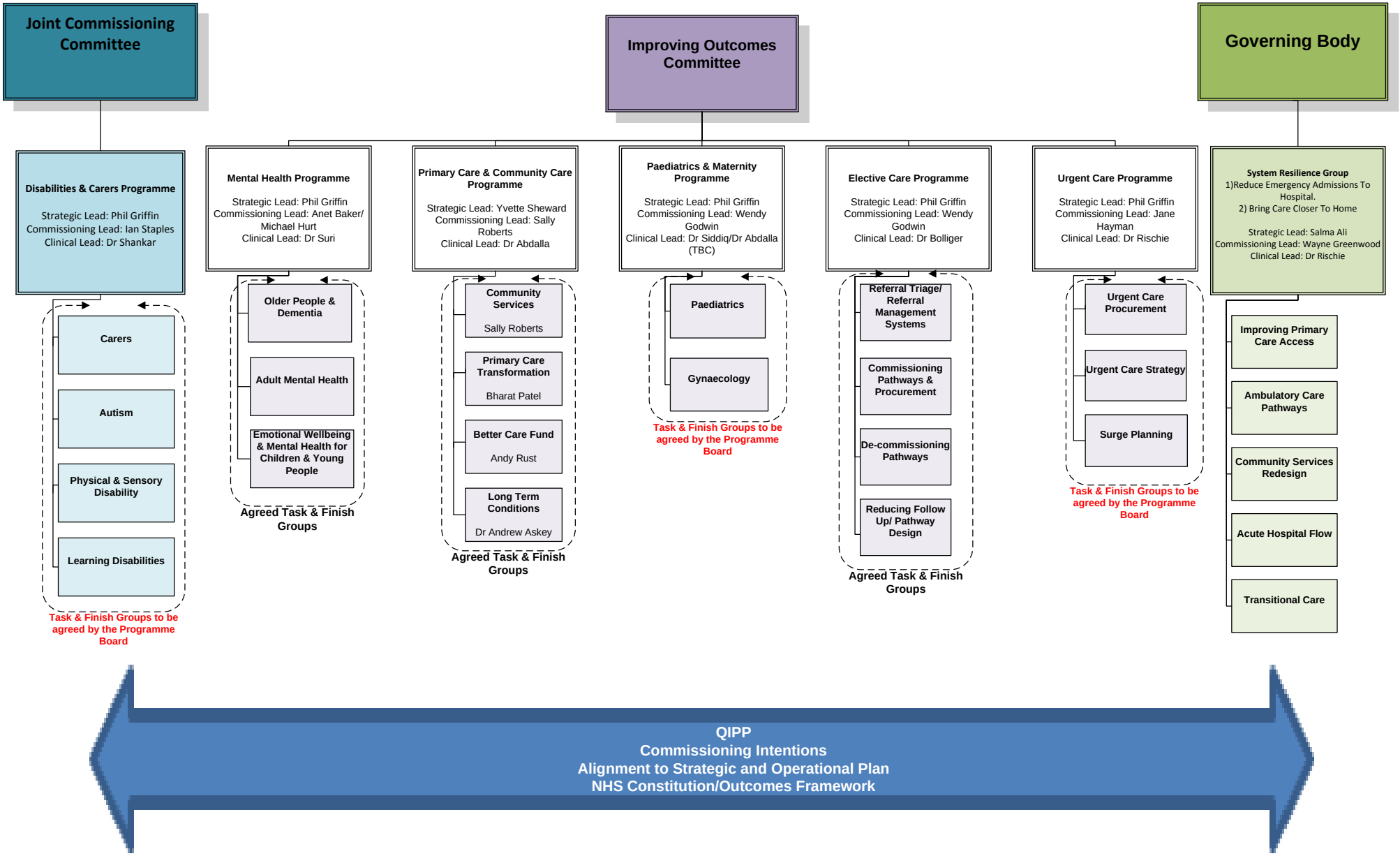


Figure 6 – WCCG Planning Structure

Why is change needed?

A short descriptive list of why the T&F group was created and rationale of change

Description	WCCG 2011/12	Best CCG's in England 2015/16	Opportunity for Saving / Outcome
List of measures applicable to the T&F group as used in the SPOT tool	Latest Metric	The metric of the CCG expected to be the best as at 2015/16	The difference between the 2 metrics

WCCG Outcome Indicator Set Trajectories	2011/12	2012/13	2013/14	2014/15	2015/16
List of the measures from the five domains which are applicable to the T&F group	The trajectories are calculated from where WCCG are to where it is believed WCCG can be.				

Strategic Objectives and priority

The corporate objectives the T&F works to

National Guidance

The guidance used when formulating plans and taking decisions.

Where we want to be

A list of aims of where WCCG would like to be. This could take longer than the period shown in the plan.

Our plans	15/16	16/17	Investment	
			£k +	£k -
A high level list of the plans which are backed up by the PMO office with detailed plans including milestones, timescales, issues, risks etc.	A tick represents whether the plan is active / implemented in the corresponding year.		The amount of investment need	The estimated amount of saving

How we will measure success

The measures in Appendix 4 are used by the programmes to identify areas of concern and monitor the effects of any changes made.

These are specific to individual programmes and are at a low detailed level which contributes to the higher level indicators.

What KPIs will we use to monitor progress?

The measures in Appendix 5 are incorporated into the service specifications and the contract to assure that agreed changes/plans are on target. Some of which are nationally defined and others specific to the service involved.

Risks and Mitigating Actions

RISKS	MITIGATING ACTIONS
A list of risks where it is believed to be outside of the control of the T&F group	A list of the mitigating actions the T&F group has implemented

7.1 Elective Care Programme

7.1.1 Elective Care – Trauma & Orthopaedics, Rheumatology and Pain Management

Why is change needed?

- Unsustainable levels of hospital activity if admissions cannot be reduced
- Not all patients are being seen at the right time, in the right place
- Disjointed planned care services
- Care often not close to home
- Breaches of National Standards (18 weeks / RTT)

Description	WCCG 2012/13	Best CCG's in England 2015/16	Opportunity for Saving / Outcome
£ per head of population – Musculoskeletal System	£ 105.37	£ 70.04	£ 35.33
Total Expenditure £ – Musculoskeletal System	£ 29,563,837	£ 19,651,239	£ 9,912,598
£ per head of population – Trauma & Injuries	£ 55.10	£ 57.38	(£ 2.28)
Total Expenditure £ – Trauma & Injuries	£ 15,459,061	£ 16,099,202	(£ 640,141)
% of patients with a fragility fracture, confirmed on DXA scan, and treated (OST 2)	100.00%	100.00%	0.0%
% of patients aged 75 over with a fragility fracture, treated with an appropriate bone-sparing agent (OST 3)	77.55%	98.28%	20.73%
Mortality from accidents: DSR	13.8	5.11	8.69
Mortality from accidental falls: DSR	1.74	1.17	0.57
Mortality from fractured femur: DSR	3.54	1.54	2.00
Mortality from skull fracture and intercranial injury: DSR	2.22	1.33	0.89
Mortality from land transport accidents: DSR	2.39	1.48	0.91

WCCG Outcome Indicator Set Trajectories	2012/13	2013/14	2014/15	2015/16	2016/17
Patient reported outcome measures for elective procedures - hip replacement	0.407	-	0.443	0.454	0.466
Patient reported outcome measures for elective procedures - knee replacement	0.287	-	0.326	0.333	0.340

Strategic Objectives and Priority

- See Section 1.4 of this plan

National Guidance

- See references at Appendix 3

Where we want to be

- More care delivered within localities with primary and community support for patients and reduction in number of treatments carried out in acute care settings including virtual clinics etc.
- Clinicians and patients reviewing and redesigning pathways
- Greater use of patient satisfaction surveys
- Regular use of benchmarking
- Patients will receive seamless care in line with best practice no matter where they are seen with variation around patient needs not the system
- Patients are treated with dignity and respect
- Patients supported and proactively managed in primary and community settings with locality based GP specialists
- GPs can access multi-disciplinary expertise with access to range of diagnostics and advice from specialists to avoid unnecessary appointments and admissions for patients
- Patients experience of services are beyond their expectations
- Effective patient education programmes
- Patients have links to lifestyle services
- Avoid unnecessary appointments and admissions for patients
- Have a range of services that meet patients' needs
- A wider range of providers for clinical services

Our plans	15/16	16/17	Investment £k +	Investment £k -
○ Referral Management	✓	✓		
○ Review fracture neck of femur	✓	✓		
○ Community / Primary care pathways for Rheumatology	✓	✓		
○ Review & implement Vitamin D & Bone health guidance	✓	✓		
○ Review Medicines Management Pathway for Denosumab injections.	✓	✓		
○ Integrated pathways for chronic pain	✓	✓		

How we will measure success

- Performance against agreed measures as detailed in Appendix 4

What KPI's will we use to monitor progress?

- Operational plan, Local and contractual measures as detailed in Appendix 5

Risks and Mitigating Actions

RISKS	MITIGATING ACTIONS

7.1.2 Elective Care – Dermatology

Why is change needed?

- Unsustainable levels of hospital activity if admissions cannot be reduced
- Not all patients are being seen at the right time, in the right place
- Disjointed planned care services
- Care often not close to home
- Breaches of National Standards (18 weeks / RTT)
- Procedures of Limited Clinical Value

Description	WCCG 2012/13	Best CCG's in England 2015/16	Opportunity for Saving / Outcome
£ per head of population	£ 37.21	£ 23.08	£ 14.13
Total Expenditure £	£ 10,439,142	£ 6,475,594	£ 3,963,548

WCCG Outcome Indicator Set Trajectories	2012/13	2013/14	2014/15	2015/16	2016/17

Strategic Objectives and Priority

- See Section 1.4 of this plan

National Guidance

- See references at Appendix 3

Where we want to be

- More care delivered within localities with primary and community support for patients and reduction in number of treatments carried out in acute care settings including virtual clinics etc.
- Clinicians and patients reviewing and redesigning pathways
- Greater use of patient satisfaction surveys
- Regular use of benchmarking
- Patients will receive seamless care in line with best practice no matter where they are seen with variation around patient needs not the system
- Patients are treated with dignity and respect
- Patients supported and proactively managed in primary and community settings with locality based GP specialists
- GPs can access multi-disciplinary expertise with access to range of diagnostics and advice from specialists to avoid unnecessary appointments and admissions for patients
- Patients experience of services are beyond their expectations
- Effective patient education programmes
- Patients have links to lifestyle services
- Avoid unnecessary appointments and admissions for patients
- Have a range of services that meet patients' needs
- A wider range of providers for clinical services

Our plans	15/16	16/17	Investment £k +	Investment £k -
○ Care closer to home and development of specification	✓			239

How we will measure success

- Performance against agreed measures as detailed in Appendix 4

What KPI's will we use to monitor progress?

- Operational plan, Local and contractual measures as detailed in Appendix 5

Risks and Mitigating Actions

RISKS	MITIGATING ACTIONS

7.1.3 Elective Care – Cancer, Palliative Care and End of Life

Why is change needed?

- Unsustainable levels of hospital activity if admissions cannot be reduced
- Not all patients are being seen at the right time, in the right place
- Disjointed planned care services
- Care often not close to home

Description	WCCG 2012/13	Best CCG's in England 2015/16	Opportunity for Saving / Outcome
£ per head of population	£ 106.71	£ 49.36	£ 57.35
Total Expenditure £	£ 29,942,000	£ 13,849,017	£ 16,092,983
Mortality from all cancers: All ages, DSR	180.89	142.96	37.93
Mortality from all cancers: Under 75 DSR	124.80	86.32	38.48
Mortality from colorectal cancer: Under 75 (DSR)	9.95	7.86	2.09
Mortality from lung cancer: Under 75 DSR	31.99	16.64	15.35
Mortality from breast cancer: Under 75 DSR Women	17.71	15.95	1.76
Under 75 mortality from cancer (per 100,000 females)	141.60	93.90	47.70
Under 75 mortality from cancer (per 100,000 males)	141.10	106.10	35.00
Rate of potential years of life lost per 100,000 - Neoplasms	643.30	431.30	212.00
Patients on Cancer Register since 1/4/2003	1.75%	0.72%	1.03%
% of patients with cancer, diagnosed within last 18 months and patient review within 6 months of confirmed diagnosis	93.66%	95.91%	2.25%

WCCG Outcome Indicator Set Trajectories	2012/13	2013/14	2014/15	2015/16	2016/17

Strategic Objectives & priority

- See Section 1.4 of this plan

National Guidance

- See references at Appendix 3

Where we want to be

- More care delivered within localities with primary and community support for patients and reduction in number of treatments carried out in acute care settings including virtual clinics etc.
- Clinicians and patients reviewing and redesigning pathways
- Greater use of patient satisfaction surveys
- Regular use of benchmarking
- Patients will receive seamless care in line with best practice no matter where they are seen with variation around patient needs not the system
- Patients are treated with dignity and respect
- A wider range of providers for clinical services
- Have a range of services that meet patients' needs
- Patients supported and proactively managed in primary and community settings with locality based GP specialists
- GPs can access multi-disciplinary expertise with access to range of diagnostics and advice from specialists to avoid unnecessary appointments and admissions for patients
- Patients experience of services are beyond their expectations
- Effective patient education programmes
- Patients have links to lifestyle services
- Avoid unnecessary appointments and admissions for patients

Our plans	15/16	16/17	Investment £k +	Investment £k -
○ Review EOL Strategy	✓	✓		
○ Self-assessment against EOL strategy	✓	✓		
○ Cancer survivorship	✓	✓		
○ Chemotherapy access to diagnostics	✓	✓		
○ Screening & Diagnostics	✓	✓		
○ Plasma Exchange for Palliative Care Patients	✓			126

How we will measure success

- Performance against agreed measures as detailed in Appendix 4

What KPI's will we use to monitor progress?

- Operational plan, Local and contractual measures as detailed in Appendix 5

Risks and Mitigating Actions

RISKS	MITIGATING ACTIONS

7.2 Paediatrics & Maternity Programme

7.2.1 Paediatrics & Maternity - Infant Mortality Project

Why is change needed?

- Unsustainable levels of hospital activity if admissions cannot be reduced
- Not all patients are being seen at the right time, in the right place
- Disjointed maternity care services
- Care often not close to home
- Improved performance on the Maternity
- Breaches of National Standards (18 weeks / RTT)

Description	WCCG 2012/13	Best CCG's in England 2015/16	Opportunity for Saving / Outcome
£ per head of population	£ 13.30	£ 9.05	£ 4.25
Total Expenditure £	£ 3,731,000	£ 2,539,174	£ 1,191,826
Neonatal infant mortality per 1000 births (infants aged less than 28 days)	5.50	1.20	4.30

WCCG Outcome Indicator Set Trajectories	2011/12	2012/13	2013/14	2014/15	2015/16
Maternal Smoking at Delivery	18.1%	15.1%	13.7%	12.7%	11.7%

Strategic Objectives and priority

- See Section 1.4 of this plan

National Guidance

- See references at Appendix 3

Where we want to be

- Reduction in infant mortality
- More care delivered within localities with primary and community support for patients and reduction in number of treatments carried out in acute care settings including virtual clinics etc.
- Clinicians and patients reviewing and redesigning pathways
- Greater use of patient satisfaction surveys
- Regular use of benchmarking
- Patients will receive seamless care in line with best practice no matter where they are seen with variation around patient needs not the system
- Patients are treated with dignity and respect
- Patients supported and proactively managed in primary and community settings with locality based GP specialists
- GPs can access multi-disciplinary expertise with access to range of diagnostics and advice from specialists to avoid unnecessary appointments and admissions for patients
- Patients experience of services are beyond their expectations
- Effective patient education programmes
- Patients have links to lifestyle services
- Avoid unnecessary appointments and admissions for patients
- Have a range of services that meet patients' needs
- A wider range of providers for clinical services

Our plans	15/16	16/17	Investment £k +	Investment £k -
○ Shared Action plan with Public Health and WHNHST. Includes the Perinatal Institute commissioned audit of all infant deaths, the independent midwifery audit and a review of all SI's. This is aimed to improve outcomes a reduce the rate of infant mortality in Walsall as part of the NOF	✓	✓		

How we will measure success

- Performance against agreed measures as detailed in Appendix 4

What KPI's will we use to monitor progress?

- Operational plan, Local and contractual measures as detailed in Appendix 5

Risks and Mitigating Actions

RISKS	MITIGATING ACTIONS
Adoption of new Maternity Dashboard	

7.2.2 Paediatrics & Maternity – Gynaecology/Maternity

Why is change needed?

- Unsustainable levels of hospital activity if admissions cannot be reduced
- Not all patients are being seen at the right time, in the right place
- Disjointed gynaecology / maternity services
- Care often not close to home
- Breaches of National Standards (18 weeks / RTT)

Description	WCCG 2011/12	Best CCG's in England 2015/16	Opportunity for Saving / Outcome
£ per head of population	£ 74.25	£ 42.71	£ 31.54
Total Expenditure £	£ 20,832,968	£ 11,983,216	£ 8,849,752

WCCG Outcome Indicator Set Trajectories	2011/12	2012/13	2013/14	2014/15	2015/16

Strategic Objectives and priority

- See Section 1.4 of this plan

National Guidance

- See references at Appendix 3

Where we want to be

- More care delivered within localities with primary and community support for patients and reduction in number of treatments carried out in acute care settings including virtual clinics etc.
- Clinicians and patients reviewing and redesigning pathways
- Greater use of patient satisfaction surveys
- Regular use of benchmarking
- Patients will receive seamless care in line with best practice no matter where they are seen with variation around patient needs not the system
- Patients are treated with dignity and respect
- Patients supported and proactively managed in primary and community settings with locality based GP specialists
- GPs can access multi-disciplinary expertise with access to range of diagnostics and advice from specialists to avoid unnecessary appointments and admissions for patients
- Patients experience of services are beyond their expectations
- Effective patient education programmes
- Patients have links to lifestyle services
- Avoid unnecessary appointments and admissions for patients
- Have a range of services that meet patients' needs
- A wider range of providers for clinical services

Our plans	15/16	16/17	Investment £k +	Investment £k -
○ Review of services with the prospect of moving to Primary Care	✓	✓		16
○ Parenting Education	✓	✓		

How we will measure success

- Performance against agreed measures as detailed in Appendix 4

What KPI's will we use to monitor progress?

- Operational plan, Local and contractual measures as detailed in Appendix 5

Risks and Mitigating Actions

RISKS	MITIGATING ACTIONS

7.2.3 Paediatrics & Maternity – Paediatrics

Why is change needed?

- Unsustainable levels of hospital activity if admissions cannot be reduced
- Not all patients are being seen at the right time, in the right place
- Disjointed paediatric services
- Care often not close to home
- Breaches of National Standards (18 weeks / RTT)

Description	WCCG 2012/13	Best CCG's in England 2015/16	Opportunity for Saving / Outcome
£ per head of population			
Total Expenditure £			
Emergency admissions for children with lower respiratory tract infections (per 100,000 females)	339.60	48.20	291.40
Emergency admissions for children with lower respiratory tract infections (per 100,000 males)	401.50	97.20	304.30
% of patients with asthma between the ages of 14 and 19 years with record of smoking status (ASTHMA 10)	90.26%	94.80%	4.54%
% of patients aged eight and over with measures of variability or reversibility (ASTHMA 8)	90.26%	88.50%	(1.76%)

WCCG Outcome Indicator Set Trajectories	2012/13	2013/14	2014/15	2015/16	2016/17
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	468.9	346.8	329.0	311.2	293.4
Emergency admissions for children with lower respiratory tract infections	367.8	389.7	372.6	355.5	338.5

Strategic Objectives and priority

- See Section 1.4 of this plan

National Guidance

- See references at Appendix 3

Where we want to be

- More care delivered within localities with primary and community support for patients and reduction in number of treatments carried out in acute care settings including virtual clinics etc.
- Clinicians and patients reviewing and redesigning pathways
- Greater use of patient satisfaction surveys
- Regular use of benchmarking
- Patients will receive seamless care in line with best practice no matter where they are seen with variation around patient needs not the system
- Patients are treated with dignity and respect
- Patients supported and proactively managed in primary and community settings with locality based GP specialists
- GPs can access multi-disciplinary expertise with access to range of diagnostics and advice from specialists to avoid unnecessary appointments and admissions for patients
- Patients experience of services are beyond their expectations
- Effective patient education programmes
- Patients have links to lifestyle services
- Avoid unnecessary appointments and admissions for patients
- Have a range of services that meet patients' needs
- A wider range of providers for clinical services

Our plans	15/16	16/17	Investment £k +	Investment £k -
○ Care closer to home (Community Nursing/Activity)	✓	✓		
○ Emergency Care pathways (Paediatric Assessment Unit (PAU)/A&E)	✓	✓		
○ Integration of Paediatric Community Care Pathways	✓	✓		

How we will measure success

- Performance against agreed measures as detailed in Appendix 4

What KPI's will we use to monitor progress?

- Operational plan, Local and contractual measures as detailed in Appendix 5

Risks and Mitigating Actions

RISKS	MITIGATING ACTIONS

7.3 Systems Resilience Group

Why is change needed?

- Unsustainable levels of hospital activity if admissions cannot be reduced
- Not all patients are being seen at the right time, in the right place
- Disjointed planned care services
- Care often not close to home

Description	WCCG 2012/13	Best CCG's in England 2015/16	Opportunity for Saving / Outcome

WCCG Outcome Indicator Set Trajectories	2015/16	2016/17
A&E Waits (Patients should be admitted, transferred or discharged within 4 hours of their arrival at A&E)	95%	95%
A&E Waits (No waits from decision to admit to admission (trolley waits) over 12 hours)	0	0
Ambulance Handovers (Ambulance to A&E =<15 mins) (ready to accept new calls within a further 15 mins)	0	0
Category A ambulance calls (emergency response within 8 mins)	75%	75%
Category A ambulance calls (ambulance arriving at scene within 19 mins)	95%	95%

Strategic Objectives and priority

- See Section 1.4 of this plan

National Guidance

- See references at Appendix 3

Where we want to be

- Primary care is able to provide a same day service for patients with a perceived urgent care need
- Patients who access urgent care services receive a consistent and seamless approach and as a result are not passed from one service to another
- Patients with an emergency ambulatory care condition receive same day access to diagnostics and treatment
- Patients who need to be admitted stay in hospital for no longer than is necessary
- Reduce the number of emergency admissions for exacerbation of existing respiratory conditions
- Improve the long term prognosis of patients with a newly diagnosed respiratory condition
- Patients treated in a community environment wherever possible, including exacerbation management

Our plans	15/16	16/17	Investment £k +	Investment £k -
○ Choose Well Campaign	✓	✓		
○ Flu Campaign	✓	✓		
○ Perfect Week	✓	✓		
○ Spot Purchase	✓	✓		

How we will measure success

- Performance against agreed measures as detailed in Appendix 4

What KPI's will we use to monitor progress?

- Operational plan, Local and contractual measures as detailed in Appendix 5

Risks and Mitigating Actions

RISKS	MITIGATING ACTIONS

7.4 Urgent Care Programme

Why is change needed?

- Unsustainable levels of hospital activity if admissions cannot be reduced
- Not all patients are being seen at the right time, in the right place
- Disjointed planned care services
- Care often not close to home

Description	WCCG 2012/13	Best CCG's in England 2015/16	Opportunity for Saving / Outcome
£ per head of population – Ambulance	£ 30.22	£ 2.91	£ 27.31
Total Expenditure £ - Ambulance	£ 8,480,000	£ 816,464	£ 7,663,536
£ per head of population – A&E	£ 36.92	£ 1.47	£ 35.45
Total Expenditure £ - A&E	£ 10,358,124	£ 412,440	£ 9,945,684
£ per head of population – Non Elective	£250.84	£ 154.32	£ 96.52
Total Expenditure £ - Non Elective	£ 70,383,000	£ 43,297,820	£ 27,085,180

WCCG Outcome Indicator Set Trajectories	2012/13	2013/14	2014/15	2015/16	2016/17
Emergency admissions for alcohol related liver disease	24.0	31.0	30.0	28.0	26.5
Unplanned hospitalisation for chronic ambulatory sensitive conditions (adults)	1,072	1,087	959	968	976
Emergency admissions for acute conditions that should not usually require hospital admission	1,332	1,399	1,322	1,245	1,169
Emergency readmissions within 30 days of discharge from hospital			12	11	11

Strategic Objectives and priority

- See Section 1.4 of this plan

National Guidance

- See references at Appendix 3

Where we want to be

- Primary care is able to provide a same day service for patients with a perceived urgent care need
- Patients who access urgent care services receive a consistent and seamless approach and as a result are not passed from one service to another
- Patients with an emergency ambulatory care condition receive same day access to diagnostics and treatment
- Patients who need to be admitted stay in hospital for no longer than is necessary
- Reduce the number of emergency admissions for exacerbation of existing respiratory conditions
- Improve the long term prognosis of patients with a newly diagnosed respiratory condition
- Patients treated in a community environment wherever possible, including exacerbation management

Our plans	15/16	16/17	Investment £k +	Investment £k -
○ WMAS	✓	✓		
○ NHS 111	✓	✓		
○ Urgent Care Procurement	✓	✓		
○ A&E diversion scheme	✓	✓		46

How we will measure success

- Performance against agreed measures as detailed in Appendix 4

What KPI's will we use to monitor progress?

- Operational plan, Local and contractual measures as detailed in Appendix 5

Risks and Mitigating Actions

RISKS	MITIGATING ACTIONS

7.5 Mental Health Programme

7.5.1 Mental Health – Older Peoples Mental Health & Dementia

Why is change needed?

- Major cause of poor health & quality of life and increasing mental ill health prevalence
- Ageing population will increase numbers with dementia
- Variable access to adult mental health services

Description	WCCG 2012/13	Best CCG's in England 2015/16	Opportunity for Saving / Outcome
£ per head of population	£ 35.05	£ 3.64	£ 31.41
Total Expenditure £	£ 9,835,000	£ 1,021,281	£ 8,813,719
Mortality from suicide and injury undetermined: DSR	5.84	4.51	1.33
The percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months (DEM2)	84.76%	89.63%	4.87%
The percentage of patients with a new diagnosis of dementia with a record of tests (DEM 4)	81.11%	84.85%	3.74%
% of older mental health patients with a record of total cholesterol:hdl ratio (MH 19)	86.41%	89.31%	2.90%
% of older mental health patients with a record of blood glucose or HbA1c (MH 20)	90.00%	91.67%	1.67%

WCCG Outcome Indicator Set Trajectories	2012/13	2013/14	2014/15	2015/16	2016/17
Patient experience of community mental health services	88.8%	87.6%	89.4%	90.3%	91.1%
Dementia diagnosis rate			67%	67%	67%

Strategic Objectives and Priority

- See Section 1.4 of this plan

National Guidance

- See references at Appendix 3

Where we want to be

- An integrated tiered approach to mental health & dementia across the whole healthcare system
- Far greater understanding in the community about how to maintain mental health, wellbeing and challenge the stigma attached to having mental health problems and dementia.
- People with common mental health problems or signs of psychological distress - including those where these problems are secondary to a long term physical health condition/carers - can access a range of talking therapies and support in Primary Care to prevent escalation into, and extended use of, health and social care services.
- Providing high quality care and support for people who become acutely mentally ill and need specialist in-patient and community services (specialist or generic services).
- People with mental health problems/dementia remain in or as near to Walsall as they wish in a genuine home with support to remain in or get employment/meaningful occupation.
- Staff working with people who have mental health problems are recognised as doing a valuable job.
- Fully integrated model of mental health care with robust pathways with all partners working in collaboration
- Review of all Walsall older people's mental health services
- National dementia strategy implemented and Prime Minister's Challenge on dementia implemented
- Parity of esteem

Our plans	15/16	16/17	Investment £k +	Investment £k -
○ Older Peoples MH & dementia 7 day intensive support/crisis team	✓	✓		
○ Continue the rollout of specialist Dementia Support Workers	✓	✓		
○ Create a new dementia website	✓	✓		
○ Support the development of challenging behaviour facilities	✓	✓		
○ Improved activity in care homes & community groups with the use of assistive technology	✓	✓		
○ Develop Primary Care Coordinators to support localities	✓	✓		
○ OPMH acute hospital liaison team to 7 days instead of 5 days a week	✓	✓		
○ Review of the Memory Assessment Service and future ways of diagnosing dementia	✓	✓		
○ Support for care homes, particularly around improved dementia care and end of life care	✓	✓		
○ Commission Mind Matters café and encourage the voluntary sector to provide others	✓	✓		
○ Continue to provide Dementia Cafes	✓	✓		
○ Continuation of the Dementia Friendly Communities programme	✓	✓		

How we will measure success

- Performance against agreed measures as detailed in Appendix 4

What KPI's will we use to monitor progress?

- Operational plan, Local and contractual measures as detailed in Appendix 5

Risks and Mitigating Actions

RISKS	MITIGATING ACTIONS

7.5.2 Mental Health – Adult Mental Health

Why is change needed?

- Major cause of poor health & quality of life and increasing mental ill health prevalence
- Increase in depression and anxiety due to economic factors
- Variable access to adult mental health services

Description	WCCG 2012/13	Best CCG's in England 2015/16	Opportunity for Saving / Outcome
£ per head of population	£ 155.63	£ 66.72	£ 88.91
Total Expenditure £	£ 43,667,632	£ 18,719,741	£ 24,947,891
Mortality from suicide and injury undetermined: DSR	5.84	4.51	1.33
% of patients on diabetes register and/or CHD register with depression case finding (DEP 1)	91.44%	92.40%	1.04%
% of patients newly diagnosed with depression with an assessment of severity (DEP 6)	90.09%	95.56%	5.47%
% of patients newly diagnosed with depression with further assessment of severity (DEP 7)	80.77%	88.03%	7.26%
The number of new diagnoses of depression in the practice during this QOF year	0.64%	0.85%	0.21%
Patients with CHD or diabetes. (DEP PREV 1)	4.65%	2.29%	2.36%
Patients with a history of depression coded at any time (DEP PREV 2)	6.04%	2.84%	3.20%
The practice can produce a register of people with schizophrenia, bipolar disorder and other psychoses (MH 8)	0.80%	0.55%	0.25%
The percentage of patients on the register who have a comprehensive care plan (MH 10)	86.57%	92.30%	5.73%
% of patients with schizophrenia, bipolar affective disorder and other psychoses with alcohol consumption (MH 11)	94.02%	94.05%	0.03%
% of patients with schizophrenia, bipolar affective disorder and other psychoses with record of BMI (MH 12)	92.34%	94.18%	1.84%
% of patients with schizophrenia, bipolar affective disorder and other psychoses with record of blood pressure (MH 13	93.35%	95.12%	1.77%
% percentage of female mental health patients with cervical screening (MH 16)	90.56%	93.10%	2.54%
% of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months (MH 17)	97.81%	100.00%	2.19%
% of patients on lithium therapy with a record of lithium levels in the therapeutic range (MH 18)	89.15%	95.63%	6.48%

WCCG Outcome Indicator Set Trajectories	2012/13	2013/14	2014/15	2015/16	2016/17
Patient experience of community mental health services	88.8%	87.6%	89.4%	90.3%	91.1%

Strategic Objectives and Priority

- See Section 1.4 of this plan

National Guidance

- See references at Appendix 3

Where we want to be

- An integrated tiered approach to mental health across the whole healthcare system
- Far greater understanding in the community about how to maintain mental health and wellbeing and challenge the stigma attached to having mental health problems.
- People with common mental health problems or signs of psychological distress - including those where these problems are secondary to a long term physical health condition - can access a range of talking therapies and support in Primary Care to prevent escalation into, and extended use of, health and social care services.
- An integrated tiered approach to mental health across the whole healthcare system
- People with mental health problems remain in or as near to Walsall as they wish in a genuine home with support to remain in or get employment/meaningful occupation
- Staff working with people who have mental health problems are recognised as doing a valuable job.
- Fully integrated model of mental health care with robust pathways with all partners working in collaboration
- Reprovision of all Walsall inpatient services
- Providing high quality care and support for people who become acutely mentally ill and need specialist in-patient and community services (specialist or generic services).
- Parity of esteem

Our plans	15/16	16/17	Investment £k +	Investment £k -
○ Review of Section 12 processes	✓	✓		
○ Rehabilitation contract framework	✓	✓		
○ Closure & Redevelopment of Broadway North	✓	✓		
○ Interaction between MH, alcohol & frequent fliers	✓	✓		
○ Prevention & Recovery	✓	✓		
○ Maternal mental health	✓	✓		
○ Improving rehabilitation pathway for functional mental health	✓	✓		
○ Repatriation and re-evaluation of packages of support	✓	✓		
○ Increase IAPT to Older People (Visiting service)	✓	✓		
○ Crisis Car	✓	✓		
○ MH Concordat	✓	✓		
○ Implement DBT	✓	✓		
○ Develop counselling service	✓	✓		
○ Develop psychiatric liaison pathway	✓	✓		
○ Personalisation & individual personal health budgets	✓	✓		
○ Acute MH support for urgent care	✓	✓		
○ Grasmere	✓	✓		
○ Pathway redesign/contracting	✓	✓		

How we will measure success

- Performance against agreed measures as detailed in Appendix 4

What KPI's will we use to monitor progress?

- Operational plan, Local and contractual measures as detailed in Appendix 5

Risks and Mitigating Actions

RISKS	MITIGATING ACTIONS
Low level risks	Being managed within the programme board

7.5.3 Mental Health – Children & Young People's Emotional Wellbeing & Mental Health Service

Why is change needed?

- One in ten children and young people between 5 and 16 years has a mental health problem which significantly impacts on health, education and social outcomes, with half of those with lifetime mental health problems experiencing symptoms by the age of 14
- Fragmented mental health service provision for children and young people
- Lack of clarity about pathways and provision for children with complex needs and children and young people with multiple problems

Description	WCCG 2012/13	Best CCG's in England 2015/16	Opportunity for Saving / Outcome
£ per head of population	£ 16.54	£ 1.12	£ 15.42
Total Expenditure £	£ 4,641,000	£ 314,240	£ 4,326,760

WCCG Outcome Indicator Set Trajectories	2012/13	2013/14	2014/15	2015/16	2016/17
Patient experience of community mental health services	88.8%	87.6%	89.4%	90.3%	91.1%

Strategic Objectives and priority

- See Section 1.4 of this plan

National Guidance

- See references at Appendix 3

Where we want to be

- An integrated tiered approach to mental health across the whole healthcare system
- Far greater understanding in the community about how to maintain mental health and wellbeing and challenge the stigma attached to having mental health problems.
- Children and Young people with mental health problems or signs of psychological distress can access a range of talking therapies and support in Primary Care to prevent escalation into, and extended use of, health and social care services.
- In partnership with NHSE, providing high quality care and support for children and young people who become acutely mentally ill and need specialist in-patient services (specialist or generic services).
- Development of a community based service for those children and young people requiring access to Tier 3 plus arrangements.
- Children and young people with mental health problems remain in or as near to Walsall as they wish in a genuine safe placement with support to access education and relevant social activities.
- Robust arrangements for U18 admissions to acute wards are prevented through appropriate provision of specialist placements and relevant pathways e.g.: Deliberate Self Harm pathway.
- Staff working with children and young people who have mental health problems are recognised as doing a valuable job.
- Fully integrated model of mental health care with robust pathways with all partners working in collaboration

Our plans	15/16	16/17	Investment £k +	Investment £k -
○ Tier 3+ evaluation	✓	✓		
○ Develop information suite for CYP	✓	✓		
○ Children's social care commissioning	✓	✓		
○ Develop service specification for specialist CAMHS	✓	✓		
○ Development of 0-25	✓	✓		

How we will measure success

- Performance against agreed measures as detailed in Appendix 4

What KPI's will we use to monitor progress?

- Operational plan, Local and Contractual measures as detailed in Appendix 5

Risks and Mitigating Actions

RISKS	MITIGATING ACTIONS
Low level risks	Being managed within the programme board

7.6 Disabilities and Carers Programme

Why is change needed?

- Transforming Care Programme (formally Winterbourne)
- To gain best value of placements

Description	WCCG 2012/13	Best CCG's in England 2015/16	Opportunity for Saving / Outcome
£ per head of population	£ 39.92	£ 0.44	£ 39.48
Total Expenditure £	£ 11,202,000	£ 123,451	£ 11,078,549
% patients on LD register with Down's Syndrome and a record of blood TSH (excl those on thyroid register) (LD 2)	96.61%	100.00%	3.39%

WCCG Outcome Indicator Set Trajectories	2011/12	2012/13	2013/14	2014/15	2015/16

Strategic Objectives and Priority

- See Section 1.4 of this plan

National Guidance

- See references at Appendix 3

Where we want to be

- Increased use of telehealth to support self-management of long term conditions and provide useful clinical data for clinicians especially GPs and Community Nurses
- Increased use of Telecare and assistive technology to support people in the community and to prevent unnecessary hospital admissions.
- Equipment being provided to support people to remain living independently and retain or regain skills
- Facilitate timely discharges through the provision of appropriate technology and equipment
- Improved access to information and guidance on a range of equipment and assistive technology.
- Support to access & complete self-assessments to enable individuals to privately purchase equipment & assistive technology
- Support to carers through Telecare to monitor and alert the carer to issues, falls etc.
- Support to carers to enable them to complete physical and personal care through the provision of equipment.
- To procure equipment more cost effectively whilst maintaining quality.
- To promote best practice in the use of assistive technology and equipment.
- Improve the experience of children going through transition in relation to continuity of equipment services.
- All primary & secondary health care settings make the appropriate reasonable adjustments to ensure equitable access to services for people with learning disabilities, disabilities and autism. People with learning disabilities / disabilities do not experience discrimination or barriers to treatment as a result of their additional needs
- All primary & secondary health services have a system to flag patients that have a learning disability
- Primary care services are supported to complete comprehensive annual health checks in accordance with the Cardiff Health Check tool to adults with learning disabilities. Primary care services complete a Health Action Plan at the point of the annual health check.
- Primary health care services are supported to submit data reports to inform the Joint Health & Social Care Self-Assessment Framework.
- Primary health care services support people with learning disabilities to access cancer screening programmes in line with national guidance
- The health & social care economy support to reduce the reliance on assessment & treatment, Forensic step down and rehabilitation hospital beds for people with disabilities. A range of interventions and preventative pathways are developed and implemented to support hospital avoidance.
- Where people require an admission to an in-patient services their stay is not prolonged more than required and a timely return to the community is facilitated. All patients shall have a defined Care Pathway which specifies a time frame against which individual progress is measured.
- Delivery of the Transforming Care programme / Concordat and subsequent reports: Winterbourne View, Time for Change (Sir Stephen Bubb, 2014) & Transforming Care for People with Learning Disabilities, Next Steps (NHS England, January 2015).
- Delivery of Joint Health & Social Care Self-Assessment Framework and accompanying action plan & work stream.
- Delivery of the findings from the Confidential Inquiry of Premature Deaths of people with Learning Disabilities.
- CCG collaboratively works with the Local Authority to promote Joint Commissioning approaches to providing person centred support
- CCG utilises robust contracting & governance procedures and processes to ensure that adults with learning disabilities, disabilities and autism are safeguarded
- Healthcare settings demonstrate a comprehensive understanding as well as demonstrate the application of the Mental Health Act including best interest, Deprivation of Liberties safeguarding
- To commission a spectrum of local services for adults with learning disabilities, disabilities and autism that promote citizenship & access to mainstream services where possible in partnership with the local authority
- To commission services which represent value for money, person centred and support the patients networks
- People with disabilities can access supported employment services and achieve 'job readiness'
- Carers are supported across the health economy in line with the NHS Commitment to Carers
- People with ASD can access diagnostic services , mainstream health services and appropriate specialist services in meeting the outcomes of the autism Strategy
- Parity of esteem

Our plans	15/16	16/17	Investment £k +	Investment £k -
○ Empowerment, Engagement and Decision Making	✓			
○ Befriending	✓	✓		
○ Advocacy	✓	✓		
○ Summer Scheme	✓	✓		
○ Carers Commissioning Plan	✓	✓		
○ Emergency Response Service to Carers	✓	✓		
○ Transforming Care (winterbourne and Bubb Report)	✓	✓		
○ Joint Health and Social Care Health Self-Assessment Framework and Action Plan	✓	✓		
○ Autism Commissioning Plan	✓	✓		528
○ Autism Diagnostic Pathway	✓	✓		
○ Autism Joint Self-Assessment Framework and Action Plan	✓	✓		
○ Respite Care review	✓	✓		
○ Telehealth and Telecare Plan	✓	✓		
○ Empowerment, Engagement and Decision Making	✓	✓		
○ Befriending	✓	✓		
○ Personal Budgets	✓	✓		

How we will measure success

- Performance against agreed measures as detailed in Appendix 4

What KPI's will we use to monitor progress?

- Operational plan, Local and contractual measures as detailed in Appendix 5

Risks and Mitigating Actions

RISKS	MITIGATING ACTIONS
Low level risks	Being managed within the programme board

7.7 Primary Care & Community Care Programme

Why is change needed?

- Realisation of benefits in terms of the shift of investment in community services needs to be clearer.
- Ageing population, requiring increased support at home, with increasing fragility requiring different skill set & approach.
- We recognise the opportunities that exist for collaboration with key partners e.g.: mental health trust, Social care to provide a more integrated approach to the delivery of community services, including arrangements within 'Better Care' arrangements..
- More joined up community infrastructure, including community locality models across primary care & work with Care & Nursing Homes, voluntary sector and social care.
- To ensure value for money (VFM), including effective currency arrangements for commissioners and providers.
- Exploring opportunities for collaborative working across primary and secondary care ensuring delivery of care closer to home.
- Capacity of the current system and analysis of resilience in the face of growing challenges is required.

Description	WCCG 2012/13	Best CCG's in England 2015/16	Opportunity for Saving / Outcome
£ per head of population – Primary Care	£ 219.56	£ 5.80	£ 213.76
Total Expenditure £ - Primary Care	£ 60,604,000	£ 1,627,316	£ 58,976,685
£ per head of population – Primary Prescribing	£ 204.98	£ 1.16	£ 203.82
Total Expenditure £ - Primary Prescribing	£ 57,513,000	£ 326,709	£ 57,186,291
£ per head of population – Community Care	£ 218.79	£ 2.02	£ 216.77
Total Expenditure £ - Community Care	£ 61,388,000	£ 566,634	£ 60,821,366
% of diabetic patients whose last HbA1c was 8 or less (DM27)	78.17%	81.03%	2.86%
% of diabetic patients whose last HbA1c was 9 or less (DM28)	87.70%	90.09%	2.39%
The percentage of patients with diabetes with a record of a foot examination and risk classification	91.56%	92.53%	0.97%
% of diabetic patients whose last blood pressure was 150/90 or less (DM30)	89.60%	92.44%	2.84%
% of diabetic patients whose last blood pressure was 140/80 or less (DM31)	74.27%	78.80%	4.53%
Diabetes and Neuropathy test in 15 months (DM10)	91.31%	92.77%	1.46%
Diabetes and Micro-albuminiria testing done (DM13)	88.80%	91.20%	2.40%
Diabetes and Proteinuria or Microalbuminuria on ACEi (DM15)	88.43%	90.61%	2.18%
Diabetes and Cholesterol 5.0 or less (DM17)	75.81%	88.29%	12.48%
Diabetes given Influenza Vaccine (DM18)	89.93%	93.01%	3.08%
Diabetes with BMI in last 15 months (DM2)	94.79%	96.16%	1.37%
% of patients with diabetes who have a record of retinal screening in the previous 15 months (DM21)	92.81%	93.69%	0.88%
% of patients with diabetes who have a record of eGFR or serum creatinine testing in the previous 15 months (DM22)	96.33%	98.55%	2.22%
% of diabetic patients whose last HbA1c was 7.5 or less (DM26)	71.29%	74.15%	2.86%
Myocardial infarction, stroke and stage 5 chronic kidney disease in people with diabetes (ISR)	2.14	1.36	0.78
The percentage of people with diabetes diagnosed less than one year who are referred to structured education	13.90%	54.60%	40.70%
Rate of complications associated with diabetes, per 100 people with diabetes	7.61	4.31	3.30
Hypothyroid Patients with TFT done (THYROID02)	95.14%	98.65%	3.51%
Mortality from epilepsy: Under 75 DSR	2.35	0.72	1.63
% of patients age 18 and over on drug treatment for epilepsy who have a record of seizure frequency (EPILEPSY 6)	95.45%	96.19%	0.74%
% of patients age 18 and over on drug treatment for epilepsy and seizure free for the last 12 months (EPILEPSY 8)	74.73%	82.91%	8.18%
% of women on antiepileptic drugs given information about contraception, conception and pregnancy (EPILEPSY 9)	94.85%	98.58%	3.73%
Mortality from all circulatory diseases: Under 75 DSR	79.40	42.01	37.39
Mortality from coronary heart disease: Under 75 DSR	47.40	18.85	28.55
Mortality from acute MI: Under 75 DSR	22.37	8.29	14.08
Mortality from stroke: Under 75 DSR	14.73	9.39	5.34
Under 75 mortality from cardiovascular disease (per 100,000 females)	60.00	14.70	45.30
Under 75 mortality from cardiovascular disease (per 100,000 males)	105.20	61.30	43.90
Rate of potential years of life lost per 100,000 - Ischaemic Heart Disease	980.70	446.00	534.70
Rate of potential years of life lost per 100,000 - Cerebrovascular Diseases	300.30	194.00	106.30
% of patients with Atrial Fibrillation with stroke risk assessment using CHADS2 (AF 5)	97.85%	98.64%	0.79%
% of Atrial Fibrillation patients with CHADS2 score of 1 on anti-coagulation drug or an anti-platelet therapy. (AF 6)	95.20%	97.19%	1.99%
% of Atrial Fibrillation patients with CHADS2 score > 1, treated with anti-coagulation drug therapy (AF 7)	82.16%	92.23%	10.07%
Hypertension and BP check in last 9 months (BP 4)	92.15%	93.87%	1.72%
Hypertension and BP 150/90 or less (BP 5)	81.81%	85.34%	3.53%
CHD on Betablockers(CHD10)	78.57%	80.35%	1.78%

Description	WCCG 2012/13	Best CCG's in England 2015/16	Opportunity for Saving / Outcome
CHD given flu jab in last season(CHD12)	92.44%	94.67%	2.23%
% of patients with history of myocardial infarction treated variously (CHD14)	86.48%	92.40%	5.92%
CHD and BP 150/90 or less(CHD06)	90.72%	91.99%	1.27%
CHD and Cholesterol 5.0mmol/l or less (CHD08)	77.02%	83.50%	6.48%
CHD taking Aspirin or equivalent (CHD09)	93.40%	95.25%	1.85%
HF since 1/4/2006 and echo or specialist confirmation(HF2)	95.06%	97.74%	2.68%
Heart failure taking ACEi(HF3)	91.59%	93.30%	1.71%
% of patients with heart failure due to LVD treated with additional beta-blocker (HF4)	88.26%	92.87%	4.61%
% of patients with peripheral arterial disease with a record that aspirin is being taken(PAD02)	91.16%	96.31%	5.15%
% of patients with peripheral arterial disease with last blood pressure reading 150/90 or less(PAD03)	90.06%	92.55%	2.49%
% of patients with peripheral arterial disease with last measured total cholesterol 5.0mmol/l or less(PAD04)	78.16%	98.17%	20.01%
% of new diagnosis of hypertension with cardiovascular risk assessment (PP1)	83.26%	88.60%	5.34%
% of people diagnosed with hypertension given lifestyle advice(PP2)	86.25%	87.22%	0.97%
Stroke / TIA given flu vaccine (STROKE10)	90.34%	91.45%	1.11%
% of patients with a stroke with anti-platelet agent being taken (STROKE12)	93.89%	95.05%	1.16%
The % of new patients with a stroke who have been referred for further investigation. (STROKE13)	88.71%	92.31%	3.60%
Stroke / TIA and BP 150/90 or less (STROKE06)	89.52%	92.04%	2.52%
Stroke / TIA and chol check in 15 months(STROKE07)	91.93%	97.58%	5.65%
Stroke / TIA and chol 5.0 or less(STROKE8)	74.57%	90.38%	15.81%
Mortality from bronchitis and emphysema and COPD:Under 75 DSR	12.63	8.03	4.60
Mortality from bronchitis and emphysema: Under 75 DSR	0.54	0.00	0.54
Mortality from asthma: DSR	1.53	0.73	0.80
Under 75 mortality from respiratory disease (per 100,000 females)	23.20	18.00	5.20
Under 75 mortality from respiratory disease (per 100,000 males)	32.90	19.30	13.60
Rate of potential years of life lost per 100,000 - Respiratory Diseases	155.70	86.70	69.00
% of patients with asthma between the ages of 14 and 19 years with record of smoking status (ASTHMA 10)	90.26%	94.80%	4.54%
% of patients aged eight and over with measures of variability or reversibility (ASTHMA 8)	90.26%	88.50%	(1.76%)
% of patients with asthma with assessment of asthma control (ASTHMA 9)	76.82%	77.44%	0.62%
The % of patients with COPD with a record of FeV1 (COPD 10)	87.35%	91.62%	4.27%
% of patients with COPD with review, including dyspnoea score(COPD 13)	90.85%	93.87%	3.02%
% of all patients with COPD with diagnosis confirmed by post bronchodilator spirometry (COPD 15)	93.64%	94.14%	0.50%
COPD who had flu vaccine (COPD 8)	92.05%	94.99%	2.94%
% of patients on ACE/ARB therapy for patients with chronic renal failure and hypertension (CKD05)	87.65%	93.11%	5.46%
The percentage of patients on the CKD register with a blood pressure recording (CKD 2)	97.22%	98.21%	0.99%
% of patients on the CKD register whose# last blood pressure reading is 140/85 or less (CKD 3)	77.86%	80.71%	2.85%
% of patients on the CKD register with albumin: creatinine ratio (CKD 6)	84.96%	85.94%	0.98%

WCCG Outcome Indicator Set Trajectories	2012/13	2013/14	2014/15	2015/16	2016/17
Proportion of people feeling supported to manage their condition	64%	63%	66%	66%	66%
Health related quality of life for people with long term conditions	0.702	0.711	0.729	0.744	0.760
Under 75 mortality rate from cardiovascular disease	83	84	72	70	68
Under 75 mortality rate from respiratory disease	28	28	27	26	25

Strategic Objectives

- See Section 1.4

National Guidance

- See references at Appendix 3

Where we want to be

- Change in culture to support prevention, self-care, patient empowerment, with patients & primary healthcare teams including use of information relating to health care
- High quality collaborative services
- Aligning with other work streams – Urgent Care and Long Term Conditions.
- Maximise opportunities of primary care at scale, with collaborative secondary care programmes, ensuring care delivery closer to home.
- Ability to identify those patients 'at risk' early on ensuring community preventative measures are in place & evidenced through robust risk stratification of patient groups.
- Develop the right infrastructure for community nursing and rapid response ensuring highly responsive and skilled service.
- Virtual wards – patients being managed safely in the community where they want to be with the right care & ability to 'step up & down' along a continuum of care delivery.
- All community healthcare teams to act as care co-ordinators navigating & tracking patients through the system & removing blocks
- Ability to respond rapidly to changing clinical & social care situations through an integrated care 'step up' model preventing admission to hospital or expediting discharge through an effective 'Step down' model through the use of FEP.
- Through good health and social care models of care prevent long term admissions to residential or nursing care.
- Ensuring robust arrangements for Nursing homes, ensuring appropriate medical support available when required and maximise opportunities to develop nursing home skills to ensure alignment with a revised community service.
- Effective risk stratification and prevention services
- Patient empowerment and self-care management
- Defined pathways of care
- Hospital avoidance
- Maximising use of digital technology

Our plans	15/16	16/17	Investment £k +	Investment £k -
○ Reduction in avoidable admissions	✓	✓		
○ Diabetes Prevention	✓	✓		
○ Patient management	✓	✓		
○ Early Diagnosis of diabetes	✓	✓		
○ 24 BP Monitoring and Diagnostics	✓	✓		
○ Expression of interest (EOI) for national evidence based diabetes prevention programme	✓			
○ Heart Failure including telehealth	✓	✓		
○ Stroke Rehab (BCC stroke review – hyper acute)	✓	✓		
○ Breathlessness Clinics (integration of Heart Failure)	✓	✓		
○ Neurological Conditions	✓	✓		78
○ Primary Care Development programmes	✓	✓		
○ Locality Business Cases	✓	✓		
○ Development & support of CCG wide Practice Nurse Strategy, ensuring fitness to practice.	✓	✓		
○ Medicines Strategy	✓	✓		1,700
○ Revised community nursing model	✓	✓		
○ Review existing community services & specifications with response to winter	✓	✓		
○ Performance Frameworks	✓	✓		
○ To give CHC eligible people the 'right to have' a personal health budget from 1/10/14	✓	✓		
○ Develop CHC PHB process	✓	✓		
○ Complete all Retrospective Reviews by 2017 as per guidance from NHS England.	✓	✓		
○ Advise & support CCG on the roll-out of PHB's to Long Term Conditions from 1/4/15	✓	✓		315
○ Engage GP's on CHC and their potential input to PHB's for their patients.	✓	✓		
○ Engage the voluntary sector & user groups in the development of rolling out of PHB's.	✓	✓		
○ Work with NHS England in developing a national quality tool for CHC.	✓	✓		

How we will measure success

- Performance against agreed measures as detailed in Appendix 4

What KPI's will we use to monitor progress?

- Operational plan, local and contractual measures as detailed in Appendix 5

Risks and Mitigating Actions

RISKS	MITIGATING ACTIONS
Low level risks	Being managed within the programme board

7.8 Provider Management and Development

WCCG has adopted a multi-faceted approach to provider management and development which embraces:

7.8.1 Spend Analysis

WCCG recognises that it needs a clear understanding of it's spend profile including identifying: the top providers by spend; the distribution of spend by provider sector (e.g. NHS, other public sector, third sector; private sector etc.); and the distribution of spend between healthcare sector (i.e. acute, community, primary care and mental health). Such an analysis is conducted of the NHS contracts awarded each year as part of the NHS contract round and for 2014-15 contracts, an example of some of the key findings are illustrated in Figure 7 and Figure 8. It is clear from this analysis that WCCG is faced with a dominant provider (Walsall Healthcare NHS Trust) and that a high proportion of spend is within the Acute sector. The various initiatives identified in this Plan seek to address this imbalance.

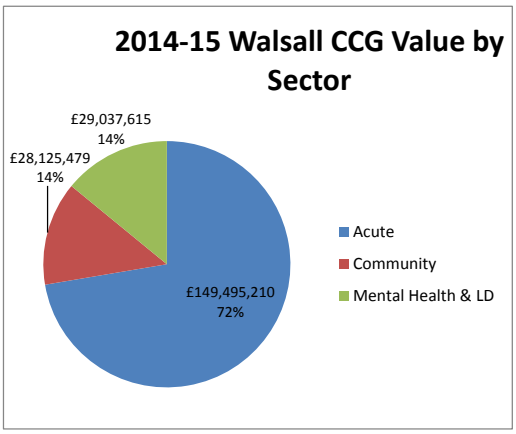


Figure 7 - 2014-15 NHS Contract Value by Sector

7.8.2 Contract Management

As illustrated in Figure 9, WCCG has adopted a multi-disciplinary approach to contract management which ensures clinical leadership. It has adopted a proactive approach to the use of the incentives and sanctions within the Standard NHS Contract which aims to balance partnership working with robust contract management.

7.8.3 Healthcare Market Analysis

WCCG recognises that prior to determining the approach to specific services and pathways it needs an understanding of the market, and therefore regularly employs health market analysis techniques which help identify the following factors:

- Concentration – The market share of providers serving a defined area (i.e. where patients actually choose to receive treatment as opposed to where they could receive treatment).
- Switching - Changes in patient flows from, year to year potentially proxied by changes in market share.
- Rivalry - The degree of actual or potential entry into and exit from a market.
- Quality - Level of quality of service.

This approach has already made a significant contribution in helping to determine the strategy to be adopted in areas such as urgent care and this will continue to be applied throughout 2015-17 in helping shape WCCG's approach to the market in areas that it recognises that there is a need for change.

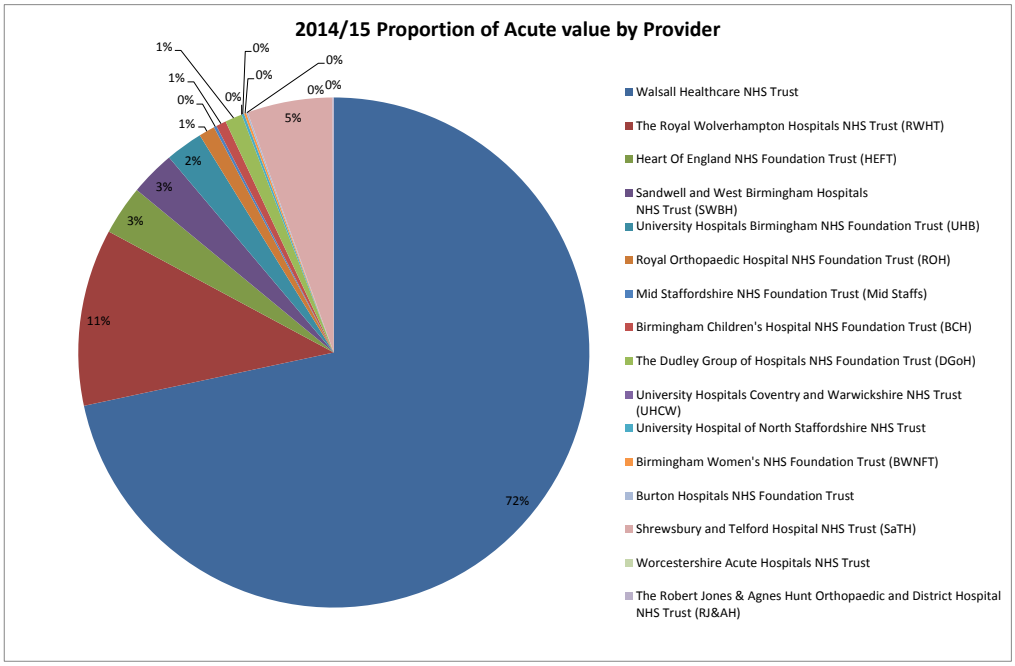


Figure 8 - 2014-15 NHS Acute Contract Value by Provider

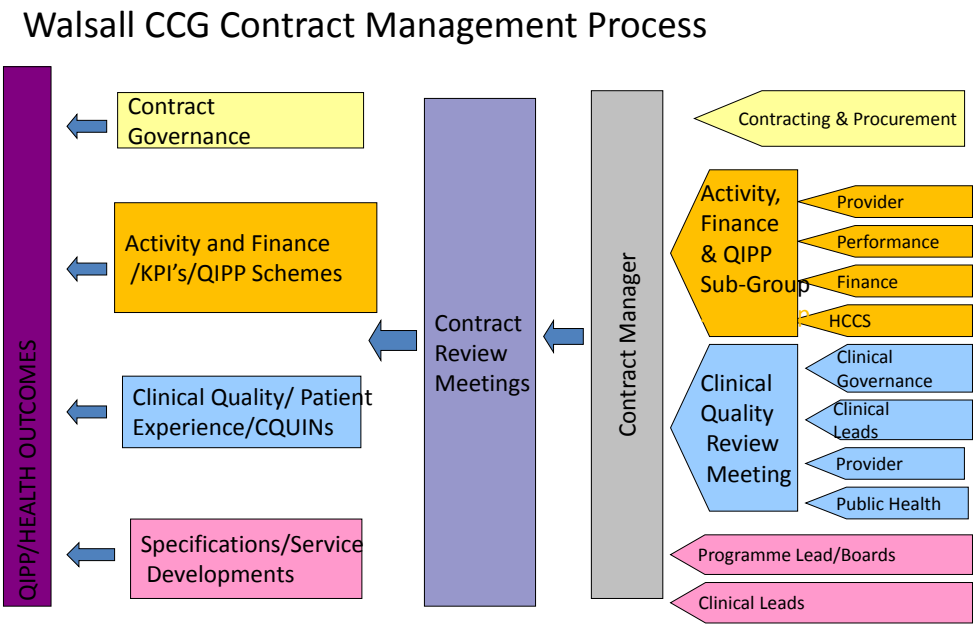


Figure 9 - Walsall CCG – Contract Management Process

7.8.4 Market development

WCCG recognises that it has a responsibility to develop sectors of the market where an improved service can be delivered to patients through a greater diversity and range of providers. Two particularly areas of focus are:

Third Sector:

- WCCG has assumed the role of local 'activist agent' through its leadership of the Rough Hay Connecting Communities project which aims to tacking health inequalities at a grass roots level. This has brought a range of partners together including Walsall Housing Group Community Health Champions programme, Police, Walsall Healthcare Trust, Public Health, Neighbourhood Services and Area Partnerships to support the community to begin to bring about change in an area that has some of the worst health indicators in the Borough. There are also an emerging area of joint working between WCCG, Registered Social Landlords (RSLs) and the Council's Strategic Housing Department in supporting safe and timely discharge of patients from hospital.

- WCCG is working with Walsall Voluntary Action (WVA) to develop the third sector and have been working to agree a forward strategy for the strategic development of the sector, so that it can support delivery of core HWB strategic objectives and support Better Care Fund redesign work stream programmes. The strategy will be taken forward in discussion with the Council and WVA.

- In conjunction with the Local Authority WCCG has established a strong relationship and dialogue with the third sector in Walsall through Walsall Voluntary Action and will continue to explore opportunities for the third sector providers to contribute to improving the health and welfare of the people of Walsall. It is intended to build on a recent pilot exercise with Age UK where, as illustrated in Figure 10, in conjunction with GP practices, care co-ordinators, identified the health and social needs of over 75s and mobilised third sector organisations to provide those needs such as befriending services.

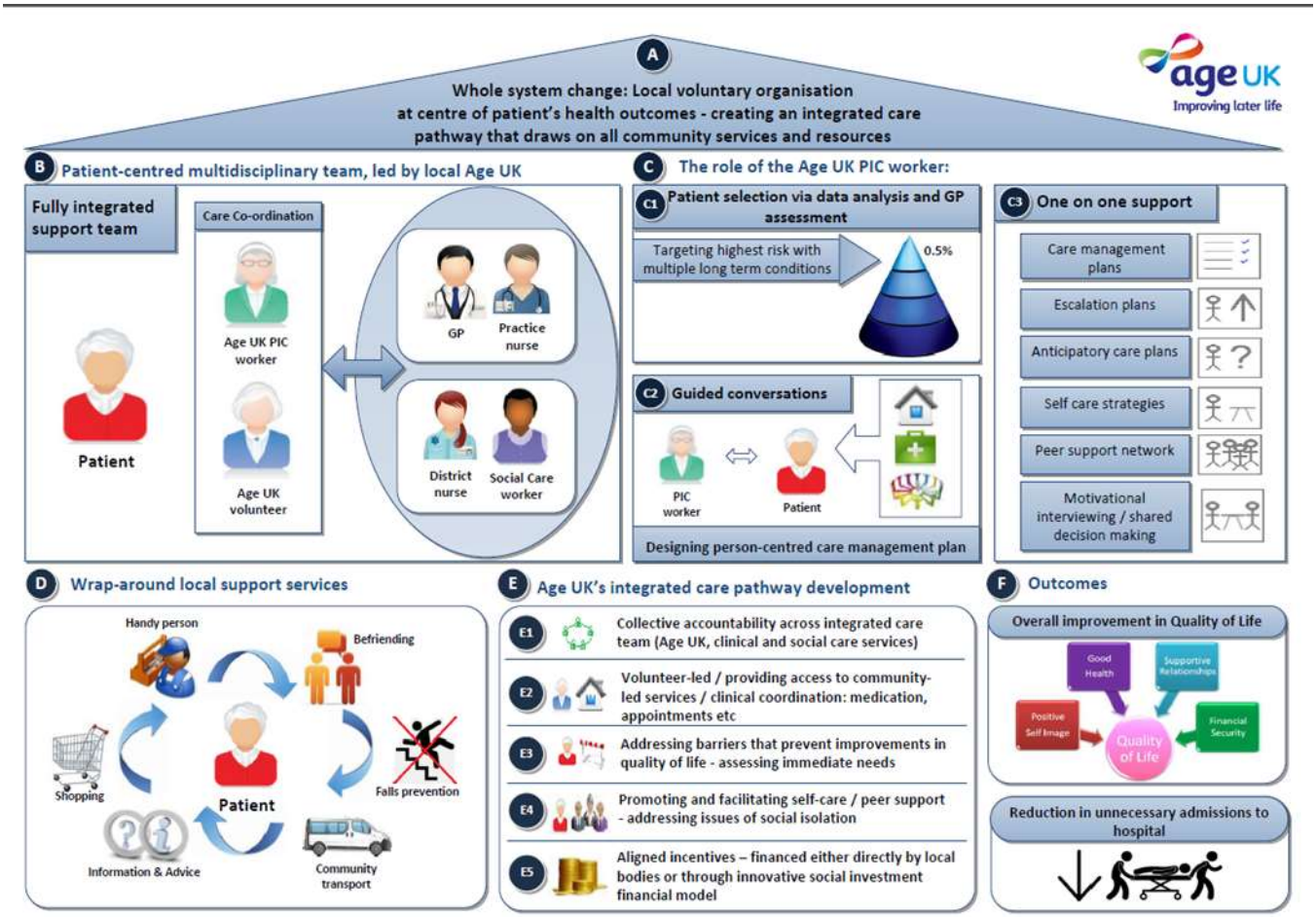


Figure 10 - Community Partners Project with Age UK

Primary Care:

- As illustrated in Section 2.4.1, WCCG is committed to developing a strong primary care sector and is supporting the federated approach. In doing so it is anticipated that the primary care sector will be better equipped to expand the range of services offered to patients in Walsall and, where applicable, compete more effectively in the market.

7.9 Procurement including Any Qualified Provider (AQP)

In support of the initiatives identified in this Plan, WCCG has developed a Procurement Plan which identifies those services that it intends to be subject to formal procurement. This includes those services which, following the preparation of a Sourcing Plan, are felt to be suitable for Any Qualified Provider.

Current and planned initiatives include:

- Mental Health Adult Complex Needs Rehabilitation and Learning Disability Placements.
- Personal Assistants Dementia (PAD's).
- 111 Service (Regional).
- Residential and Nursing Homes (joint with Local Authority).
- Support for Living at Home Services (SLHS) (joint with Local Authority).
- Parent Education.
- Mental Health Capacity Act (MCA) / Deprivation of Liberty Safeguards (DoLS).
- Urgent Care.
- Community Physiotherapy.
- Community Paediatrics.
- Ophthalmology – to include (PEARS, Cataracts).
- MSK Pain Management.
- Neuro Rehabilitation.
- Community Hypo Alert.
- Cardiac Rehabilitation.
- AQP Diabetes (Round 2).
- Medical Support to Nursing Homes.
- Educational Diabetes.

7.10 Clinical networks and senates

We are continuing to work with clinical networks and senates and partners to develop collaborative commissioning arrangements.

7.11 Personal Health Budgets (PHB)

7.11.1 Continuing Heath Care

WCCG has been a pilot site for Personal Health Budget's (PHB) since September 2012 and has developed the necessary arrangements for everyone who is assessed as meeting eligibility for Continuing Heath Care (CHC) to be informed of their right to have a PHB from October 2014. This has been done in partnership with WMBC to ensure there is a co-ordination of these arrangements with the development of personal budgets for social care. The introduction for PHB has enabled systems & processes to be put for individuals who take up the PHB option including those with a learning disability.

All CCG's are required to offer either a notional budget, direct payment or third party arrangement including the right to receive a budget via a direct payment to a bank account, over which they have control, in order to deliver the support plan which has been agreed with them. Budget holders are required to take out Public Liability Insurance. The cost for this is included in the budget.

Going forward while there is no national requirement to do so, CCG's are advised to provide additional costs to provide extra insurance cover for any personal assistants who carry out delegated health tasks for which they have been specifically trained.

All PHB recipients in Walsall are encouraged to appoint a Direct Payment Support Organisations (DPSO), from a list of DPSO's recently approved by WMBC, to assist them in the management of a direct payment. This includes giving support with recruitment and contracts of employment for PA's, payroll, audit of accounts etc. The individual contracts directly with their preferred organisation and the cost for the level of service they required is included in the budget.

Personal Assistant's undertaking delivery of complex care tasks need to undergo training and assessment to determine competence. Going forward the CHC team are in discussion with private agencies to achieve an outcome that ensures safety of the individual's in their own home and assurance for WCCG. In addition to this the CHC team are working with WHNHST community staff to ensure a holistic service is being delivered to the individual.

The case management arrangements for PHB recipients are the same as other CHC individuals who receive care at home, but this will need to be reviewed with increased uptake of PHB.

7.11.2 Long Term Conditions

During 2015/16, WCCG will be investigating the issues related to offering a Personal Budget to a wider group of patients, particularly to those with a Long Term Condition. WCCG is awaiting NHS England guidance.

7.11.3 Carers

During 2015/16, WCCG and WMBC through the Joint Commissioning Unit will be assessing the issues and opportunities related to offering a Personal Budget to Carers. WCCG is awaiting NHS England guidance.

Section 8
Infrastructure

8.1 Provider Workforce Assurance

Our quality performance management arrangements with our providers include for the provision of key workforce indicators.

WCCG is actively engaged with the Older Adults Workforce Improvement group, which is a sub group of the Local Education Training Board (LETB), and supports the development of Older Adults Workforce Programmes that respond to strategic drivers. In addition WCCG is the lead commissioner representing Black Country CCGs on the Black Country Local Education Training Committee (LETC). Workforce development and assurance is supported within the CCG by CSU and key CCG officers and coordinated through WCCGs Organisational Development Committee. Regular review of workforce reports via Clinical Quality Review Meetings provides on-going oversight and assurance of provider workforce plans with evidence of challenge through contracting arrangements in place.

There are regular discussions with our acute provider covering the need to increase the number of Health Visitors and to ensure that plans are in line with desired increases.

The CSU is using the Workforce Assurance tool. This will be a key area of development to provide assurance to WCCG that providers have adequate workforce plans in place to deliver the commissioning objectives including our QIPP priorities.

Provider Workforce plans and strategies are currently being refreshed. WCCG will evidence and assure compliance of plans through CSU workforce teams in place.

The current work with our providers to agree the QIPP priorities will enable us to describe the "system wide" changes that are expected in activity and patient flows and the subsequent impact of the shape of the workforce.

The effect of the expected tenders and AQPs that flow from our programme of transformation could impact on the workforce at WHNHST. The Workforce Assurance Tool will support the assessment of the potential risk.

WCCG have processes in place that provide assurance that staffing and workforce plans of our main providers are affordable and support local transformational strategies; this is undertaken through CSU on behalf of WCCG and considers a wide range of indicators. In addition workforce plans are in place for all providers and are reviewed at least quarterly via Clinical Quality Review Meetings to ensure they are continuing to meet the annual plan set out.

8.2 Informatics

The Information Strategy for WCCG will be developed in line with the National Strategy including Empowering Patients through access to their own records. Work will commence on:

- Improved use of aggregated information through Business Intelligence systems.
- Start pilot of patient access to GP Records, depending upon technological readiness.

8.3 Estates

WCCG will continue to work with NHS Property Services to ensure that the property portfolio being used to deliver health care is managed safety and efficiently. Work will continue on estate rationalisation and WCCG will work with Partner Organisations to examine opportunities for further estates optimisation.

There are a number of initiatives being considered to reduce the property overheads, including enhanced mobile technology, sharing space and reducing the overall building space occupied.

A priority on 2015/16 will be the development of a GP Practice estates strategy.

When realised, these plans will reduce costs in both the short and long term.

8.4 Co-commissioning of Specialised Commissioning

Specialised services are services that are provided in relatively few hospitals to a catchment population of more than one million people. The number of patients accessing these rarer services is small and a critical mass of patients is needed in each centre in order to deliver the best outcomes. In addition a concentration of skills and expertise by the clinical team undertaking the treatment also benefits the standard of care delivered.

These services are commissioned directly by NHS England and locally this is undertaken through the Birmingham, Solihull and Black Country Area Team for the West Midlands.

It is important for WCCG (and the local unit of planning) to align its local strategy to the direction of travel nationally for specialised services over the next five years.

Renal, Bariatric Surgery, Specialised Wheelchairs and Neurology outpatients are the four services expected to be commissioned directly by CCGs in 2016/17. Although further detail is awaited on how to move forward with these proposals, it is clear that they are likely to have an impact on WCCG with key issues being:

- This will provide an increased opportunity for local engagement, including clinical engagement, in the commissioning of specialised services.
- This is likely to require increased collaborative working both with NHS England and other CCGs.
- In order to provide the level of engagement required, this is likely to represent increased pressures on clinical and management resource.
- As Walsall Healthcare Trust (WHNHST) is one of the regional centres for bariatric surgery, the delegation of this service to WCCG is likely, in itself, to require considerable resource and management input .This may potentially represent a financial risk to WCCG.

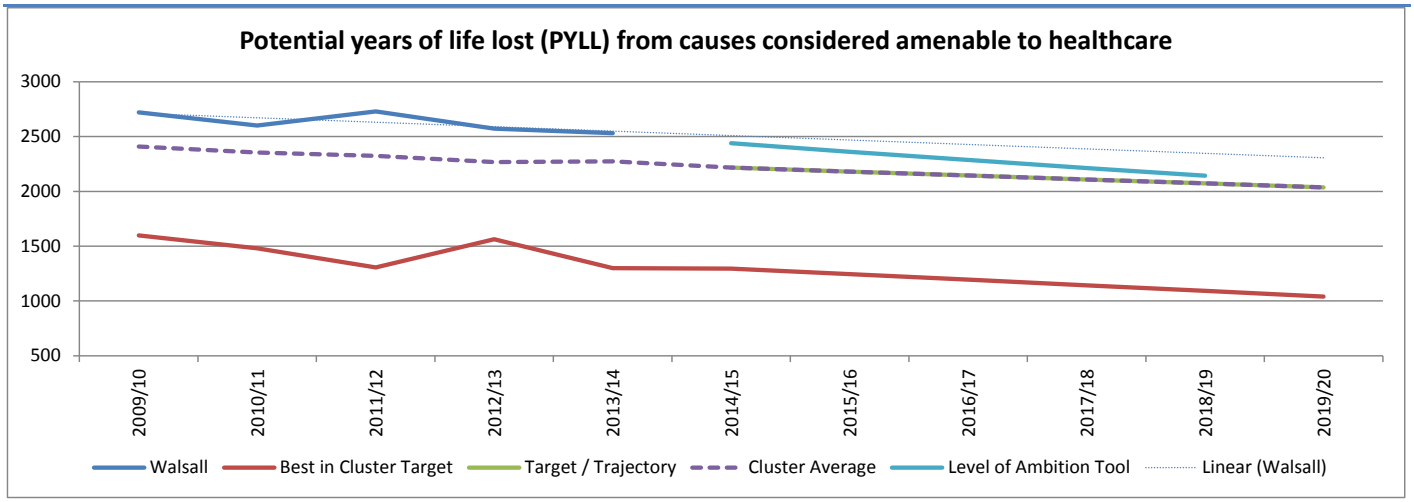
8.5 Commissioning Support Services

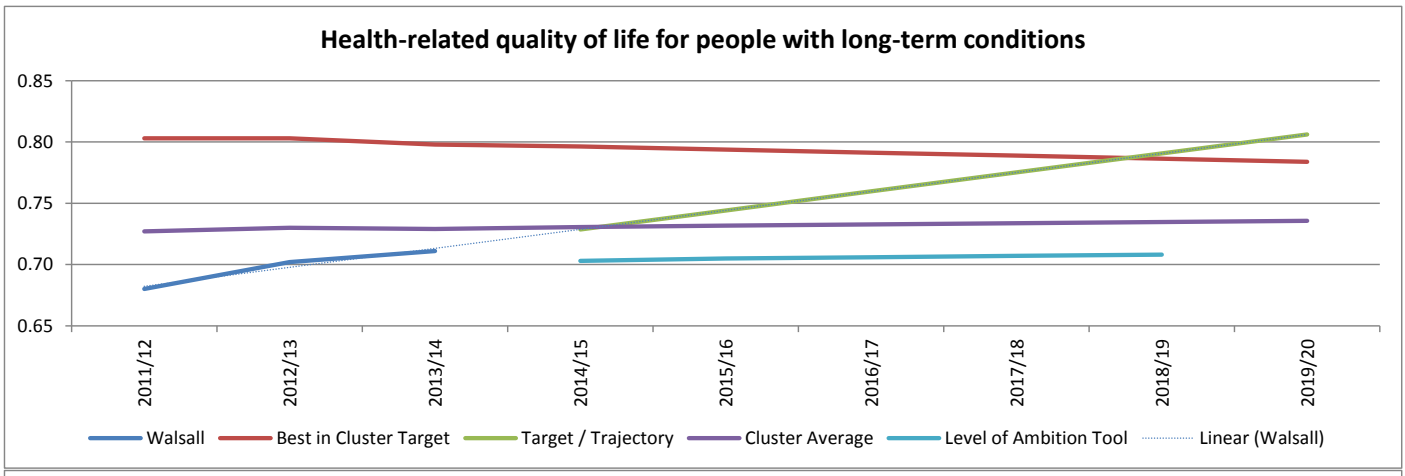
During 2014-15, WCCG undertook a “make, share, buy” exercise to review the services purchased from the CSU and, as a result, decided to bring services, such as financial management, contracting and procurement and communications and engagement in-house and these arrangements are in the process of being fully implemented.

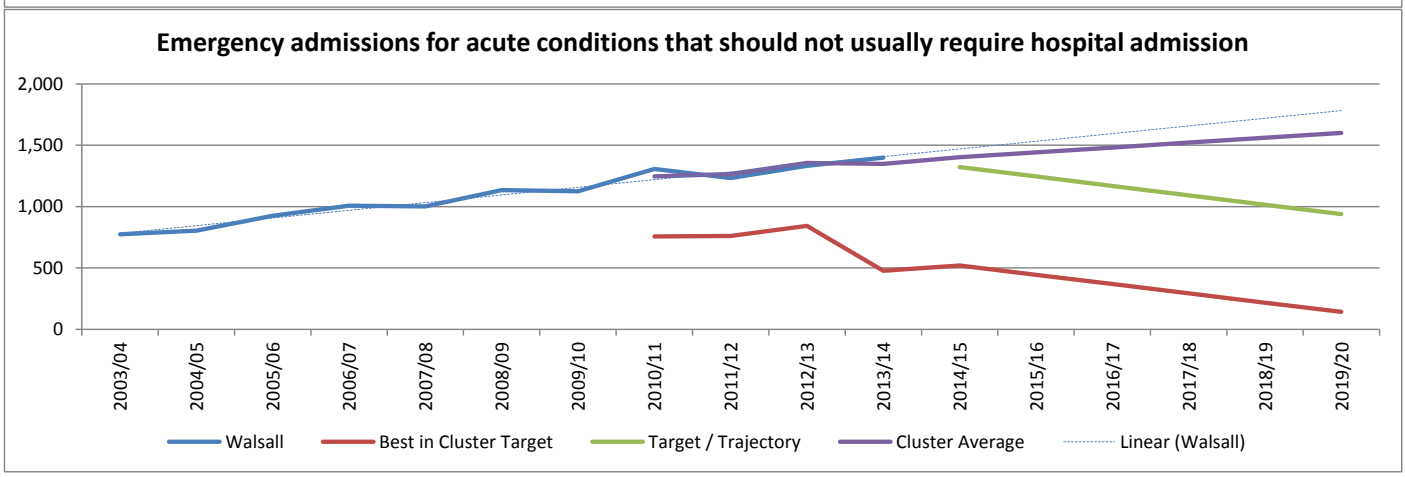
However a core range of services, including HR and business intelligence, will continue to be out-sourced to the CSU with the current SLA being in place until 31st March 2016. Thereafter, in conjunction with other Birmingham and Black Country CCGs, WCCG intends to utilise the Lead Provider Framework to determine its future provider of commissioning support services. Indeed this project is being led and project managed by WCCG.

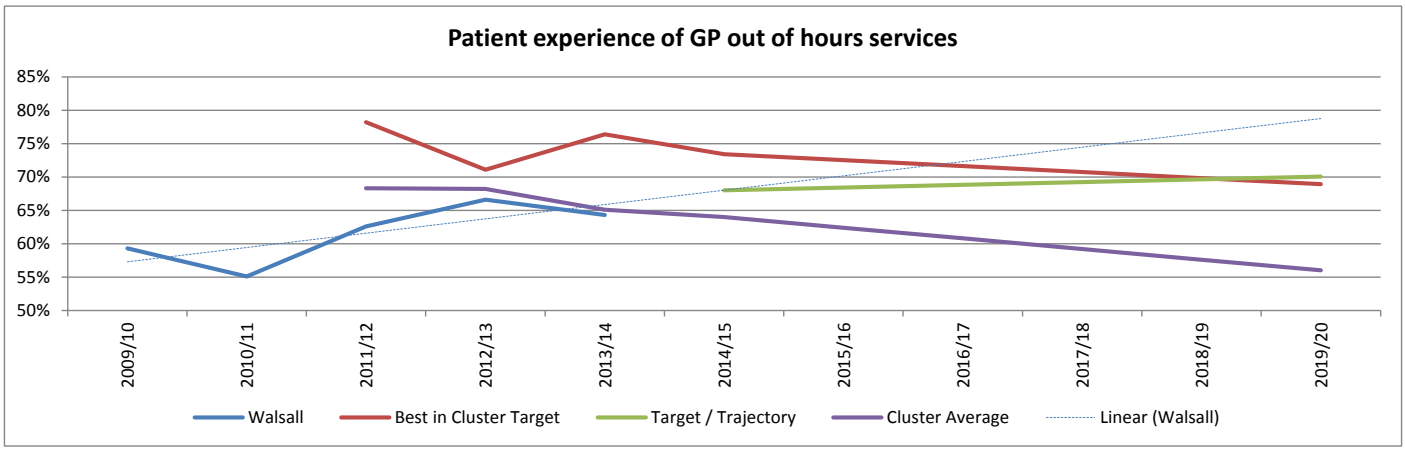
Section 9
Appendices

Appendix 1: CCG Outcome Indicator Trajectories









Detailed QIPP Programme 2015/16

QIPP	Activity	£000's
Elective		
Diversion for Plasma Exchange for Palliative Care Patients - Elective	1	1
Diversion for Plasma Exchange for Palliative Care Patients - Planned Same Day	378	121
Sub Total Elective	379	121
Non Elective		
Diversion for Plasma Exchange for Palliative Care Patients	4	4
Emergency Admission Reduction per BCF,facilitated through targeted investment in Community Services	629	1,153
Sub Total Non Elective	633	1,157
Outpatients		
Ophthalmology - Cataract - Reduce to 1 follow up pre and post procedure where appropriate	1,292	300
Neurological - First to Follow Up - Move to National Average	1,025	78
Dermatology - First Attendances	500	44
Dermatology - First to Follow Up - Move to Wolverhampton CCG ratio	993	64
Dermatology - Outpatient Procedures done in Community	490	131
Ring Pessaries done in Community	349	16
First to Follow Up ratios - Move towards national average	412	12
Sub Total Outpatients	5,061	645
A&E		
A&E Diversion schemes - badger Triage - GP In A&E	539	46
Sub Total A&E	539	46
Other		1,031
Total Walsall Healthcare NHS Trust	**6,612**	**3,000**
Learning Disabilities		528
Prescribing Schemes		1,700
Continuing Healthcare		315
Running Costs		650
Total	**6,612**	**6,193**

Operational Plan – National Guidance & reference documents

General

Five Year Forward View
The Forward View into Action: Planning for 2015/16
Care Act 2014
Child & Family Act 2014
The Special Educational Needs and Disability Regulations 2014.
Right treatment, right time, right place
Quality, innovation, productivity and prevention (QIPP)
National Institute for Health and Clinical Excellence. http://www.nice.org.uk/
The NHS Outcomes Framework – *Department of Health 2014/15*
NHS Cooperation and Competition requirements – *Department of Health, published 30th July 2010*
Report of Mid Staffordshire NHS Foundation Trust Public Inquiry
Innovation Health and Wealth: accelerating adaption and diffusion in the NHS: December 2011
Catalogue of Potential innovations

Elective Care and Urgent Care

Cancer reform Strategy
National End of Life Care Strategy
Working to Safeguard Children (2012)
Healthy Child Programme (2009)
Getting it right for Children and Young People (2010)
Achieving Equality and Excellence for Children (2010)
West Midlands Quality Review Matrix
Transforming urgent and emergency care services in England: the Keogh report
College of Emergency Medicine (website)
Future Hospital Commission to the Royal College of Physicians (2013), Future hospital: caring for medical patients, Available at: http://www.rcplondon.ac.uk/sites/default/files/future-hospital-commission-report.pdf
Kings Fund (2013), Urgent and emergency care: a review for NHS South of England, Available at: http://www.hsj.co.uk/Journals/2013/05/02/z/d/s/Kings-Fund-report-urgent-and-emergency-care.pdf
NHS Improving Quality (2013), NHS services - open seven days a week: every day counts, Available at: http://www.nhsiq.nhs.uk/improvement-programmes/acute-care/seven-day-services.aspx
Guidance for commissioning integrated URGENT AND EMERGENCY CARE A 'whole system' approach (2011), http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/Urgent-emergency-care-whole-system-approach.ashx

Mental Health & Learning Disabilities

'Closing the Gap' 2014
Fulfilling & Rewarding Lives (2010)
No Health without Mental Health
National Autism Strategy 2012
Think Autism 2014
National Commissioning for Quality Learning Disability Health Self-Assessment Framework (LD HSAF)
Equality Act 2010

Operational Plan – National Guidance & reference documents

Mental Capacity Act 2005

Transforming Care Programme

NHS Commitment to Carers 2014

Physical Disability and Sensory Impairment (PDSI) Strategy

Community & Primary Care

King's Fund. Securing the Future of General Practice – new models of primary care, July 2013

King's Fund. District Nursing 'Who will care in the future' 2013

BMA General Practitioners Committee. Developing General Practice today. BMA 2013

NHS England, Primary Care Strategic Framework Discussion Document October 2013

QIPP https://www.evidence.nhs.uk/qipp

Keele University. Centre for Medicines Optimisation. http://www.keele.ac.uk/pharmacy/general/

Nottingham University. PRIMIS-Making clinical data work. http://www.nottingham.ac.uk/primis/index.aspx

ScriptSwitch™ Prescribing Decision Support. http://www.unitedhealthuk.co.uk/OurTechnology/ScriptSwitch.aspx

NHS Business Services Authority. http://www.nhsbsa.nhs.uk/

World Health Organisation. Drugs and Therapeutics Committees-a practical guide. 2003

http://apps.who.int/medicinedocs/en/d/Js4882e/

NICE Developing and Updating Local Formularies. Medicines Practice Guideline. 2012-updated 2014

http://publications.nice.org.uk/developing-and-updating-local-formularies-mpg1

Transforming Nursing for Community and Primary Care (TNfCPC) Programme

Quality Innovation Productivity and Prevention Programme

The process for identifying QIPP programmes is based upon the utilisation of a number of information sources providing a comparative analysis of current performance against the "Best in Class" target. The sources of information are detailed below:

The West Midlands and National QIPP work streams

Walsall JSNA

CCG Programme Boards (Clinical & GP Led)

CCG Service Transformation Teams

CCG GP Localities

NICE QIPP Evidence

NHS Benchmarking

Better Care, Better Value Indicators

NHS Comparators

Programme Budgeting (Spend and Outcome Tool) (SPOT)

Atlas Programme Budgets of Variation

Commissioning for Value

West Midlands Estimated Potential Savings

CSU Report - Identifying Potential QIPP Opportunities for 2015/16

CCG Outcome Indicators

Primary Care Web Tool

How we will measure success

- **Process Measures**
- Benchmarking - to be in top quartile - for all quality and safety indicators available
- Better worked up referrals demonstrated by benchmarking conversion rates, referral rates, New/Follow up rates
- Complete the urgent care review and implement recommendations
- Evidence of MCA and best interest decision making processes
- GP prescribing growth and cost of weighted prescribing - to be in bottom quartile
- High uptake of community pharmacist medicines review services – to be in top quartile
- Improved early dementia diagnosis rates
- Increased range of care offered in primary care and community settings
- Less reliance on nursing and residential care
- Limited admissions to mental health services
- Maintain and increase QOF scores as they become more challenging
- Minimise avoidable hospital admissions
- New patient pathways that result in a shorter time in the system – LOS, return to work/education, less cancelled operations
- Over performance on delivery of the QIPP savings programme
- Practice use of data tool and referrals information
- Primary care knows how to access emergency ambulatory care pathways
- Reduced emergency and hospital bed days all ages for people with mental health problems
- Reduced emergency hospital bed days
- Reduced length of hospital stay and number of bed days
- Reduced variation in activity and number of referrals between practices
- Reduction in the number of admissions and outpatient attendances
- Reduction in the number of low priority procedures
- Reduction of people admitted to Acute care
- Secondary care prescribing costs for PBR excluded drugs – to be in the bottom quartile
- Tendering & Procurement achievement of new contracts
- **Outcome Measures**
- Active and visible public mental health messages as part of World Mental Health Day with on-going programme of public information across the next year.
- Carer satisfaction
- Decrease the length of stay for patients admitted for COPD or Bronchiectasis
- Ensure all patient have had a review of their need for oxygen therapy and care plan adjusted appropriately
- Every COPD patient should have a relevant and current disease management plan and access to support for self-care.
- Good benchmarking from Community Pharmacy and secondary care medicines patient experience surveys
- Improved patient outcomes and evidence of take up of screening programmes
- Increase in number of people living in their own homes and gaining paid employment
- Increase in the number of patients discharged the same day
- Increase the number of patients managed in the community / their own home rather than in an acute setting
- Increase the numbers of patients having spirometry in the GP practice
- Increased number of patients managed at home by the community IV therapy service
- Maintenance of performance against quality indicators for people in specialist mental health services in settled accommodation and employment
- Minimise avoidable hospital admissions
- More people access talking therapies, 50% recovery rates for people at clinical scoring threshold and improved social functioning outcomes for everyone accessing a service
- More people with dementia accessing early inventions
- More people with dementia making an informed choice
- More people with dementia supported in the community
- Number of patients with LD receiving Annual Health check and follow up Health Action Plans
- Patient experience of primary and community support
- Patient reported experience of accessing range of health care services – primary/acute/community
- Patient reported experience of accessing urgent care services
- Patient reported experience of specialist mental health services
- Patients feeling supported along their pathway and managing their expectations
- People maintaining and returning to employment with mental health problems
- Reduce the number of emergency admissions for exacerbation of COPD and Bronchiectasis
- Reduction in referrals for conditions relating to known harmful lifestyle choices e.g. smoking, alcohol, weight.

KPI's that will be used to monitor progress	
Operating Framework Measures • 1st outpatient attendances following General Practitioner referral • 6 week diagnostic waiting times (15 key diagnostics) • A & E 95% target • Accident and Emergency attendances • Accident and Emergency waiting times – total time in the department • All 1st outpatient attendances • Ambulance quality – Cat A response times • Ambulance Urgent & Emergency journeys • Bed Capacity – General and Acute • Bookings to services where named consultant led team available • Cancer referral to treatment measures • Care programme approach (CPA) 7 day follow up • Commissioning comprehensive Child and Adolescent Mental Health service • Crisis resolution home treatment • Delayed transfer of care • Diagnostic Activity • Early intervention in psychosis • Elective First Finished Consultant Episode • Emergency admissions for acute conditions that should not normally require hospital admission • General Practitioner written referrals to hospital • Improved access to psychological therapies (IAPT) • Non-elective First Finished Consultant Episodes • Number waiting on incomplete Referral to Treatment pathway • Other referrals for a 1st outpatient appointment • Patient experience survey • Proportion of General Practitioner referrals to 1st op appointments booked using Choose & Book • Referral to Treatment Pathways • Trend in value/volume of patients being treated at non NHS hospitals • Unplanned hospitalisation for asthma, diabetes and epilepsy <19s • Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) • Venous Thromboembolism risk assessment	**Local Measures** • Accident and Emergency quality indicators (all other measures) • Ambulance quality indicators (all other measures) • Consultant to Consultant Referrals • Day case rate • Development of local comprehensive quality improvement/outcomes framework • Discharge summaries • Emergency Admissions • Emergency Readmissions • First to Follow up Ratio • Hospital admissions related to medicines • Length of stay (acute) • Length of stay (emergency admissions) • Local prescribing measures • Maternity Dashboard • Number of patients completed structured diabetes education programmes • Number of referrals to structured diabetes education programmes • Outpatient Procedures • Patient Reported Outcome Measures Scores • PAU attendances • Prescribing cost per Astro-PU (age, sex & temporary resident originated prescribing unit) • Prescribing growth cost • Procedures of Limited Clinical Value • Total assertive outreach caseload • Total Early Intervention Programme caseload • Urgent care metrics **Contractual Measures** • Cancelled elective operations for non-clinical reasons • Choose and Book – direct booking • Choose and Book – slot issues • MRSA (meticillin-resistant staphylococcus aureus) Screening • 18 weeks Route To Treatment RTT

These metrics are to be validated and are therefore currently draft. Some will apply to all transformation projects and others will be specific

Walsall Council

NHS
Walsall Clinical Commissioning Group

Better Care Fund Plan Submission – 12 December 2014

Please find attached our completed templates setting out our plans for the Better Care Fund in Walsall.

The outcome of the assurance process for our September 2014 submission was that we were 'approved with conditions'. The NCAR assurance template highlighted five areas of risk and in four of those areas the risk related to the setting of our target for a reduction in emergency admissions during 2015 at 3.2% reduction, compared to the 3.5% reduction that had been proposed at national level. The other area of risk was the inclusion of our local enhanced service for GP case management of people over the age of 75 years old, where the there was a query as to whether this duplicates the national enhanced scheme for GP case management.

We have therefore included in the revised narrative template submitted for the 12 December 2014 a more detailed explanation of our analysis of emergency admissions over the last three years and strengthened our rationale for setting a target of 3.2% (see additional information in Section 4). We are continuing to monitor the rate of emergency admissions on a daily basis as part of our arrangements under the System Resilience Group for daily operational management of the urgent care system, and in order to identify the impact of our numerous change schemes designed to bring down the rate of emergency admissions, in particular, the impact from the redesign of community health services based on additional investment.

We will therefore be well placed to consider how the trajectory for reducing emergency admissions by 15% up to 2019/20 will be achieved.

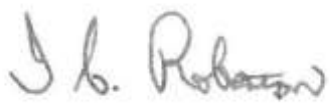
We have also included in the revised narrative a more detailed explanation of our local scheme for GP case management and how this differs markedly from the national enhanced scheme. (see Section 8d (ii)).

The other queries arising during the assurance process were related to the calculations and benefits analysis in the financial template, and these were addressed as part of the assurance process. There were some small adjustments to the some of the text descriptors and the revised financial template is attached. There was a suggestion that the financial sections of the Annex 1's for each work-stream should be aligned to the financial template, and this work has been completed and the updated Annexes are also attached. Finally, we have attached the latest version of the NCAR Action Plan. Thanks to Denise McLellan who was appointed to provide us with support.

We have reported the outcome of the assurance process and our responses to the conditions to our Health and Well Being Board on 8 December and to the Joint Commissioning Committee on the 11 December and both the HWBB and the JCC have given their approval to this re-submission.

We will continue to develop and implement our plans for the Better Care Fund and we are confident that we will have all of our arrangements in place in good time for April 2015.

Yours Sincerely



Councillor Ian Robertson

Summary of Plan

Local Authority	Walsall Metropolitan Borough Council
Clinical Commissioning Groups	Walsall Clinical Commissioning Group (CCG)
Boundary Differences	The boundaries are within the Borough of Walsall.
Date agreed at Health and Well-Being Board:	8 September 2014
Date submitted:	19 September 2014
Minimum required value of BCF pooled budget: 2014/15	£10,654,343
2015/16	£23,976,530
Total agreed value of pooled budget: 2014/15	£10,654,343
2015/16	£23,976,530

Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Walsall CCG
By	*Salma Ali*
Position	Accountable Officer, Walsall CCG
Date	12 December 2014

Signed on behalf of the Council	Walsall Metropolitan Borough Council
By	*Keith Skerman*
Position	Interim Executive Director of Social Care & Inclusion
Date	12 December 2014

Signed on behalf of the Health and Wellbeing Board	Walsall Health and Well Being Board
By Chair of Health and Wellbeing Board	*Councillor Ian Robertson*
Date	12 December 2014

Related documentation

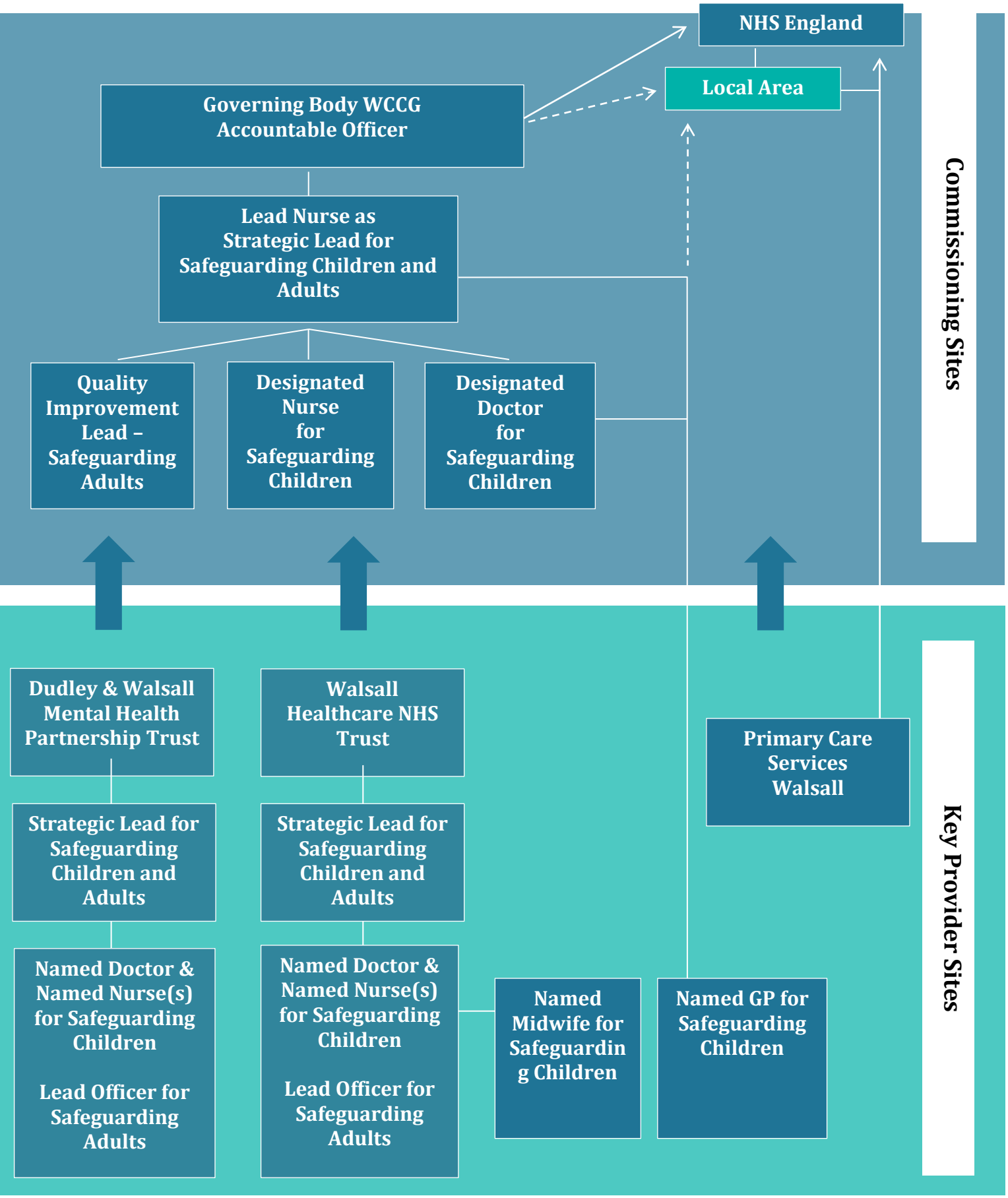
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Integration of Health and Social Care – Implementing the Better Care Fund	Walsall Council Website - Reports to HWBB: 20 January 2014; 3 March 2014; 8 September 2014; 11 December 2014
The Health and Well Being Strategy for Walsall 2013 to 2016	Walsall Council Website
Walsall Joint Strategic Needs Assessment refresh 2013	Walsall Council Website
Walsall CCG Strategic Operating Plan 2014/19	As submitted at September 2014
Walsall ASC&I Directorate Operating Model and Vision for Adult Social Care	Walsall Council Website - Cabinet Reports June 2013 and November 2013

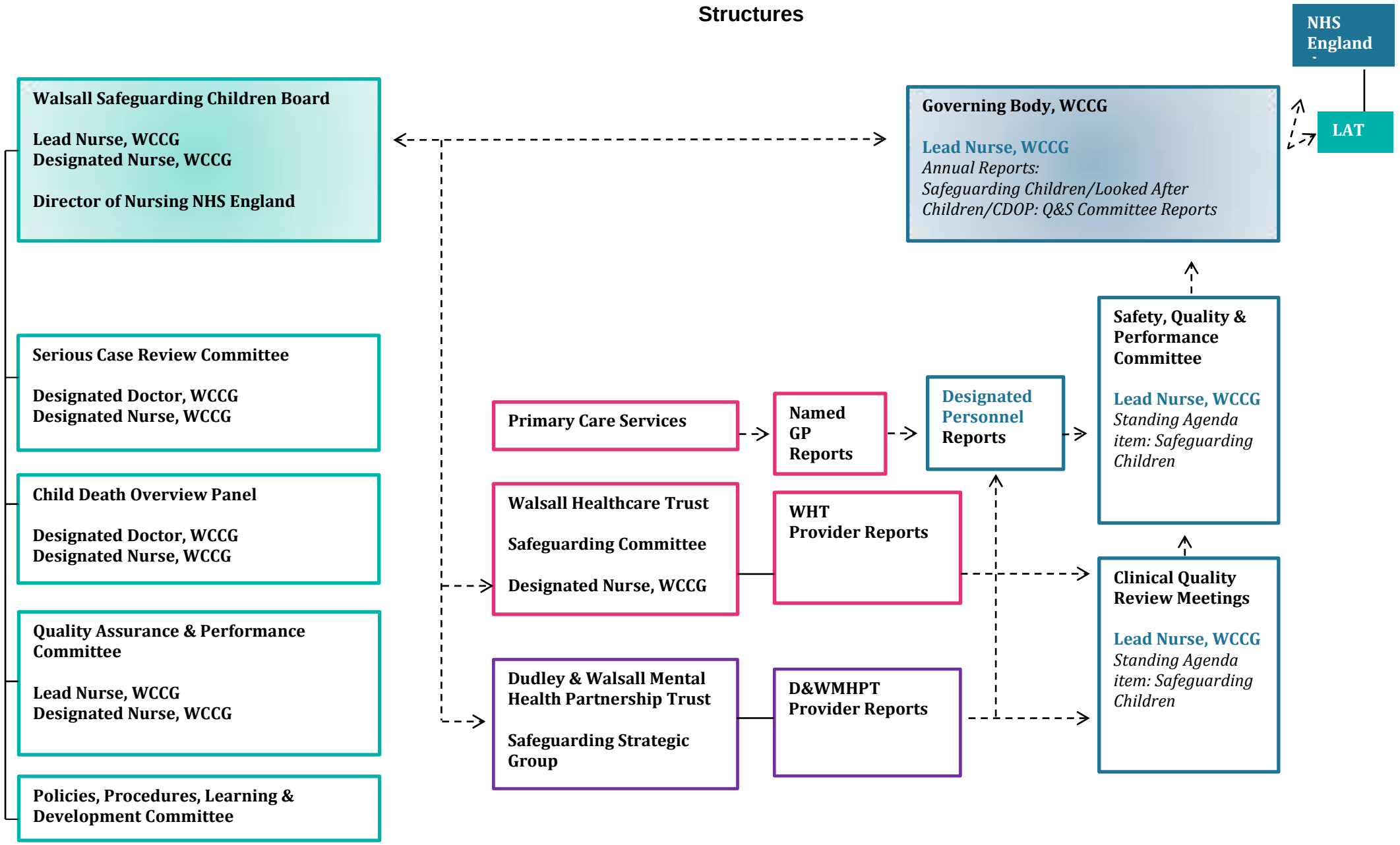
Appendix 7: Operational Plan 2015-17 Glossary of Main Abbreviations Used

A&E	Accident & Emergency
AQP	Any Qualified Provider
BCF	Better Care Fund
CAMHS	Child & Adolescent Mental Health Service
CMR	Contract Monitoring Review
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CQR	Contract Quality Review
CQUIN	Commissioning for Quality and Innovation
CSU	Commissioning Support Unit
DWMHPT	Dudley & Walsall Mental Health Partnership NHS Trust
HCAI	Health Care Associated Infections
HWB	Health & Well Being Board
IOB	Improving Outcomes Board
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LCS	Local Commissioned Service
LES	Local Enhanced Service
LTC	Long Term Condition
MRSA	Methicillin Resistant Staphylococcus Aureus
NHS	National Health Service
OOA	Out Of Area
PMO	Project Management Office
PRIMIS	Primary Care Management Information System
PROM's	Patient Reporting Outcome Measures
PYLL	Potential Years of Life's Lost
QIPP	Quality, Innovation, Productivity & Prevention
SDIP	Service Delivery Improvement Plan
SLA	Service Level Agreement
SQP	Safety, Quality and Performance Committee
T&F	Task & Finish Group
T&O	Trauma & Orthopaedics
VTE	Vocational Training & Education
WCCG	Walsall Clinical Commissioning Group
WHNHST	Walsall Healthcare NHS Trust
WMBC	Walsall Metropolitan Borough Council

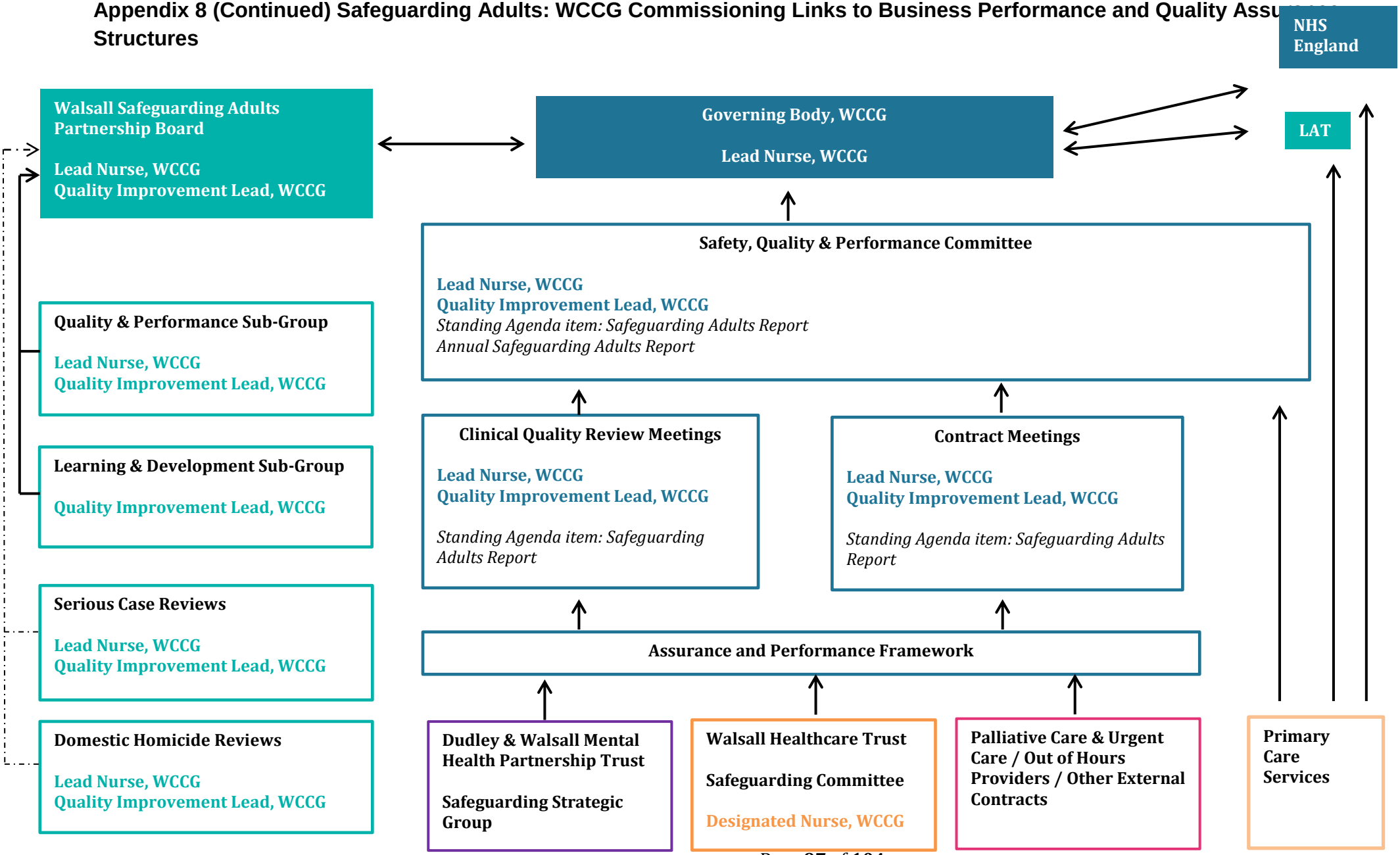
Extract re embedding of Named Doctor in Governance processes



Appendix 8 (continued) Safeguarding Children: WCCG Commissioning Links to Business Performance and Quality Assurance Structures



Appendix 8 (Continued) Safeguarding Adults: WCCG Commissioning Links to Business Performance and Quality Assu… Structures



References

Department of Health (2000)	No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse
Department of Health (2009)	Statutory Guidance on Promoting the Health and Well-being of Looked After Children
HM Government (2005)	Statutory Guidance on making arrangements to safeguard and promote the welfare of children under Section 11 of the Children Act 2004
HM Government (2013)	Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children
NHS Commissioning Board (2013)	Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework
Key Legislation	Children Act 1989 Children Act 2004 Mental Capacity Act 2005 *Draft* Care Bill 2012

SAFEGUARDING CHILDREN ANNUAL REPORT

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1. Purpose of the report

1.1 This report serves to inform on key aspects of corporate Safeguarding Children business that have taken place during 2014 and in the acknowledgement that the Annual Safeguarding Children and Looked After Children Reports as submitted by local provider organisations have been duly received and considered by the Clinical Quality Review forum[1][2][3].

1.2 The report aims to inform on:

- The national and local drivers influencing corporate business in the context of commissioning, provider and multi-agency service provision,
- The progress and achievements of the 2014 Safeguarding Children work programme, and as that which incorporates reference to Looked After Children,
- The priority areas of work to be focussed upon during 2015 and beyond.

2. National and Local Drivers

2.1 The national Accountability and Assurance Framework[4] and the statutory Safeguarding Children requirements relating to the health economy as referenced therein, served to inform and underpin the contents of the WCCG Safeguarding Assurance Strategy[5] that was formulated at the start of the year and which has since steered the associated work programme throughout 2014.

2.1.1 ***Related item: 2015/16 work programme***

[1] Safeguarding Children Annual Report 2013 - 2014, WHT, 2014
[2] Looked After Children Health Team Annual Report April 2013-March 2014, WHT, 2014
[3] Safeguarding Annual Report April 2013 – March 2014, D&WMHPT, 2014
[4] Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework, NHSCB, 2013
[5] Safeguarding Assurance Strategy, WCCG, 2014

A revision of the national framework is due to be published May 2015 which will inform an up-dated version of the WCCG Safeguarding Assurance Strategy in due course.

2.2 A broad range of key areas for priority were outlined in the local Safeguarding Assurance Strategy, all aspects of which received attention during 2014.

2.3 The development and establishment of Safeguarding Performance Frameworks across the respective provider organisations were preliminary features of the overall work programme and as such, details were factored into contracts from April 2014 onwards and progress monitored accordingly. A more recent review of the components of the Framework has resulted in refinement and enhancement of data requirements which will be accommodated as part of contract detail for 2015/16.

2.4 An independent internal review of WCCG Safeguarding arrangements was undertaken as part of the internal audit plan 2014/2015 during the latter part of the year[6]. The audit concluded that key controls had been adequately designed and were operating effectively to deliver the key objectives of the system.

2.5 The statutory 'Working Together' guidance[7] continued to direct both the corporate and operational features of local Safeguarding Children concerns throughout the year and as predominantly steered by Walsall Safeguarding Children Board (WSCB) and its associated Committees[8]. The local health economy remained suitably engaged in the overall business of the annual WSCB work programme.

2.5.1 ***Related Item: 2015/16 work programme***
Sub-sections of the existing 'Working Together' document are currently being reviewed, the outcome of which will serve to further inform the management of allegations whilst in receipt of services ('Position of Trust' Safeguarding Children concerns) and the standardised criteria for determining the instigation of Serious Case Reviews.

2.6 WCCG representation at the monthly WSCB meetings was maintained at 100% for 2014. WCCG direct engagement in four[9] of the five WSCB serving Committees continued throughout the year. Close association with the fifth[10] Committee was achieved via full and active participation in consultation and feedback activities in relation to its business.

2.7 WCCG engagement in the business of the local Corporate Parenting Board was strengthened during 2014. Appropriate contribution to the development of the Corporate Parenting Strategy[11] was made by the health economy, subsequent to which a multi-agency Health Sub Group was formed. The associated work programme continues to be led by the Designated Nurse for Safeguarding Children and involvement of children and young people in the associated business has been integral from the onset.

2.7.1 ***Related Item: 2015/16 work programme***
Existing statutory guidance[12] which directs the health economy regarding its responsibilities to looked after children and young people and care leavers is currently being revised and due for publication late spring 2015. Healthcare services as both commissioning and provider organisations will be required to accommodate any adjusted or/and additional directives in collaboration with partner agencies.

2.7.2 ***Related Item: 2015/16 work programme***
Local oversight of healthcare provision to looked after children who experience complex health needs and as both commissioning and provider service concerns are to be strengthened during

[6] Internal Audit Report 2014/15: WC10 Safeguarding Arrangements, cw audit services, November 2014
[7] Working Together to Safeguard Children, HM Govt., 2013
[8] Safeguarding Children Annual Report 2014, Walsall Safeguarding Children Board, 2014
[9] Serious Cases/Significant Incident Committee; Child Death Overview Panel; Quality, Assurance and Performance Committee; Child Sexual Exploitation and Missing Committee, WSCB 2014
[10] Policies, Procedures, Learning and Development Committee, WSCB 2014
[11] Walsall Looked After Children Strategy 2014-2017, WMBC
[12] Promoting the Health and Welfare of Looked After Children, DOH, 2009

2015. Particular focus will be placed upon service delivery and outcomes relating to children placed out of area and to those requiring specialist care provision in relation to their respective mental health needs and emotional well-being. The findings from local reflection and review of healthcare provision to individual children and the learning acquired from the most recent local Serious Case Review[13], have served to inform the agenda.

2.8 Whilst WSCB and the Corporate Parenting Board continued to operate as the key corporate multi-agency forums that serve the interests of vulnerable children and young people of Walsall, on-going engagement in the business of a number of other strategic forums informed the local agenda during 2014. The work programme was enhanced via association with the business of the following forums in particular:

- Children and Young People Partnership Board
- Health and Well-being Board
- Youth Justice Board
- Domestic Abuse Strategic Group
- Safeguarding Adults Partnership Board
- Regional Safeguarding Professionals / Leads Forums

2.9 Engagement in the business of Safer Walsall Partnership will be increased during 2015 via direct membership of the Partnership. Direct association will serve to strengthen the interface between the associated work of the Safeguarding Children and Safeguarding Adults agenda.

2.10 Healthcare services' contribution to the delivery of the local Multi-Agency Screening Team (MAST) was afforded on-going consideration throughout 2014. Whilst local MAST involvement by health services was strengthened at an operational level, the decision to establish a local Multi-Agency Safeguarding Hub (MASH), as determined towards the end of the year, has presented the health economy with an opportunity to influence and inform local arrangements in their revised state. Strategic leads from both commissioning and provider sites are closely engaged in the corporate planning activities and as business that will also determine the future arrangements for the management of incidents of domestic abuse that impact upon children in the context of multi-agency practice.

2.10.1 ***Related Item: 2015/16 work programme***
Close collaboration between healthcare sites and partner agencies is to be maintained throughout 2015/16 to support effective establishment of the MASH and its attention to both the management of thresholds of need, vulnerability and harm and the concerns for children and young people where domestic abuse features in their lives.

2.11 The year's programme of external Safeguarding and Looked After Children Inspection as undertaken by the regulatory body[14] did not result in local enquiry. This stated, in order to ensure that the requirements of the inspection regime were well understood across the health economy, to support a state of preparedness for the exercise and to share learning of the findings from out of area inspection by which to inform local work programmes, WCCG instigated and led an information forum that has engaged key personnel from across the provider sites. The business of this forum will continue and serve to strengthen a collaborative approach to Safeguarding Children matters across the health economy.

3 Local Competencies and Practices

3.1 Maximising the knowledge, skill and overall competency of the health workforce for fulfilment of Safeguarding Children responsibilities and duties as both clinical and non-clinical demands is a critical element of any Safeguarding Children business agenda. The third edition of the intercollegiate competency guidance as published March 2014[15] which affords overarching guidance and recommendation on competency requirements of the healthcare workforce has informed and

[13] W4 Serious Case Review, Walsall Safeguarding Children Board, 2015
[14] Children looked after and safeguarding reviews (CLAS), Care Quality Commission, 2013

[15] Safeguarding Children and Young People: roles and competencies for health care staff, RCPCH 2014

influenced the local training strategies, plans and programmes for learning in the context of both commissioning and provider requirements. The on-going activity of local provider organisations was closely monitored throughout the year and action taken as need arose to effect improvement of compliance rates.

3.2 The overall Safeguarding Children work programmes as operated across the provider sites was guided and influenced via an established programme of regular contact with the respective Safeguarding Children leads by the Designated Safeguarding personnel. Clinical support and supervision featured as part of the programme of activities and was extended late year to enhance direct support to the Named Safeguarding Children practitioners.

3.3 Active engagement by WCCG representatives in the on-going business of the Safeguarding Committee, WHT, enabled greater oversight of the progress of the corporate Safeguarding Improvement Programme as that derived from the findings of the independent internal review[16] that was jointly commissioned by WCCG and WHT early 2014.

3.4 Having regard for the extent of the availability of appropriate specialist resources and the commissioning arrangements for such, effective management of children by the hospital site where deliberate self-harm featured, presented both the provider and commissioning sites with additional challenges during 2014. Direct engagement by WCCG in care management relating to individual children was necessary on a number of occasions and specific attention was duly paid to strengthen overall system. Policy and practice via on-going collaborative effort and WCCG oversight. The agreement to establish a local Tier 3 Plus CAMHS that was secured towards the latter part of the year was borne out of these activities as both operational and corporate concerns.

3.5 In light of the unavailability of a suitably-trained, out-of-hours Paediatric workforce for specialist medical examination of children when sexual assault and abuse concerns present, WCCG secured the arrangements for service delivery by the Royal Wolverhampton NHS Trust, mid-year.

3.5.1 ***Related Item: 2015/16 work programme***
Due to the impending reduction in the number of local Paediatricians suitably trained to undertake child sexual assault/abuse medical examinations during routine hours,the service will be further reviewed to ensure that the needs of children who require such examination can be accommodated effectively.

3.6 The unannounced visit by WCCG to the Accident and Emergency Department, WHT, that took place late 2014, highlighted a number of features of Safeguarding system and practice that required attention by the Trust. Assurance of impact regarding actions taken will be sought via the established governance arrangements.

3.6.1 ***Related Item: 2015/16 work programme***
Focus will continue to be placed upon Safeguarding Children system, process and practices across unscheduled access sites as part of the on-going programme of monitoring and review.

4 Primary Care Services

4.1 The healthcare workforce of Primary Care Services was supported by WCCG to acquire compliance with RCPCH 2014 Safeguarding Children competency recommendations via an annual programme of face-face learning across levels 1-3. Subject matter incorporated into the level 3 programme enabled learning on a number of priority areas, namely, local Serious Case Review findings, Private Fostering, Child Sexual Exploitation and Domestic Abuse. Attendance levels across the programme were high and overall evaluation of the content and its delivery was extremely positive.[17][18][19]

[16] Safeguarding review to assist Walsall Healthcare NHS Trust, S Gray, 2014

[17] Feedback Safeguarding Children: GP Practice Level 3 Training, WCCG, March 2014
[18] Feedback Safeguarding Children: GP Practice Level 3 Training, WCCG, June 2014
[19] Feedback Safeguarding Children: GP Practice Level 3 Training, WCCG, September 2014

4.2 WCCG implemented the local Action Plans (Primary Care Services and WCCG/NHSE) that were formulated from the findings of the W3 Serious Case Review,[20] the majority of requirements of which were completed by the end of the year. The development of an electronic report template, as accessible via the EMIS system to better support GPs to provide information into Child Protection Conferences, was a feature of the work programme, as was the development and usage of a self-assessment tool to ascertain levels of compliance with key Safeguarding Children practice requirements.

4.2.1 ***Related Item: 2015/16 work programme***

The on-going work programme to support Primary Care Services to effectively engage in local Working Together Safeguarding Children activities will remain a priority area of business and will be afforded due corporate governance. Consideration will be afforded to Safeguarding Children matters in the context of any future co-commissioning arrangements.

5. WCCG: Items for priority 2015/2016

5.1 A considerable number of achievements have been made during the reporting time-frame in the interests of safeguarding children across thresholds of need, vulnerability, harm, abuse and neglect. Items of business that remain as work in progress are to inform the objectives and work programme for the forthcoming year and in the context of collaborative activity across commissioning, provider and partner agency sites.

5.2 It is understood that the key priorities as formulated by provider organisations and as referenced in their respective Annual Safeguarding Reports continue to receive attention and are reported on accordingly.

5.3 **The areas for WCCG priority for the forthcoming year are as follows:**

i) To accommodate the requirements of revised national directives, namely:

- **Accountability and Assurance Framework for Safeguarding Vulnerable People**
- **Promoting the Health and Welfare of Looked After Children**
- **Working Together to Safeguard Children,**

ii) To influence and support the establishment of a MASH, including:

- **Effective application of multi-agency thresholds of need, vulnerability, harm and abuse,**
- **Effective management of children's needs as multi-agency concerns when domestic abuse features in family life,**

iii) To enhance oversight of care provision to children looked after, with particular reference to out of area placement and complex mental health needs and emotional well-being,

iv) To support multi agency activity relating to the management of trilogy of risk factors (the impact on children where domestic abuse, parental mental ill-health, parental substance misuse feature in their lives),

v) To support multi-agency activity relating to child sexual exploitation,

vi) To apply focus on Safeguarding Children system, process and practice across local unscheduled access sites,

vii) To apply focus on Safeguarding Children competencies of the local Paediatric workforce,

viii) To monitor and assure that the arrangements for specialist medical examination of children when sexual assault / abuse presents are effectively delivered,

[20] Serious Case Review: Child W3, Walsall Safeguarding Children Board, 2014

ix) To enhance local GP engagement in Working Together activities in the interests of Safeguarding Children,

x) To apply focus on the review of infant mortality and associated work programmes for improvement in the prevention and reduction of childhood deaths.

5.4 To conclude and with reference to the expectations of the role of the Clinical Commissioning Group as cited in the Accountability and Assurance Framework:

WCCG will continue to work with others to ensure that critical services are in place to respond to children who are at risk of or who have been harmed, and will remain concerned for the delivery of improved outcomes and life chances for individuals as those most vulnerable.

Preventative approaches, timely and effective intervention and quality assurance of such remain fundamental elements of overall Safeguarding Children

CCG: Walsall

2015/16 operational plan on a page: Version 14: 02/4/15

The 4 key priorities for the 15/16 operational plan are :

1. **To reduce emergency admissions to hospital**. In 2015/16 Urgent care pathways will continue to be reviewed, transformed, and designed to produce better outcomes. The BCF will drive the integration of commissioning and provision to reduce emergency admissions to hospital of people aged 65 years and over. This will include primary, community and social care services redesign
2. **To improve service performance and**. **quality** In 2015/16 we will continue to work with our main acute provider to maintain and assure quality and safety of planned care services including recovery of RTT standards. We will be working to ensure that demand management around elective care pathways is robust and focus on these areas: an agreed high level milestone plan for recovery; a single regular reporting system ; and have developed & agreed specialty level recovery plans
3. **To Improve mental health and wellbeing and parity of esteem** - In 2015/16 achieve dementia diagnosis, IAPT and additional access standards
4. **To Provide the right care, in the right place, at the right time**- In 2015/16 devpt of primary care (PC) provider capacity to support new models of delivery and PC co commissioning

Access

- **Timely access for everyone** - Implement the new standards relating to mental health and for our acute provider implementing a minimum of 5 of the 10 7 day working standards in 2015/16
- **Meeting the NHS Constitution standards** – 2015/16 WNHST contract includes recovery plans to deliver NHS Constitution standards : Urgent Care 95% 4 Hour Wait and RTT standards
- **Winter resilience** - Agreed SRP funded through recurrent CCG winter baseline budget adjustment
- **Cancer** -- ensure that all of the NHS Constitutional Requirement related to Cancer Waiting times are delivered, using both contracting and quality assurance mechanisms; reviewing current fast track referrals to ensure that they are clinically appropriate and where possible exploring pathways where patients can be managed in primary care e.g. PSA Pathway for Prostate Cancer.
- **Diagnostics** -optimise the delivery of the NHS Constitutional Measure's for diagnostic treatment waiting times and where clinically appropriate seek opportunities to shift some diagnostics to the delivered in the community, via procurement thereby increasing opportunities in working with the Independent Sector and non NHS providers
- **Mental Health- IAPT:** improve our recovery rates from 50% to 60% by March 2016 through reducing DNA rates and improving on the treatment for older people and **Dementia** – improve diagnosis rates to 67% by March 2016 through PC training
- **Early intervention in psychosis** – to improve timescales from referral to treatment to under 2 weeks – through mental health contract
- **Primary Care** – new models of care enabled through development of other primary care and VS provider market, promote access and use of web consultations, online appointment booking, access to medical records and ability to cancel appointments by texting services to DNA rates. Increase the use of Telehealth to manage patients with LTCs , promote patient self-help by signposting to credible sources of information and champion the use of Shared Decision-Making tools
- **Community access** –to improve access to therapy services i.e. physio and podiatry by looking at potential for contracting differently and KPIs
- **Better Care Fund** – improving community access and care of over75s

Outcomes

•Outcomes -delivery across the outcome framework domains

The CCG has reviewed and updated the outcome indicators to show the planned improvements to outcomes for 2015/16 and 2016/17. These are measuring improvement in WCCG Health outcomes and included in the narrative plan

•Improving health

To continue to improve the Flu uptake rates for at risk groups and reduce and better manage Long Term Conditions

Priorities from our JSNA include male life expectancy and infant mortality. Improvement ambition for male life expectancy in 2015/16 is 78.42 years

For Infant mortality to reduce the Infant mortality rate per 1000 live births in 2015/16 to 7.2.. Other ambitions are:

Improve the management of diabetes. Last HB1AC is <=8% in last 15 months -78.2% of patients on diabetes disease registers

Reduce Under 75 mortality rate from respiratory disease to 35 per 100,000 and reduce Under 75 mortality rate from cardiovascular disease to 80 per 100,000

Incidence of obesity in children- the percentage of 4 and 5 year old children who are overweight to 22.8%

•Reducing health inequalities

Close the gap in Life Expectancy within the Borough between the most deprived and affluent areas of Walsall (years) Men 10.36 and women 7.62. through HWBB interventions and prevention

•Parity of esteem

The CCG is working with partners who have signed up to the Mental Health Crisis Concordat to address mental health needs in Walsall and reducing the gap

Access and waiting time standards in mental health services set out by NHS England will be implemented as part of our contract with our mental health provider so as to ensure reduced inequity in access and to improve outcomes for all that require care.

- **Primary care**

Use Primary care Co commissioning, to improve PC contractor quality, safety and outcomes and increase patient satisfaction.

Quality

- **Response to Francis Berwick and Winterbourne View (Transforming Care Agenda) -**

✓ continue to strengthen the quality Improvement systems and processes in place across Primary Care and utilising the opportunities Co-Commissioning will present

✓ Continue to work with provider organisations to ensure recommendations laid down are now embedded and fully transparent through existing Quality strategies. The revised contract quality schedule will be in place to monitor progress, capture and celebrate improvement and hold to account through contractual arrangements.

✓ Reviewing our patient engagement strategy s to ensure a strengthened approach.

- **Patient Safety**

✓ Ensure continued KPI improvement for Pressure ulcers (50% reduction Cat 3 on previous year and 0 tolerance Cat 4) , Falls, serious incidents , HCAI rates(C Diff rate 18 -15/16 and 0 Tolerance MRSA) and mortality reporting to include private nursing homes.

✓ Utilise a range of learning themes and actions from previous serious incidents/never events/ incidents, to support a proactive culture of learning and improvement across provider organisations.

✓ Work with our providers to provide the appropriate support and response at times of increased capacity and pressure, this includes initiating the CCG quality and safety escalation plan, in order to mitigate clinical risk and potential patient harm.

✓ The use of an evidence-based systematic technology solution (PRIMIS PINCER) to identify patients at risk of harm from medicines and reduce admissions due to medicines harm (data suggests that 5-7% admissions are due to meds and about 60% are preventable)

- **Patient experience**

✓ Revising and developing the roles of PRGs

✓ Reviewing our patient engagement strategy and refreshing existing arrangements to ensure a strengthened approach.

✓ Personal health budgets

- **Compassion in practice and skills development**

✓ Ensuring Compassion in Practice – 6 c's is an integral part of clinical practice and evident in improved patient experience outcomes for provider organisations.

✓ Development and progression of the Walsall Practice Nurse Strategy to ensure full implementation of 6c'S across Primary Care and identify new roles through LETB

- **CCG Staff satisfaction**

✓ Develop and implement a leadership framework

✓ Provide all staff with detailed, constructive feedback as well as fair recognition for their efforts.

- **Seven day services**

✓ Provider contracts will include seven day service delivery.

✓ Providers will be monitored to ensure seven day services are universal across all relevant services,.

- **Safeguarding**

✓ Implement Statutory accountabilities laid out within the Care Act for Adult Safeguarding.

✓ MCA/Designated Safeguarding Lead will be developed and progressed in line with the revised statutory arrangements for Adult Safeguarding arrangements.

✓ Safeguarding responsibilities of CCG and Provider will be in line with NHS Accountability framework document.

✓ Provider contracts include reference and action with regards the PREVENT agenda and guidance.

Delivering value

Financial resilience: delivering VFM for taxpayers and patients and procurement.

- WCCG is able to deliver the **required level of surplus** in 15/16. Plans are that £5.4m surplus will be delivered and an assumption that drawdown will not be required. The recurrent underlying surplus, after excluding planned non recurrent expenditure, exceeds this at £7.5m
- **QIPP 2 year plans** have been reviewed and developed with the support of our Clinical Leads based upon a review of benchmarked spend by programme area In addition, the inclusion of planned outcome measures around the required reduction in emergency admissions, enabled by investment in the BCF programme has also contributed . The total QIPP challenge for 2015/16 is £6.2m. 16/17 will be considerably more challenging dependent upon the requirement for CCG's to be within 5% of their target allocation by 2016/17.
- has applied the **key business rules** as outlined in the NHSE planning guidance which provides for the minimum provision of a 1% non-recurrent expenditure and a **0.5% contingency** fund, the combined value of which is £5.5m
- **Agreed Activity and finance plans** include QIPP assumptions and investment priorities and take account of providers opting for ETO
- Plan includes a broader view on value so benefits delivered are not purely financial i.e. economic, social and environmental

Transformation programmes, reconfiguration plans and reprocurement

- Urgent care pathway redesign and NHS 111 procurement
- Personal Assistants Dementia & MH and LD Placements
- CAMHs Tier 3+
- Primary care at scale
- Care home support
- Public Value Accounts