Agenda item 9

Health and Wellbeing Board

25 April 2016

Walsall Clinical Commissioning Group Draft Operational Plan 2016/17

1. Purpose

To update members on the latest position regarding the refresh of the Walsall CCG Operational plan 2016/17 due for submission to NHS England on 18 April.

The report gives an overview of actions taken to date to refresh the CCG operational plan and current status of the plan. The 2 March plan submission has been revised to take account of latest assurance requirements from NHSE. The final submission is required on 18 April and following full assurance being given by NHSE, the plan will be brought back to the CCG Governing Body for formal approval.

2. Recommendations

2.1 That HWB note the report

2.2 That HWB note that the fully assured plan will be published on the CCG website once all NHS England assurance requirements have been met and the plan signed off as assured by them.

3. Report detail

Draft Operational Plan 2016/17- 11 April submission

1. Introduction

The Draft Operational Plan 2016/17 (attached as appendix)

This is a refresh of the current CCG operational plan 2015-17. Year 2 of the current Operational Plan has been constructed in the context of: the national strategy as set out in the Five Year Forward View and subsequent planning and technical guidance issued in December 2015: the CCG's Strategic Plan 2015-19 which sets out the CCG's strategic objectives, priorities and values; the work of the newly founded Healthy Walsall Partnership Board and the implications of working within the broader Black Country planning footprint. The Plan's development is in parallel to the development of 5 year sustainability and transformation plan (STP) for the Black

Country Health system, and as such this operational plan forms year 1 for the Walsall CCG Locality.

2. The Operational Plan 2016/17 priorities

The plan continues to make the triple aim its primary focus. The CCG will through the plan continue to commission services that narrow the health inequalities, financial and quality gap. The plan also focuses on delivery of the 9 national must dos including parity of esteem, transforming care and NHS constitutional targets for RTT, Cancer, Diagnostic and urgent care.

The considerable challenges facing our local system at this time and in the future means that the plan is focusing on four key priorities:

Priority One – Recover performance: Recover and stabilise our current system to ensure we recover performance against key NHS constitutional targets including the 4 hours A&E target, the 18 weeks Referral to Treatment (RTT) Target and cancer targets.

Priority Two – Restore quality of Services: Ensure we restore quality of services and patient safety by supporting WHT to respond to the recommendations set out in the recent Care Quality Commission's (CQC) inspection of Walsall Healthcare Trust (WHT) with particular focus on maternity and emergency and urgent care services. A further key focus here is to reduce health inequalities and improve health outcomes.

Priority Three – To deliver transformational change through the STP footprint: Work with our strategic partners on the wider footprint of the Black Country and West Birmingham to develop a sustainable plan for services in the future including the initial four service areas identified for collaborative working across the footprint: urgent care, primary care, mental health and maternity services. These build on the approach already adopted in Walsall to address these issues.

Priority Four – Maximise Value and Secure Financial Balance through Right Care: Ensure we remain in financial balance by using the Right Care Programmes and other mechanisms to identify and deliver our Quality, Innovation, Productivity and Prevention (QIPP) programme and secure best value for the Walsall pound. The Better Care Fund and improvements in community services are key drivers within this context.

3. QIPP challenge

We are also faced with a very challenging £22 million QIPP programme. Section 2.4.2 of the Plan covers this. At the time of writing this report work was still on going at Programme level to identify the level of savings required. An update concerning overall progress and the work of programme including using the Rightcare approach

is to be given at the Improving Outcomes Committee meeting under the QIPP agenda item.

4. Commissioning for Quality and Innovation (CQINNs)

At the time of writing the report national guidance on CQINNs had only just been received. There will be national as well as local CQINNs included in provider contracts to support delivery of QIPP and Right care approaches.

5. Indicative Hospital Activity Model (IHAM) modelling and impact of 10 national improvement programmes on CCG activity

As part of the submission this year the CCG is required to assess the impact on activity of the 10 national improvement work streams. This can be either a positive or negative number. An assessment has been made based on transformation and QIPP schemes so far developed and were submitted as part of the 18 April submission. This process is on-going and it should be noted activity modelled is triangulated with the operational plan narrative.

6. Provider and CCG activity and financial assumptions as part of the contract

The Area and Team and Regional office is undertaking assurance of these returns to ensure they are consistent with one another and ensure their resilience and meets the national requirements. The Chief Finance Officer is leading this submission of the financial plans and other activity and financial templates via the UNIFY system (a national reporting system for CCGs and Trusts). Providers are responsible for making their submissions to Trust Development Authority.

7. Assurance of the Plan by NHS England and Regional Office

The first and second iterations of the Plan submitted on 8th February and 2 March 2016 have been reviewed by NHS England and Regional Office and the outcome of that assessment will be reflected in the 18 April submission.

8. Engagement

The initial draft submitted on 8 February was circulated widely for comment on 11th February as follows:

- CCG Governing Body
- Clinical Operational Group
- Walsall CCG member practices- GP and Practice managers.
- Chief Executives of WHT, Dudley Walsall Mental Health Partnership Trust (DWMHPT), and Walsall MBC
- Walsall Local Medical Committee.
- Public Health at WMBC

An engagement event with member practices took place in early April 2016 and key themes to emerge from these events have been reflected in the plan as follows:

- The need to revise pathways and to have agreed referral protocols potentially on a Black Country-wide basis with increased support from secondary care clinicians with effective multi-disciplinary teams (MDTs).
- The need for improved integration of acute, community, urgent care, social care and primary care services with the transfer of services from the acute sector wherever possible.
- Enhanced mental health services and CAMHS (child and adolescent mental health service) with significant improvement in access and increased support for General Practitioners.
- The need to address workforce and capacity issues within all sectors.
- Improved patient education in terms of both self-care and improved knowledge about the availability of services and where to go for which services.
- A more joined-up and robust urgent care system which prevents inappropriate visits to A&E.
- To focus the RIGHTCARE (QIPP) programme on areas that would give the greatest opportunity/return but which are achievable in relatively quick timescales.

Although most of these issues were already addressed by the previous version of the Operational Plan, where applicable the 18 April version has been updated to reflect these concerns.

4. Implications for Joint Working arrangements:

As part of the latest planning guidance, “Delivering the Forward View: NHS 2016-17 2020-21”, health economies are urged to review their current planning footprints so as to maximise the ability to deliver service transformation as set out in five year Sustainability and Transformation Plans (STPs). It has also been made clear that larger footprints are more likely to attract additional Sustainability and Transformation Fund (STF) monies from April 2017.

Following discussions within the West Midlands it has been agreed that four main planning footprints should be established as set out in **Figure 1.**

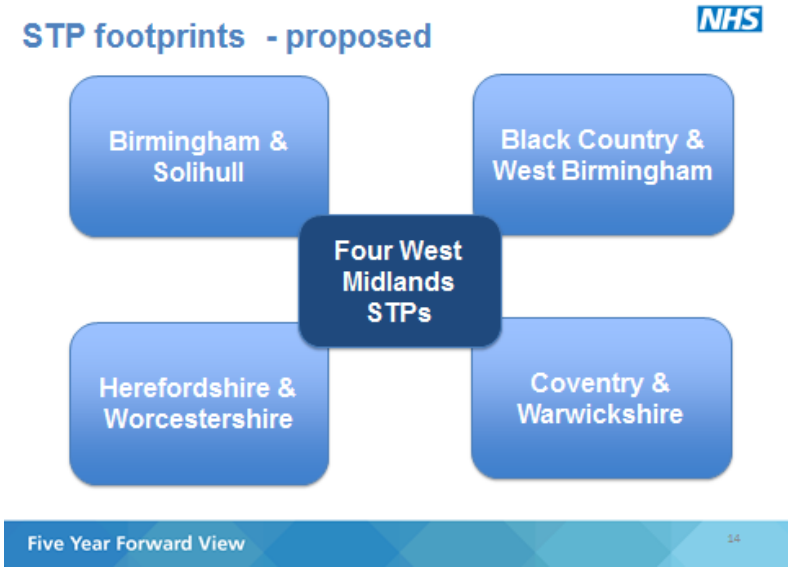

Figure 1 - West Midlands Planning Footprints

This approach is consistent with the belief that the challenges now being faced by the Walsall health and social care system, are best approached on a wider planning footprint. Accordingly, we have agreed to work closely with Wolverhampton, Dudley and Sandwell and West Birmingham health and social care systems to establish a Sustainability and Transformation Plan (STP) on a Black Country footprint as illustrated in **Figure 2.**

It is important to recognize that the Black Country STP will be a plan not just devised by commissioners but involves all key providers and local authorities within this broader area. Therefore, for Walsall key contributors are Walsall Metropolitan Borough Council, Walsall Healthcare NHS Trust (WHT), Dudley and Walsall Mental Health Partnership Trust (DWMHPT) as well as the CCG**.** In doing so we have agreed that we will continue to build on the existing local partnerships in each of our areas whilst seeking to collaborate on (initially) a small number of priority areas where we can maximise individual and collective benefit across the wider STP footprint.

Figure 2 – Black Country and West Birmingham Planning Footprint

5. Health and Wellbeing Priorities:

The Draft Operational Plan 2016/17 aligns closely with the strategic aims and objectives of the HWB and is intended to tackle health inequalities in the Borough as part of a combined approach with all HWB partners and with Walsall people; ensure that high quality and safe services are commissioned to meet need now and in the future; and services commissioned are value based and bridge the affordability gap.

Background papers

The Operational Plan for Walsall CCG for the financial year 2016-17 has been constructed in the context of: the national strategy as set out in the Five Year Forward View and subsequent NHS planning guidance; the CCG's Strategic Plan 2015-19 which sets out the CCG's strategic objectives, priorities and values; the subsequent Operational Plan for 2015-17; the work of the newly founded Healthy Walsall Partnership Board; and the implications of working within the broader Black Country planning footprint and developing a 5 year sustainability and transformation plan (STP) for the Black Country Health system of which the Operational Plan forms year 1 for the Walsall CCG Locality.

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Appendix 1

NHS
Walsall Clinical Commissioning Group

Draft Operational Plan

2016 - 2017

Version 1.2

Foreword – Dr. Amrik Gill and Salma Ali

Walsall is one of four localities in the Black Country which sits within the West Midlands Region. We serve a population of 274,000 and we are coterminous with Walsall Metropolitan Borough Council. Our borough is characterised by great contrast, with significant deprivation in the West of the Borough and relative affluence in the East. Differences in deprivation levels and lifestyles such as smoking and excessive consumption of alcohol lead to poorer health outcomes for our communities living in these localities. This translates into high levels of infant mortality in our babies and lower life expectancy in our adult population. High levels of morbidity from a range of diseases such as coronary heart disease and diabetes sits alongside often poorer experiences of health services. Reducing these health inequalities is an important driver in our strategy.

In addition to these challenges our current health system is facing significant challenges in a number of key areas including poor performance against a number of NHS Constitutional Standards. At the time of developing this plan the Care Quality Commission has rated some services at one of our main health providers, Walsall Health Care NHS Trust as inadequate and in need of rapid improvement. The change in financial outlook for the NHS has also exacerbated the pressures we face as our CCG has received minimal levels of growth funding thereby limiting our ability to invest in services for our patients.

In order to meet these challenges we have had to radically rethink how we continue to deliver effective and safe services for our populations. Our approach will focus on how we stabilise and restore our current system to ensure patient safety and improved performance against key NHS constitutional targets in the short to medium term whilst we work with our strategic partners on the wider strategic footprint of the Black Country to develop a Sustainability and Transformation Plan (STP) for the future. Accordingly we are seeking to build greater alignment between communities, organisations and agencies enabling us to move together in the same direction at greater scale and pace.

This Operational Plan is the first year of that STP and details how we in 2016-17 intend to translate our vision to transform health for local people in Walsall within the context of increasing health and social care needs against the background of increased resource constraints across the public sector. Our approach will seek to incorporate the following:

- Describe the key issues that we need to address in order to improve services and outcomes for local people based upon a detailed understanding of the drivers shaping our local system.
- Set out our operational priorities for delivering the critical changes on our transformational journey drawing upon the Five Year Forward View and our local response.
- Set out how we will deliver our challenging QIPP programme of £16.6m through service redesign and transformation.
- Set out how we will measure key improvements in services and health outcomes.
- Describe how we will work with our key stakeholders to respond to public and political expectations, manage financial constraints and assure system regulators of the impact of our role in shaping our increasingly integrated health and social economy and wider strategic partnerships.
- Describe how we have strengthened our organisations leadership, governance and processes to ensure we have the necessary capacity and capability to deliver our plans.

In addressing these issues we will be able to build on the significant work we have already undertaken in forming the Healthy Walsall Partnership Board which includes representation from the CCG, Walsall Council, Walsall Healthcare NHS Trust, the Dudley and Walsall Mental Health Partnership Trust and others, by extending our influence throughout the Black County and West Birmingham health and social care system in a way so that services deliver the best care for the people of Walsall irrespective of the commissioning footprint on which they are based. Working within this broader footprint 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.

We will continue to draw upon the learning from new models of service delivery within the Black Country and elsewhere e.g. Multispecialty Community Providers (MCPs), to promote the development of GP Federations in Walsall. We will also support the development of the new Provider Networks such as the Black Country Alliance and the MERIT where such models are the best vehicles for the delivery of the best care for the people of Walsall.

In setting out these plans, as well as addressing the immediate challenges in the Walsall Economy, we are also ensuring the wider objectives as set out in the "NHS Mandate 2016/17, "Delivering the Forward View: NHS Planning Guidance 2016/7 to 2020/21" and other supplementary planning guidance.

Dr. Amrik Gill
Chair
Walsall Clinical Commissioning Group

Salma Ali
Accountable Officer
Walsall Clinical Commissioning Group

Table of Contents

Document reference information

Version:	1.2
Status	Draft
Director responsible	Director of Commissioning , Performance and Transformation
Name of originator/authors:	Alan Turrell, Phil Griffin, Michelle Gordon & Kelvin Edge
Date Ratified and by whom:	Health and Well Being Board CCG Improving Outcomes Committee CCG Governing Body
Date Effective From	1st April 2016
Review date:	This should be 6 months prior to expiry date
Expiry date:	31st March 2017
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	
Archive	One calendar year from expiry date	31st March 2018
Destroy	Twenty years from expiry date	31st March 2038

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CCG Governing Body	Accountable Body

Circulated to all of the above for consultation

Version Control Summary

Significant or Substantive Changes from Previous Version

Version	Date	Comments on Changes	Author
2.1	21 3 16	Update of Urgent care section to reflect latest trajectory for 95% 4 hour wait and SRG recovery plan	John Wicks
2.2	22 3 16	Update of NHS Constitutional standards Table 13	Andy Field
2.3	23.3.16	Amendments to cancer section 2.1.3	Dr Teoh

Section 1
Strategic Context

1.1 Introduction

This Operational Plan for Walsall CCG for the financial year 2016-17 has been constructed in the context of: the national strategy as set out in the Five Year Forward View and subsequent guidance: the CCG's Strategic Plan 2015-19 which sets out the CCG's strategic objectives, priorities and values; the subsequent Operational Plan for 2015-17; the work of the newly founded Healthy Walsall Partnership Board and the implications of working within the broader Black Country planning footprint and development of a 5 year sustainability and transformation plan (STP) for the Black Country Health system of which this operational plan forms year 1 for the Walsall CCG Locality .

1.2 The National Context: Five Year Forward View and 2016-17 Planning Guidance

The Five Year Forward View 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 aspiration 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.

This refreshed Operational Plan is set in the context of the current WCCG Strategic Plan but takes full account of the subsequently published Five Year forward View and recently published planning guidance. It sets out how the CCG will close the health and well-being gap, how we will drive transformation to close the care and quality gap and how we will close the finance and efficiency gap.

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. These are equally all essential ingredients to our local 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.

The latest planning guidance, "Delivering the Forward View: NHS 2016-17 2020-21" reinforces this approach and specifically identifies nine 'must dos':

1. Develop a high quality and agreed **STP**, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the **Forward View**. This is addressed in **Sections 1.3 and 2.3** of this Plan.

2. Return the system to **aggregate financial balance**. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider

productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the Right Care programme in every locality. This is addressed in **Section 1.4** of this Plan. And in our Financial Plan.

3. Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues. This is addressed in **Section 2.3.3** of this Plan.

4. Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots. This is addressed in **Section 2.1.1** of this Plan.

5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice. This is addressed in **Section 2.1.2** of this Plan.

6. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission. This is addressed in **Section 2.1.3** of this Plan.

7. Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia. This is addressed in **Section 2.3.4** of this Plan.

8. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy. This is addressed in **Section 4.5** of this Plan.

9. Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality** rates by individual trusts. This is addressed in **Section 2.2** of this Plan.

1.3 The Black Country and West Birmingham Planning Footprint and STP

As part of the latest planning guidance, "Delivering the Forward View: NHS 2016-17 2020-21", and as reiterated under **"Must Do no 1",** health economies are urged to review their current planning footprints so as to maximise the ability to deliver service transformation as set out in five year Sustainability and Transformation Plans(STPs). It has also been made clear that larger footprints are more likely to attract additional Sustainability and Transformation Fund (STF) monies from April 2017.

Following discussions within the West Midlands it has been agreed that four main planning footprints should be established as set out in **Figure 1.**

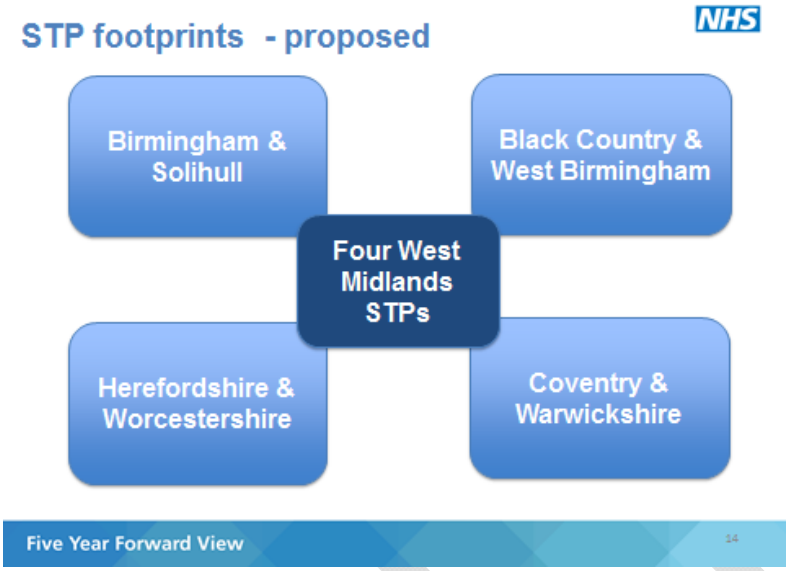


Figure 1 - West Midlands Planning Footprints

This approach is consistent with the belief that the challenges now being faced by the Walsall health and social care system, as set out in **Section 1.4** below, are best approached on a wider planning footprint. Accordingly, we have agreed to work closely with Wolverhampton, Dudley and Sandwell and West Birmingham health and social care systems to establish a Sustainability and Transformation Plan (STP) on a Black Country and West Birmingham footprint as illustrated in **Figure 2.** In doing so we have agreed that we will continue to build on the existing local partnerships in each of our areas whilst seeking to collaborate on (initially) a small number of priority areas where we can maximise individual and collective benefit across the wider STP footprint.

Figure 2 – Black Country and West Birmingham Planning Footprint

1.4 Walsall Context and our Approach

The CCG's Strategic Plan 2014-19 laid a useful foundation for the way forward in that it sets out the overall vision "To improve the health and well-being of the people of Walsall" and the related strategic objectives and priorities as illustrated in **Figure 3.**

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.	Improve mental health and well-being of 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

This vision is underpinned by the following values and as set out in **Figure 4**:

- 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.

Figure 4 – Walsall CCG Organisational Values

These values are enshrined throughout this Operational Plan and set the standard for how the WCCG conducts itself.

The subsequent CCG Operational Plan covering the period 2015-16 to 2016-17 identified the operational priorities in order to deliver the Strategic Plan and to put this into the context of the subsequently issued Five Years Forward View.

This approach is also mirrored by the 3 year Health and Wellbeing Strategy for Walsall (2013/14 – 2016/17) overseen by the Walsall Health and Well-Being Board (HWB) which identifies 19 priorities within 8 themes that cover the human life cycle with the overall aim *"To improve the health and wellbeing of everyone in Walsall and reduce the inequalities by improving the outcomes of people in deprived communities and vulnerable groups faster than the average for the borough of Walsall".*

However it is recognised that the Walsall health and social care system is facing significant challenges in a number of key areas including poor performance against several NHS Constitutional Standards. At the time of developing this plan the Care Quality Commission has rated some services at one of our main health providers, Walsall Healthcare NHS Trust as inadequate and in need of rapid improvement.

The change in financial outlook for the NHS has also exacerbated the pressures we face as our CCG has received minimal levels of growth funding thereby limiting our ability to invest in services for our patients. In order to meet these challenges we have had to radically rethink how we continue to deliver effective and safe services for our populations.

These considerable challenges facing our local system require us to focus on four key priorities:

Priority One – Recover performance: Recover and stabilise our current system to ensure we recover performance against key NHS constitutional targets including the 4 hours A&E target, the 18 weeks Referral to Treatment Target and cancer targets.
Priority Two – Restore quality of Services: Ensure we restore quality of services and patient safety by supporting WHT to respond to the recommendations set out in the recent Care Quality Commission's inspection of Walsall Healthcare Trust (WHT) with particular focus on maternity and emergency and urgent care services. A further key focus here is to reduce health inequalities and improve health outcomes.

Priority Three – To deliver transformational change through the STP footprint: Work with our strategic partners on the wider footprint of the Black Country and West Birmingham to develop a sustainable plan for services in the future including the initial four service areas identified for collaborative working across the footprint: urgent care, primary care, mental health and maternity services. These build on the approach already adopted in Walsall to address these issues.

Priority Four – Maximise Value and Secure Financial Balance through RightCare: Ensure we remain in financial balance by using the RightCare Programmes and other mechanisms to identify and deliver our QIPP programme and secure best value for the Walsall pound. The Better Care Fund and improvements in community services are key drivers within this context.

Further details on these priorities are given in **Section 2**, whilst:

Section 3 details how we will measure performance and monitor quality in order to ensure that our ambitions are achieved.

Section 4 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 priorities set out in this Operational Plan.

Section 5 describes our enablers for change including our organisational development and our approach to engagement as well as information technology, estates, and commissioning support.

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

1.5 Developing and agreeing this Plan

This second draft of this CCG Operational Plan 2016-17 and first year of the STP, has been developed through the input of the CCGs commissioning managers, GPs, specialist staff, the local authority and providers and has been approved by the CCG Governing Body.

This version of the Plan represents a substantial revision in order to reflect the feedback on the initial draft by providing increased emphasis the immediate priorities required to address the current challenges facing the Walsall health and social care economy but within the context of the broader Black Country and West Birmingham planning footprint.

Further consultation will take place in the light of further assurance comments received from NHS England.

Section 2
Operational Plan Priorities

Introduction

In developing this Operational Plan for 2016-2017 and the first year of the STP, WCCG has reviewed the objectives, priorities and interventions within its previous Strategic Plan and previous Operational Plan in the light of the challenging environment facing the Walsall health and social care system as set out in Section 1.3 above. The CCG financial challenge in 2016/17 is circa £16 million which we will address through a QIPP programme of service transformation and change. We are committed to delivering significant change in some key service areas where commissioning for value intelligence suggests the CCG is spending more than its peers yet getting poorer outcomes or spending more than our peers but achieving the same outcomes.

Achieving the scale of transformation needed and the financial savings with it means that for some commissioning areas we need to work collaboratively with other CCGs through the Black Country and West Birmingham footprint as described above.

The areas we have identified for priority attention in 2016-17 as summarised in **Section 1.3** above are described in more detail in this section 2.

2.1 Priority 1 – Recover Performance

This priority addresses the immediate performance challenge facing Walsall with particular focus recovering performance in relation to urgent care, RTT and cancer.

2.1.1 Urgent Care and A&E 4 Hours Target

2.1.1.1 Urgent Care System

A review and consultation of the urgent care system in Walsall was completed and reported in November 2014. The drivers behind the review included 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.

The vision and therefore strategic direction approved by the Governing Body and assured by NHS England was to within 5 years develop a unified Urgent and Emergency Care System in one building providing a "walk-in" service 24/7. Once implemented, the new system will provide the following benefits:

- 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

However, it was recognised that this vision could not be delivered immediately as the facilities for a single centre did not exist at the Walsall Manor site and therefore it was agreed that as part of Phase One of the Urgent and Emergency Care Strategy, interim arrangements would be put in place with separate urgent care centres based in the community (within Walsall town centre) and at the hospital.

During 2015-16 substantial progress was made through the conduct of a procurement exercise to appoint a single provider, Primecare, to provide the following services with effect from 1st October 2015:

- GP out of hours service including telephone triage (following initial call to 111), home visits and face to face consultations.
- Urgent Care Centre located at the Manor Hospital.
- Urgent Care Centre located in the town centre (community site) – This was initially located in the former Walk-In Centre but moved to a new site from January 2016.
- Provision of a streaming service within the A&E Department ensuring that patients are only seen in A&E where this is appropriate.

In addition to the above, a new 111 provider, commissioned on behalf of all West Midland CCGs by Sandwell and West Birmingham CCG, was introduced during 2015-16 and this provider is already working closely with Primecare to ensure an integrated service.

These new services are already making a significant contribution to improving urgent care provision in Walsall and in 2016-17 we intend to build further on this by:

- Ensuring that the new urgent care service operated by Primecare operates smoothly and that appropriate interfaces and handovers to A&E are fully in place so as to maximise its performance.

- Fully enabling diagnostics services at the Manor Hospital to be accessed direct by the urgent care provider, Primecare, so as to eliminate the need for patients requiring diagnostics to go unnecessarily through the A&E route.
- Ensuring that all providers within the Urgent Care pathway adopt an integrated approach by implementing an "Umbrella Agreement" between them that sets out the key principles of working together and key objectives including ensuring compliance with the recently issued Urgent Care Integrated Commissioning Standards and ensuring maximum integration between the 111 and out of hours services.
- Participating in the procurement exercise, led by Sandwell and West Birmingham CCG on behalf of West Midlands CCGs, to appoint a new 111 provider and ensuring that the new service which is due to commence in October 2016 is fully integrated with other urgent care services.
- In conjunction with WHT and DWMHT, we will work to deliver improvements to assessment and treatment for people of all ages when they are experiencing a mental health crisis such as the extension of the psychiatric liaison service. This work will extend to all partners in crisis including first attenders such as the police and ambulance service. Work is already underway to improve partnerships between key agencies with developments such as the Black Country Mental Health Crisis car and enhancements to existing Crisis and Home Treatment Teams already implemented and more in planned for 2016-17. This work will continue and accelerate.

2.1.1.2 Improving Performance of the 4 Hours A&E Target

Walsall's urgent care system consistently fails to deliver the NHS constitutional standard that 95% of patients attending A&E wait a maximum of four hours from arrival to admission, transfer or discharge. A recovery in performance between May and August 2015 (ranging from 93.8% to 95.1%) has not been sustained and monthly performance subsequently dipped to between 81.2% and 86.7% during September 2015 – February 2016.

Monthly performance since January 2014 is illustrated below: **Figure 5**.

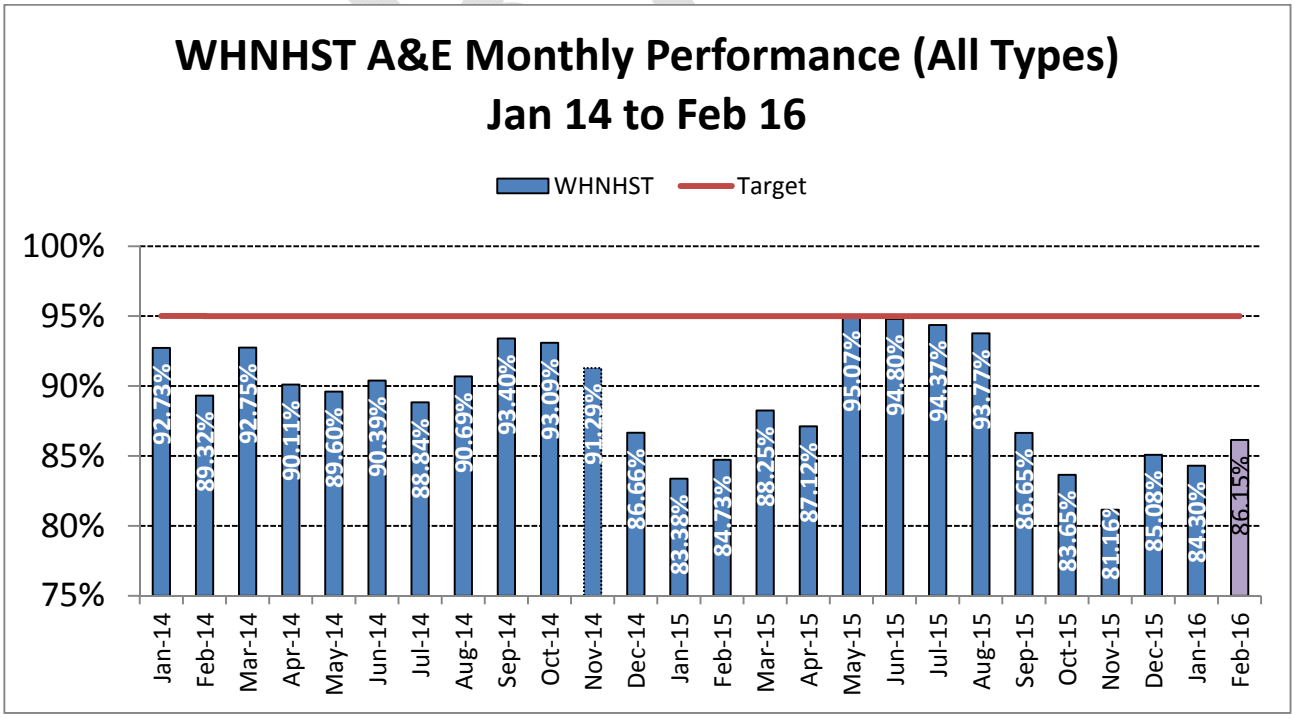


Figure 5 – A&E Monthly Performance

We recognise that the A&E 4 hour standard is a barometer, not only of the quality of care and experience of patients using Accident and Emergency services, but of the effectiveness of the entire urgent care system. Our current system is fragile and not well equipped to sustain good performance.

We have completed our diagnosis of the problems with our current urgent care system and a series of high impact interventions to improve performance where partners will be held to account for delivery through the System Resilience Group (SRG).

Key components to addressing this issue are as follows:

95% 4 hour wait target - diagnosis of System Challenges

A diagnostic review of the Walsall Urgent Care system, using national best practice tools, has identified a number of system challenges. These, alongside the key interventions to remedy them, are summarised in the **Table 1** below.

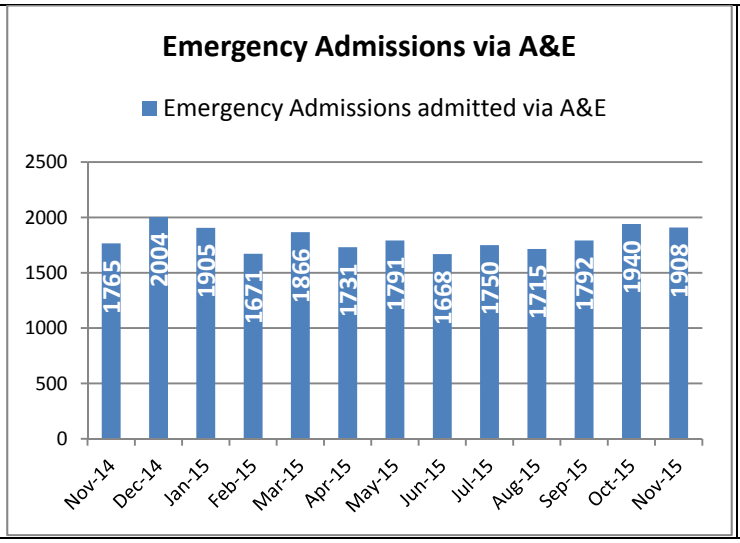
Challenge 1 – Demand Management	Interventions
• Rising numbers of emergency admissions • Rising numbers of ambulance conveyances to hospital • Disorganised systems in for streaming and triage in the Emergency Department	• Give paramedics direct access to GP advice / rapid response at incident • Improve coverage of support for care homes • Assess / treat therapy needs in hospital promptly • Mobilise comprehensive Frail Elderly Service • Improve processes within ED including improved interface between Urgent Care Centre, ED and Assessment Units
Challenge 2 – Hospital Flow	**Interventions**
• Inconsistent ward processes • Reduced discharges over the weekend	• Implement 'SAFER' bundle • Increase number of weekend discharges
Challenge 3 – Discharge	**Interventions**
• High numbers of 'medically fit for discharge' (MFFD) patients • 'Discharge to Assess' model too bed-based • Lack of alternative provision for complex patients, particularly those with dementia	• Case manage MFFD patients with length of stay > 14 days in line with Delayed Transfers Of Care (DTOC) guidance • Enhance flow through Swift Ward * • Revise Discharge to Assess pathway

Table 1 – Diagnostic Review

95% 4 hour wait target: Demand Management

Whilst unplanned activity is performing with contractually commissioned levels, there are areas of pressure which have impacted upon performance.

- Emergency admissions – There has been a circa 4% increase in emergency admissions during 2015 compared to 2014. The conversion rate of ED attendances to emergency admissions was 25% in 2014, 26% over the summer 2015 and rose to 30%-33% from September to December 2015. These are illustrated in **Figure 6.**



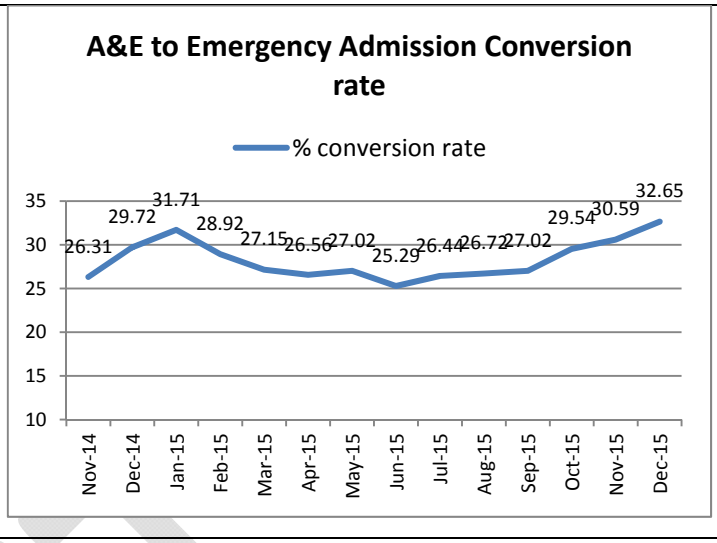


Figure 6 – Admission via A&E

There is a steady trend of increasing ambulance conveyances to Walsall Manor Hospital overall, with no change in the proportion originating in Walsall vs outside of Walsall. The volume of transports in the six months August 15 – January 16 is 2.9% higher than the equivalent period last year, reaching a new high in January 2016. These are illustrated in **Figure 7.**

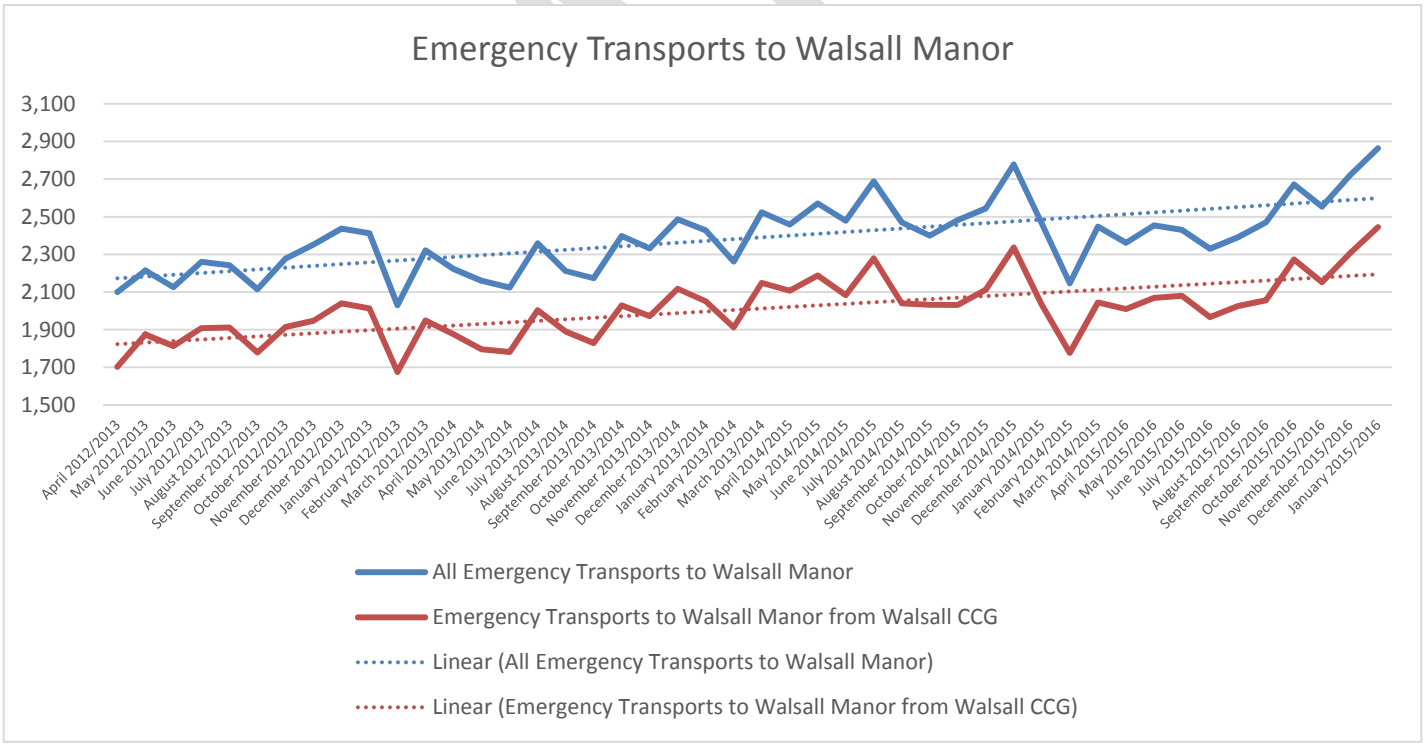


Figure 7 – Ambulance attendances at Walsall Manor Hospital

95% 4 hour wait: Managing Interfaces and Handovers

A newly procured Urgent Care Centre (UCC) was mobilised in October 2015, located on the Walsall Manor Hospital site, operated by Primecare. There are a number of interface issues between the ED and UCC including:

a) Confused streaming and triage systems which sometimes direct patients inappropriately to ED instead of UCC and vice versa.
b) Inadequate clinical triage processes.
c) Constraints in accessing pathways / services for patients out of UCC, resulting in unnecessary redirection to ED.
d) Obstacles to accessing diagnostic test results in UCC.
e) Bottlenecks and lack of space in ED compounded by channelling of UCC patients to same environment for streaming / triage.
f) Minor injuries patients continuing to present at ED due to workforce constraints in UCC.

As indicated in **Section 2.2**, the recent CQC Inspection report of Walsall Healthcare NHS Trust has identified a number of 'disorganised systems' which impact upon the efficient triage, assessment and treatment of patients.

95% 4 hour wait: Hospital Flow

WHT has a number of challenges regarding the flow of patients through the hospital. These include:

- An imbalance between admissions and discharges over a daily/weekly cycle as shown in **Figure 8.**

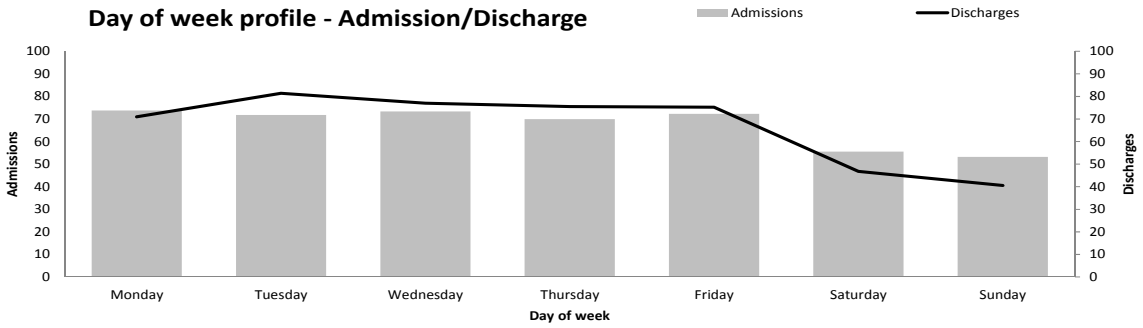


Figure 8 – Admissions and discharges

- Sub-optimal use of the Acute Medical Assessment Unit (AMU), which is intended as the receiving ward for both acute GP referrals and patients in ED requiring medical assessment. The inability to clear these beds systematically throughout the day can result in the Unit being full and patients backing up in ED.
- High variation between inpatient wards in the setting of Expected Dates of Discharge (EDD) and the proportion of discharges occurring in the morning. This reduces bed availability at times when patients need to be pulled through from AMU.
- A reduction in the availability of some services over the weekend (e.g. therapies) and the availability of senior clinical review of patients.
- Inconsistent use / streaming of patients suitable for ambulatory care to the Ambulatory Care Unit.
- Considerable physical space constraints affecting ED.

95% 4 hour wait: Discharge processes

As demonstrated in **Figure 9**, Walsall, like many health economies, has significant numbers of patients who are medically fit for discharge but who remain in an acute hospital bed, sometimes for many weeks.

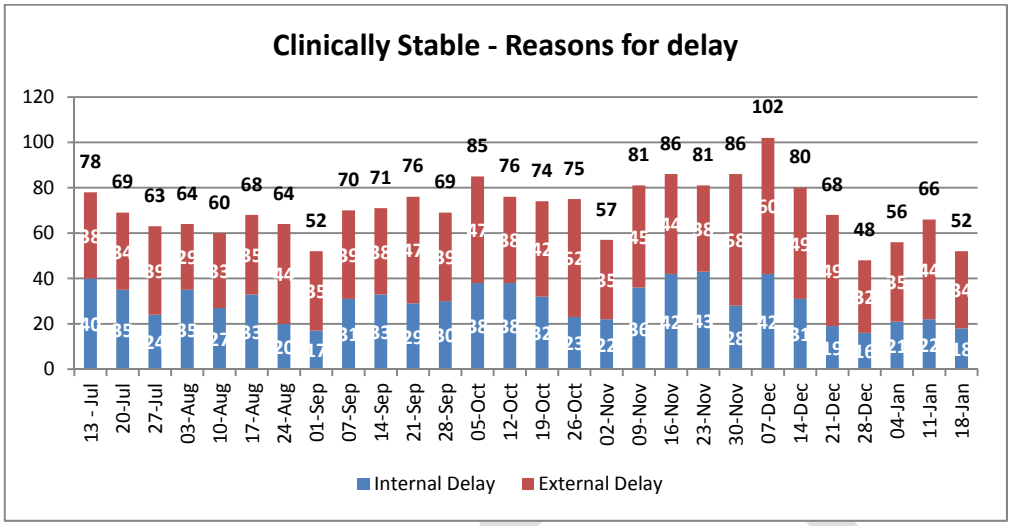


Figure 9 – Reasons for delay

The good progress that was made in the run up to Christmas to reduce these numbers has been sustained but concerted effort will be required to drive the numbers lower, particularly those who remain in hospital longer than 14 days (and ultimately 7 days) after being declared medically fit for discharge.

95% 4 hour wait: Discharge to Assess

Through the Better Care Fund, Walsall health and social care has invested £1.56m in 40 discharge to assess beds in nursing homes. The beds were commissioned to facilitate the discharge of patients whose acute phase of care was complete, for a maximum of 6 weeks, to enable the assessment of their on-going care needs and put appropriate packages of care in place. Meanwhile, their therapeutic needs would continue to be provided.

The experience of these beds has revealed some areas of weakness that need addressing, including:

- an absence of explicit GP medical cover, which if a patient's clinical condition has deteriortaed, has on occasions resulted in readmission to WHT.
- an imbalance of the use of beds which are overwhelmingly used as step-down beds from hospital, while step-up options also need attention
- a tendency for patients with poor long-term outcomes to be discharged to bed-based care when, with appropriate support, discharge home is a better option.
- too many people with dementia being discharged directly to care homes resulting in fewer returning to their usual place of residence
- the lack of a fully developed discharge to assess pathway in that admission to the beds still requires hospital-based assessment

We have an opportunity to re-commission the Discharge to Assess model to halve the number of beds and re-invest resources in additional home re-ablement capacity and enhance specialist support to both bed-based and community services.

95% 4 hour wait: Complex Discharges

Swift Ward (35 beds) in WHT has been the facility that has tended to accommodate patients on the slowest stream through the hospital, e.g. frail elderly with co-morbidities and on-going complex health and social care needs. These patients experience the longest length of stay and account for a significant proportion of hospital bed capacity that is consequently unavailable to support acute care. As part of winter resilience funding, extra investment in community home-based reablement and social worker input has successfully increased the turnover of patients through SWIFT and reduced average length of stay. However, these solutions are non-recurrent and due to end soon. The system needs to sustain the interventions which have proven to be effective.

95% 4 hour wait: Key Interventions

As previously indicated in detailed in **Table 1**, we have identified ten high impact interventions to improve system performance and recover achievement of the 95% A&E standard as required under '**must do' no 4** . These are directly aligned to the themes which have emerged from our diagnosis.

95% 4 hour wait: Recovery Trajectory

As shown in **Figure 10**, the impact of our key interventions will have a cumulatively beneficial effect upon recovery, achieving 95% recovery by October 2016.

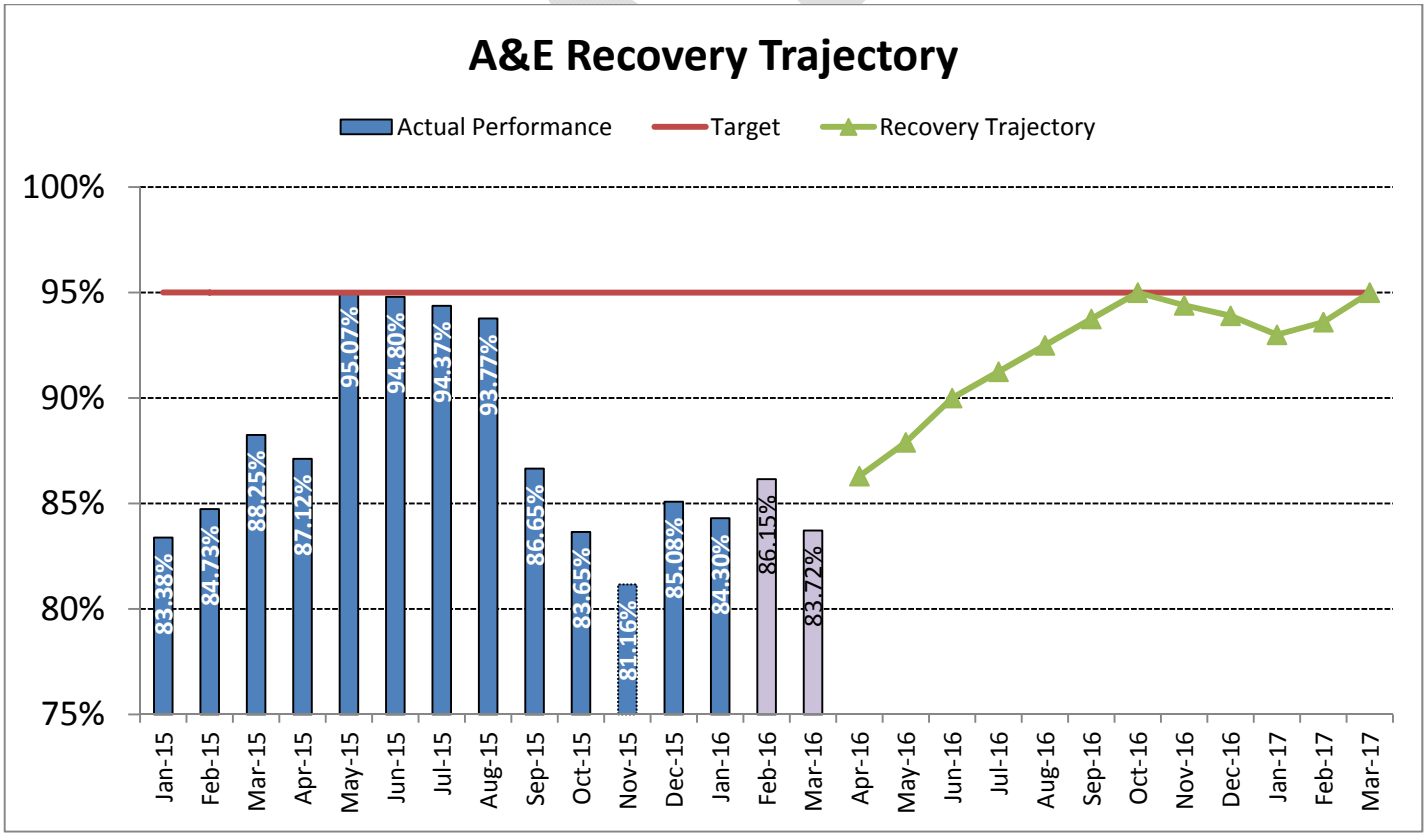


Figure 10 – A&E 4 hour waits

Key enablers of our approach in Walsall to improve the urgent care system and A&E performance are the Better Care Fund and improvements in community services which will be described in more detail under Priority 4.

2.1.2 Elective care: Recovery of Referral to Treatment times (RTT)

'Must do' no 5 in the latest Planning Guidance is particularly pertinent in Walsall, where the CCG, TDA and NHSE have been aware for some time that Walsall Healthcare NHS Trust has experienced a significant problem in delivering the RTT performance targets, namely non-admitted and admitted pathways. The achievement of these standards has been challenging for the Trust after the implementation of its new PAS system, Lorenzo, in March 2014. The implementation led to concerns over the reliability and accuracy of data in the system and there was an increase in the numbers of patients waiting to be treated. After discussion it was decided that the Trust would suspend RTT reporting to the national system until confidence in the data and system were improved.

Since the cessation of National Reporting a considerable amount of work has taken place to validate the waiting list backlog and validation by the Trust and a GP Validation exercise commissioned by the CCG has helped to reduce the numbers of patients waiting. **Table 2** below shows the reduction in the overall PTL number over the past 10 months.

Performance	April	September 15	October 15	November 15	December 15
Total PTL	31820	23533	23500	22572	20988
> 18 weeks	10069	6720	6335	6490	5604
> 40 weeks	1763	378	341	335	249
> 52 weeks	117	5	5	1	0

Table 2 – 10 months PTL

WHT and the CCG have worked collaboratively to agree a set of improvement actions to improve the 18wk RTT position including business as usual, internal Waiting list initiatives, internal efficiencies, extra waiting list initiatives and Independent Sector work. The CCG agreed £1.5 million funding to support clearing the backlog. Despite these actions the Trust was still not delivering RTT standard and in collaboration with the Trust, NHSE and TDA the Trust has now developed a recovery plan which has been signed off in the form of a quadripartite agreement. This includes plans for recovery of the RTT standard in the 8 most under pressure specialities and for the Trust overall. The overall improvement trajectory identifies that June 2016 is when the standard will be recovered and sustained going forwards. The recovery trajectory is given in **Table 3 and Figure 11.**

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Plan	73%	**72%**	**74%**	**75%**	**78%**	**81%**	**85%**	**88%**	**92%**
Actual		**71.25%**	**73.30%**						

Table 3 – WHT RTT – Incomplete Performance Trajectory

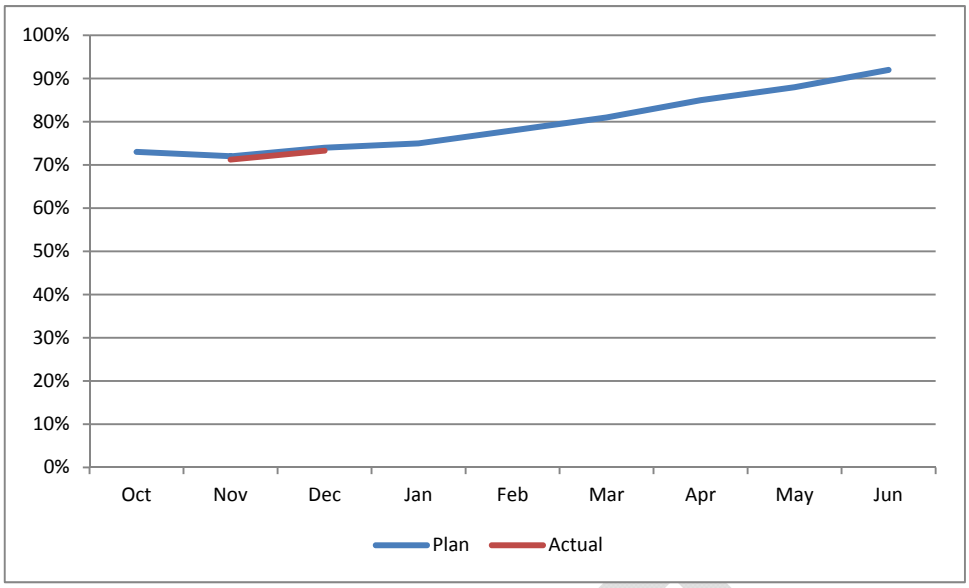


Figure 11 - WHT RTT – Incomplete Performance Trajectory

For each speciality area demand is given as referrals outturn of 2014/15 FY and capacity to deliver includes options of business as usual, internal Waiting list initiatives, internal efficiencies, extra waiting list initiatives and Independent Sector work.

The CCG have supported the Trust in funding for PMO infrastructure support.

Governance and reporting arrangements are in place including regular monthly reporting to SRG and to the Elective Access Performance Group which in addition to CCG, WHT includes NHSE and TDA representation.

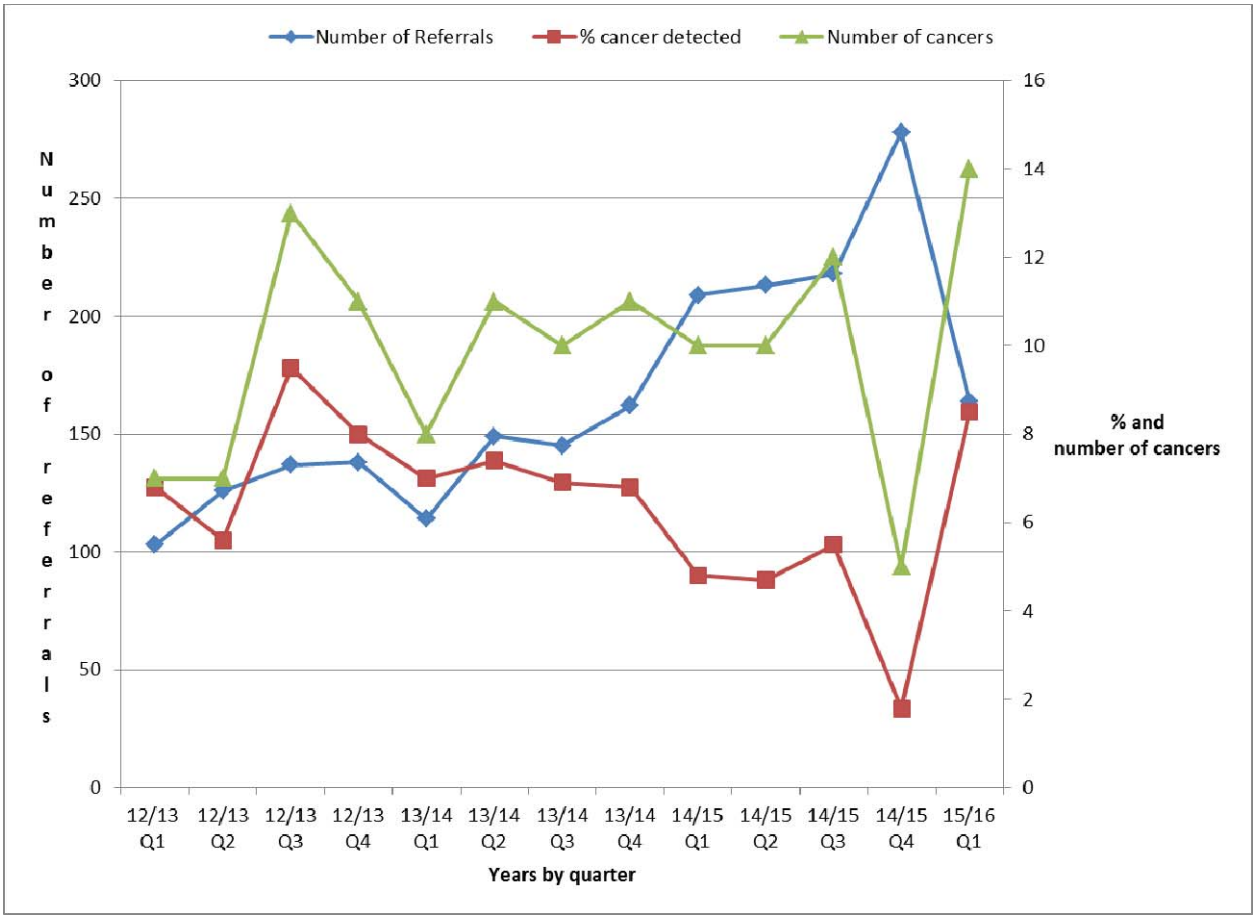
2.1.3 Cancer

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.

Following a recent cancer taskforce report, the following actions are being progressed:

- Working with WHT to produce new 2 Week Wait (2WW) 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 GPs on appropriate 2 WW referrals. A review of lower GI and urology referral pathways has been completed and are to be launched shortly, the CCG is committed to working with the Regional Cancer Network in reviewing and implementing changes to local referral pathways.
  The NICE Cancer Guideline was published in June 2015. We have worked with WHT to redesign new 2WW referral forms for Upper GI and Haematology based on new NCIE Cancer Guideline. WHT has also worked with other local trusts to produce an updated 2WW referral for gynaecology and urology. After the Macmillan Educational Event on Upper GI Cancer, WHT produced data which showed a reduction in 2WW referrals but a higher conversion rate. This is very promising in terms of appropriate use of resources and pathways. See chart below.



- The CCG are actively working with the Macmillan Sponsored GP Facilitator in delivering a series of educational updates for GPs with the support of WHT to improve early diagnosis of cancer and adoption of the appropriate use of local referral pathways.
- 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 commenced in April 2015.
- Reviewed data of Bowel Screening Uptake for Walsall and work with Public Health and the Regional Cancer Network 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 combined with a 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.
- The uptake for National Bowel Cancer Screening programme for Walsall CCG was 52.5% in 2014/15 which was below NHS England average of 57.9%. Analysis of local data showed a great disparity between areas; very low uptake was associated with deprivation and high BME population. A 12 month collaborative project with WM Strategic Clinical Network and Clinical Senate and Public Health to increase bowel screening uptake was launched in March 2016 targeting 22 practices with lowest uptake within the CCG. An improvement in bowel screening uptake will lead to earlier diagnosis of bowel cancer and improve 1 year survival rate.
- More local work via the Pharmacy Campaigns.
- The CCG are actively promoting living beyond cancer and survivorship for all cancer diagnosis including a adopting , Holistic Needs Assessment, End of Treatment Summaries, Health & Wellbeing events, Patient education, Advice on healthy lifestyles, Self-management, and Stratified follow up, with the numbers of patients surviving and living beyond cancer due to increase to 14,500 by 2030. WHT has started a Health and Wellbeing Forum for all new cancer patients as part of their care pathway since May 2015. The forum provides opportunity for patients to learn about information and support services available, chemotherapy and radiotherapy, lymphoedema services,

complimentary therapy, psychological support and Walsall Feel Good Move More programme. This pathway also ensures that patients receive Holistic Needs Assessment. Macmillan has given a grant to WHT to employ a part-time administrative person to coordinate these forums and to embed the service.

In relation to delivery of all cancer waiting time standards, 2 week wait (all cancers), 2 week wait (breast symptoms) and 62 day first treatment , WCCG continues working with WHT to ensure these standards are recovered and sustained during 2016/17.

However while WHT has identified the main causes of not meeting the standards which include patient choice and DNAs, WCCG continues to work with WHT to learn and understand the underlying causes of not meeting the cancer wait standards in more granular detail and with a view to identifying key improvement actions. This understanding was supplemented by an independent review undertaken by the national Intensive Support Team of cancer services at WHT during 2015/16. The findings within this report identified a number of key improvement actions the Trust needed to take to improve performance of their cancer services and to ensure these were sustained.

Performance of cancer services at the Trust has improved over 2015/16 from a position where they had failed both two week standards during the Q3 and Q4 of 2014/15 and Q1 of 2015/16 and the 62 day urgent referral standards to one where they achieved both two weeks standards during Q2 of 2015/16 and also made improvements to the 62 day standard over this period. The Trust's remedial action plan for the 62 day standard had forecast recovery by the end of October but this was narrowly failed with performance of 83.3% against the 85% standard. Clearly further work is required to achieve this standard in line with '**must do' no 6** and the CCG has now agreed a revised remedial action plan and recovery trajectory from the Trust. The CCG will continue to monitor WHT at Contract Review Monitoring/Contract Quality Review Meetings on these measures. Meetings are pre panned and scheduled at regular intervals throughout 2016/17 and are used by the CCG to check performance and seek assurance that these and other NHS Constitutional standards that are part of the contract are being met.

2.2 Priority 2 – Restore Quality of Services

2.2.1 CQC Report

Our response to the CQC report is in the context of our Quality Strategy sets out five key aims and our approach to commissioning high quality healthcare. As illustrated in **Table 4**, these aims incorporate the learning from the Francis, Berwick and Keogh reports.

A recently published CQC report rated our local acute provider, Walsall Healthcare NHS Trust (WHT), as "inadequate" and following a Quality Summit the Trust has now been placed into special measures. The report highlighted a significant number of areas of concern including Maternity Services and Emergency Department. An Integrated System-Wide Improvement Plan which is outcome focussed and includes specific timeframes for improvement will now be developed and the initial Patient Care Improvement Plan (PCIP) has already been shared.

Walsall CCG are key stakeholders and members of the Oversight Group established by the Trust Development Authority to provide support and challenge to ensure continued quality improvement is demonstrated by the trust. The group will provide a collective oversight of progress against delivering the quality improvement plan gaining assurance from the trust board.

Effective governance mechanisms have been agreed to monitor the plan and the provider will be held to account through local processes as well as system-wide Quality and Safety arrangements through NHS England.

Maternity Services

The CQC found that Maternity services had limited capacity and staffing resources which impacted negatively on patient experience and compromised patient safety. The additional activity in terms of birth numbers had not been properly accounted for by the trust, both in respect of staffing and environmental capacity but also with regards the impact of such a stretched service with limited resource on additional services e.g. neo natal capacity. WCCG had last year commissioned an independent review of neo natal care at the trust and an action plan for improvement was already underway prior to CQC visit. Walsall CCG has also commissioned a Maternity Clinical Advisor to review current workforce arrangements and develop key lines of enquiry to inform a maternity strategy for Walsall.

In response a sustainable maternity services committee is being led by CCG and CCG are members of the maternity & Neo-Natal Services Taskforce which has been established with immediate actions to review current staffing levels in maternity and neo-natal services and agree a sustainable future workforce plan by the trust.

The current work of the sustainable committee is Black Country wide and has also included Staffordshire and is working to immediately cap current activity at WHCT. This systems-wide approach to the current issues is already bringing benefits and additional expertise across the system to ensure the re-provision of parts of the service are safe and effective through thorough quality impact analysis activity. The system wide approach will be key to the future of safe, efficient and sustainable maternity service delivery for Walsall going forward.

The CCG are also a joint stakeholder in the Infant Mortality Task and Finish Group, reporting to the Health and Well-Being Board. The Task and Finish Group has been established to review the wider determinants of infant mortality and will support the implementation of recommendations as detailed in the Perinatal Institutes Infant mortality review of the Walsall Healthcare NHS Trust**.**

Also the CCG are leading the work across the system to develop the Maternity Services Strategy. The Infant and Maternity Services Transformation at scale group has been established which is a system wide group with representatives from the Maternity Network, Public Health and Commissioners to develop the strategy. To support the implementation of the Maternity Services Review the focus for the group will be:

- Workforce
- Sustainability of Services
- Public Health Analysis – Demographics
- Pathways
- Capacity & Demand
- Stress test current improvement plans

CCG are currently out to advertisement for a commissioning maternity strategic lead, this is a joint post with Public Health and will offer a more strategic approach to how maternity services are commissioned in Walsall going forward.

Emergency Department

Within the Emergency Department CQC identified capacity issues as having an impact on patient safety and quality and also identified that the triage process was ineffective. To support the Emergency Department, work has already taken place to refine Urgent Care Centre triage processes ensuring effective triage is taking place at the front door and only the appropriate cohort of patients are attending the Emergency Department.

Workforce review has identified gaps in funded establishment and a recruitment exercise is underway by the trust. A similar task force approach to ED improvement is also being put in place.

2.2.2 Quality Strategy

Our response to the CQC report is in the context of our Quality Strategy sets out five key aims and our approach to commissioning high quality healthcare. As illustrated in **Table 4**, 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 4 - WCCG Quality Strategy Aims

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 Director of Governance, Quality & Safety is a full member of the Borough Safety Partnership.

2.2.3 Patient Safety

Preventing problems, detecting problems quickly and taking action promptly is a key priority in the Quality Strategy. As the table above shows 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.

The overall rating for the trust was inadequate and the trust has now been placed into special measures. As a result of this WCCG has reviewed its systems and processes related to patient safety and quality and whilst recognising the majority of CQC findings were already identified as areas of concern and scrutiny, has strengthened further its approach to quality assurance and quality improvement. This includes a reviewed terms of reference for its Quality Performance and Safety Committee, with a more intensified emphasis on quality and safety. Operational performance will now be undertaken through a separate committee.

WCCG has also reviewed its capacity and strengthened clinical leadership and capability within the quality and safety directorate, the CCG will shortly be appointing a Medical Director, to work alongside the Executive lead for Quality and Safety and this has been further added to by the review of job roles to support the role of an Assistant Director of Quality and Safety within the structure.

The review of the contracting quality schedule for 15/16 has reinforced a wide range of quality metrics with increased emphasis on metrics for improvement, outcome based measures and stretch targets for areas of concern. The reporting schedule and assurance framework have also been reviewed to ensure more rigorous oversight and targeted approach to quality and safety. CQUINs are being developed to ensure a SMART and outcome based improvement, in line with some of the more fundamental issues of system and process, clinical standards and leadership that the trust has struggled with.

A visit schedule has been developed which will ensure that regular clinical quality visits take place to our providers. These regular announced and unannounced visits will inform key lines of enquiry for follow up with providers at the appropriate level for example Clinical Quality Review Meetings and the intelligence gathered will be used to triangulate submitted data from our providers. The visit schedule will be a "living" document with opportunities for system leaders to contribute to the quality agenda to target any areas of concern by conducting a clinical quality visit.

WCCG is committed to the highest standards of patient safety and is in the process of finalising its 3 year plan to save lives and reduce harm for patients as part of our registration with the "sign up to safety" campaign.

2.2.4 Quality in Primary Care

In order to discharge its responsibility for acting on any concerns / issues relating to primary care, the Safety, Quality and Performance Committee have established a Sub-Group with a role to ensuring that WCCG takes necessary action when responding to concerns / issues highlighted in primary care. The Quality Improvement Sub Group has representatives from key system stakeholders including WCCG, NHS England, Care Quality Commission, Local Medical Committee, GPs 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 key performance indicators, acting as a high level early warning system and assisting in the identification of those practices requiring support. Where such cases are identified WCCG works with practices to agree 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.

2.2.5 Mortality including Sepsis

The system wide mortality group which has been established in Walsall for some time (2011) established several work-streams to analyse specific areas of work including assurance, hospital care, nursing home care, data collection, primary care and end of life care. The group are currently reviewing the work plan for Phase 3 and are in the process of developing a strategy for mortality reduction. Phase three also includes undertaking a series of audits including cancer, sepsis, infection control and pathway focussed audits.

Work has taken place to ensure the Sepsis bundle has been implemented by our local acute provider and a joint (Primary Care, Acute & Community) review of deaths where patients had a 0-2 day hospital admission has taken place. A clinical harms review group, shared between CCG and WHCT also helps to support this work.

2.2.6 Tackling Health Care Acquired Infections (HCAIs)

Walsall Health Economy HCAI strategy states that Walsall has a zero tolerance to avoidable infections. 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 all organisations providing health and social care and is part of a robust governance framework. This is recognised in the structures as described in the Assurance Framework for Infection Prevention and Control see **Figure 12** below.

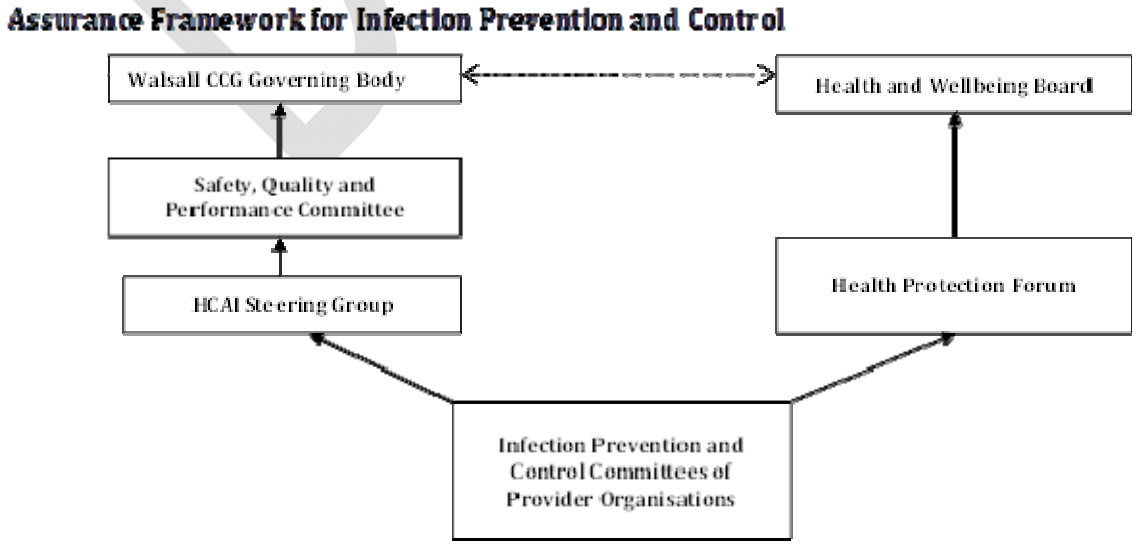


Figure 12 – Assurance Framework for Infection Prevention and Control

WCCG and Public Health representatives attend the provider organisations infection prevention and control committees.

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 a health economy approach to preventing infections in Walsall and to put infection prevention at the heart of service planning and redesign.

The Health Protection Forum is a multi-agency group that meets to review all aspects of Health Protection (Sexually transmitted diseases, cancer screening programmes, Pollution control, environmental health, HCAI, communicable diseases) across Walsall and provide assurance to the Director of Public Health around prevention, monitoring and control. A 6 monthly report is sent to the Health and Wellbeing Board from this forum.

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

As part of the Walsall Health economy approach to infection prevention, and in line with the Walsall HCAI Steering Group Strategy, Public Health fully fund an infection prevention service for all Walsall Care Homes and partially fund an infection prevention service for Walsall Dentists and Walsall General Practices. A service level agreement is in place and is reviewed on a quarterly basis.

National objectives are set for MRSA bacteraemia and *Clostridium difficile* (Cdiff). WHT and WCCG have an objective of zero for MRSA and the Cdiff objective has been reduced year on year. Other alert organisms (*E.coli* bacteraemia and Meticillin sensitive S*taphylococcus aureus* (MSSA) bacteraemia) are monitored but to date no national objectives have been set.

Root cause analysis of Cdiff cases and Post infection reviews of MRSA bacteraemias are held as required and in line with national guidance for reporting and investigation.

2.2.7 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.

Children, young people and adults with a learning disability and/or autism have the right to the same opportunities as anyone else to live satisfying and valued lives, and to be treated with dignity and respect. They should have a home within their community, be able to develop and maintain relationships, and get the support they need to live healthy, safe and rewarding lives.

Walsall aims to re-design services for people with learning disabilities and autism over the next 3 years, ensuring that care is delivered closer to home and more people are able to be supported within their own homes opposed to hospital. This is a challenging remit for any Local Authority (LA) & Clinical Commissioning Group (CCG) therefore Walsall has chosen to join with the remaining LA's and CCG's across the Black Country forming a local Transforming Care Partnership (TCP) covering a geographical area of over one million people.

There will be two distinct programmes of work consisting of multiple work streams, those which form part of the TCPB and those which will be solely delivered by Walsall Local Authority and CCG at a local level.

The TCPB programmes of work include:

- Re-design of inpatient services across the Black Country
- Development of a Positive Behaviour Service across the Black Country

The local programmes of work include:

- Reduce the number of people with learning disabilities and autism in Assessment and Treatment and Rehabilitation hospitals. In 16/17 this will equate to halving our 15/16 provision to 5 inpatient beds being utilised at any one time across all providers and 3 inpatient beds being utilised at any one time in 17/18.
- Further develop community provision that supports people with behaviours which challenge and complex health care in the community and prevents inpatient admissions and care breakdown. This will be developed and delivered over a 3 year period in partnership with Black Country colleagues and as approved by NHS England
- Review all health community services including nursing, therapies and medical to support hospital avoidance, early intervention and signposting to ensure people's needs are met within the community
- Decommission any remaining block arrangements in order that all inpatient beds are spot purchased from 01/04/16 with the intent to move to an approved provider framework during 2016/17.
- Ensure robust responses to actions and lessons learned from Care and Treatment Reviews which are embedded within processes and pathways of all providers and stakeholders
- Commence the move towards integration with the local authority for community learning disability services

- Increase the number of people with learning disabilities that receive an annual health check in line with the Cardiff Health Check Tool
- Ensure all people with learning disabilities have a Health Action Plan which is reviewed frequently
- Development and Implementation of the Green Light Tool kit across Mental Health services for Adults with a Learning Disability and in addition, Adults with Autistic Spectrum Disorder(ASD). This intention impacts upon BCPFT, Dudley and Walsall MHT, Walsall Council and Walsall CCG
- Reduce health inequalities across primary and secondary health services for people with learning disabilities and ensure robust and prompt reporting and investigation across all agencies regarding sudden, premature and unexplained deaths

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 2016/17 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.

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.

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

2.2.8 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.

2.2.9 Reducing Health Inequalities and Improving health outcomes

A key element to our approach to improving health services in Walsall is to reduce health inequalities and improve health outcomes.

2.2.9.1 Reducing Health Inequalities and Improving health outcomes

The Walsall Health and Wellbeing Strategy[1] recognises the need to foster personal responsibility for wellbeing within an environment that facilitates good health and wellbeing for all, as well as offering initial support to those individuals who are wanting to make positive, healthy changes to their lifestyles. All residents and organisations within the Borough have a potential part to play in this and a crucial role in accepting responsibility. 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 within the supportive infrastructure it has developed and the priorities it has identified.. It should be acknowledged that some determinants of wellbeing cannot be influenced by local action alone and require strategic action on a national level.
The Marmot Review report: 'Fair society, Healthy Lives' describes the life course approach and recognises that disadvantage starts before birth and accumulates throughout life, highlighting the significant relationship between early intervention and outcomes in later life. The Review also contends that creating a sustainable future is entirely compatible with action to reduce health inequalities though promoting sustainable local communities, active transport, sustainable food production, and zero carbon houses, all of which have health benefits. For this reason the local JSNA[2] recommends that the core of Walsall's 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.

[1] Walsall Health & Wellbeing Strategy 2013 to 2016 Link: http://cms.walsall.gov.uk/final_2014_hws_refresh.pdf

[2] Walsall Joint Strategic Needs Assessment December 2013 Link: http://cms.walsall.gov.uk/walsall_jsna_refresh_draft_10.pdf

- 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
- Ensure focus on prevention and early intervention through:
  - Brief advice and interventions by all (e.g. Health Chat)
  - Encouraging participation in National Screening Programmes and NHS Health Checks.
  - Robust pathways of care for all long term conditions across the healthcare economy. These should incorporate the elements of self-care required to reduce the impact of the health condition.

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.

Our improvement ambitions for 2016/17 are to:

- Close the gap in life expectancy (years) between males and females, currently 10.1 for men and 7.5 for women.
- Close the gap in life expectancy (years) between those living in the most deprived and the most affluent areas of Walsall.
- Increase overall life expectancy within the Borough, particularly for males where we will set a target of 78.68 years.

We aim to achieve those ambitions through coordinated HWB intervention 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, ensuring men and those with long term conditions are prioritised within services.
- 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 and improve resilience in the population through the 'Health Chat' (previously 'Making Every Contact Count') initiative.
- Promote uptake of the NHS Health Checks and national screening programmes.
- Ensuring there are robust pathways of care across all health care providers.
- Improving access to physical health checks for adults with psychosis and schizophrenia.

In relation to infant mortality our improvement ambition for 2016/17 is to reduce the Infant mortality rate per 1000 live births to 6.7. WCCG will be working with partners to deliver the following range of initiatives over the strategy period in order to reduce infant mortality by:

- Encouraging early booking for antenatal care, improving antenatal care and, continuity of care throughout pregnancy and improving detection of intrauterine growth restriction (IUGR).

- Reducing levels of maternal obesity and smoking in pregnancy through projects such as the Maternal and Early Years' Service, Smoke-Free Homes, improving smoking cessation in pregnancy and working with ethnic communities to reduce the use of alternative 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.
- Targeting vulnerable groups through specialised programmes, which will be redesigned e.g. the current Family Nurse Partnership.
- Developing and improving access to psychological support for perinatal mental health.

With regard to mental health, Walsall faces the following challenges:

- Childrens' Mental Health
  - Lack of mental health support for pre, anti and post natal care.
  - Limited access to talking therapies for children and adolescents.
  - CAMHs provision ends at age 17.
- Adult Mental Health
  - 80% of GP provision in surgeries may have underlying links with 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 will work to address these challenges in order to contribute to improvements in life expectancy of people with severe mental health needs. Therefore, the priorities for this Operational Plan period addressing 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-natally.
- 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 knowledge of mental health issues 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.
- Reviewing the referral pathways with the relevant specialist consultants, 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
- Physical activity levels (where possible)
- Uptake of key screening and prevention programmes.

2.2.9.2 Improving Health Outcomes: 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.

2.3 Priority 3 – To deliver transformational change through the STP footprint

This priority focusses on building on the progress we have made in Walsall place based planning and taking this forward within the vehicle of the wider Black Country and West Birmingham planning footprint particularly for the identified priority areas of urgent care, primary care, mental health and maternity services.

2.3.1 Progress to Date: Walsall place based planning

Over the last 12-18 months our local system has recognised that we are facing some significant challenges across health and social care in Walsall and in order to meet these challenges we will have had to radically rethink how we continue to deliver safe and effective services across our system. We have therefore been working together to develop a local transformation programme for health and social care in Walsall. The recent national context and requirement for planning across a larger population footprint has presented us with some further challenges as the requirements to move to planning across a wider footprint could result in a loss of continuity and momentum with our local transformation plans. However we recognise that the new arrangement identify some opportunities as well, as it provides some options to collaborate with partners to address issues that require a larger scale of population than afforded by Walsall alone. Our approach therefore is to organise our planning arrangements at several layers to enable us to retain those elements that require a local place based focus whilst scaling up across Black Country where this provides us with greater benefit. We will therefore mould the Black Country STP accordingly, noting that that will be the vehicle to collaborate to address mutual priorities and access transformation funding. In doing so we will also recognise that we will need to address current local challenges in Walsall in ways that don't contradict the preferred strategic future for the wider STP.

At present, the main components of our transformation programme consist of the following areas of work:

- Establishment of a 'Healthy Walsall Partnership Board' which has brought together strategic partners across our local health and social care system.
- An agreed case for change to ensure a sustainable health and social care system for local people in Walsall
- Development of a demand and capacity model across our local health and social care system. Phase one of this model is reaching completion and we will shortly be in a position to translate the outcomes into service priorities.
- Development of a ' model logic' for strategic investments to enable transformation
- Commissioned a health and social care data system to enable is to develop joint priorities for improvement
- Developed a programme to prevent avoid emergency admissions of older adults into hospital. This focuses on streamlining and integration of three currently distinct services for our frail elderly population into a single coherent programme.
- Our plans are to extend this programme to form one of a wider set of programmes which will become key enablers in the delivery of our transformation strategy.

2.3.2 Progress to date: Black Country and West Birmingham based planning

We have reviewed our current transformation programme within the context of the Black Country and West Birmingham STP and have committed to bringing together local plans with those that will be

developed on a wider planning footprint. As the Black Country and West Birmingham STP, we have agreed a number of guiding principles to inform our approach to this and these are as follows:

- Subsidiarity - Build on existing arrangements and partnership.
- Mutuality - Act together to maximise benefit and access development monies.
- Add Value - Avoid duplication and cutting across existing partnerships.
- Boundaries - Avoid the creation of new boundaries in response to STP footprint.

Governance arrangements have been agreed and are illustrated in **Figure 13.**

Figure 13 – STP Governance Arrangements

Our programme of work to deliver the plan has already started and we will complete this by June of this year as detailed in **Figure 14.**

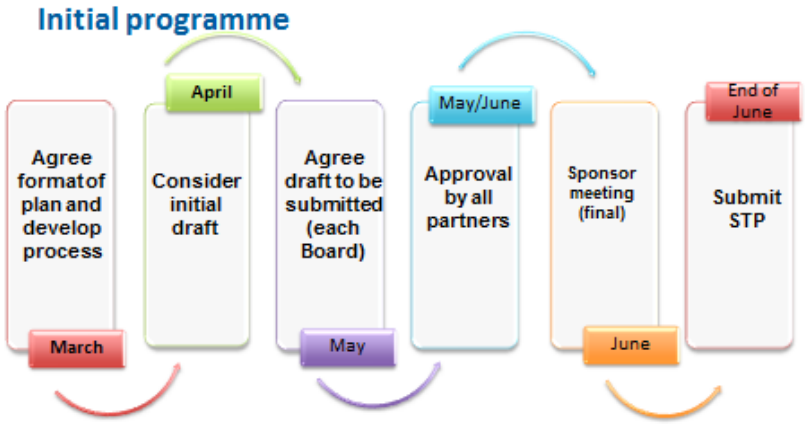


Figure 14– STP Initial Work Programme

As illustrated in **Figure 15**, we have agreed to work together on a number of early priorities:

- Urgent care
- Primary Care
- Mental Health
- Maternity Services

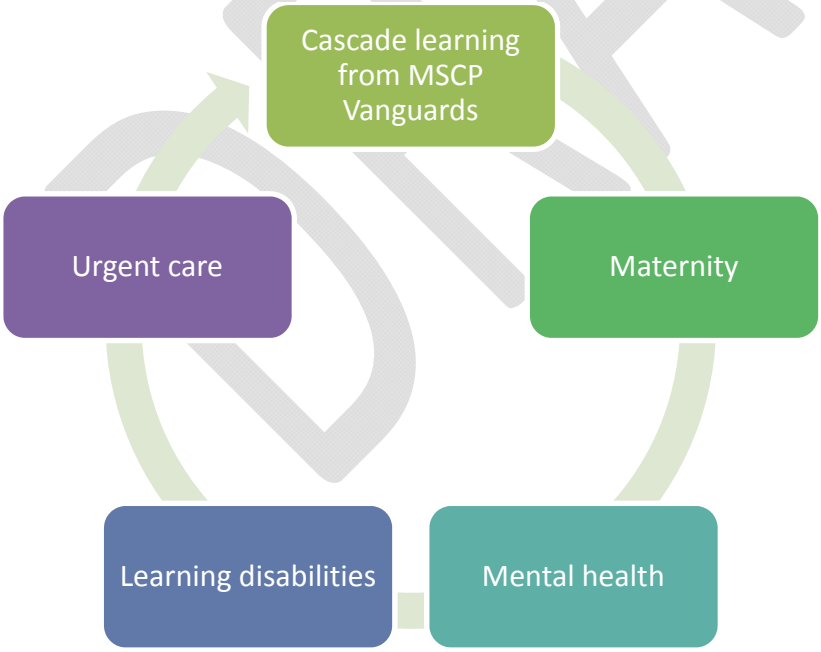


Figure 15 – STP Priorities

These priorities are of particular relevance to our local system as our main provider, Walsall Health Care Trust (WHT) has struggled to meet the A&E 4 hour standard for a considerable period of time. Within this context we have already grasped the opportunities to develop collaborative arrangements with neighbouring partners to develop services that require commissioning on a larger footprint such as the Black Country Crisis Response car. This has enabled us to manage some demand for emergency

care away from WHT and we are working as part of the wider Urgent and Emergency Care Network to share learning and increasingly collaborate on further initiatives that will enable our local system to recover.

An early demonstrator for the potential benefits that can be delivered through the STP arrangements relate to Maternity Services in Walsall. This is another priority area for us locally, as set out in **Section 2.2.1**, as WHT's maternity services have been recently rated by the CQC as inadequate. We are working with the Trust to implement a number of improvement actions to stabilise current service provision however we recognise that this will not on its own be sufficient to match demand for local services against the current levels of capacity available at the Trust. The STP footprint has enabled us to work across the wider geography to seek mutual aid from neighbouring providers by diverting 'excess' activity away from WHT to neighbouring units to enable WHT to stabilise current services. Our next step is to explore how the STP arrangements can be developed further to enable us to transition from reacting to issues of immediate concerns towards ensuring sustainable maternity services which provide greater choice for all women in the Black Country.

Next Steps

Our plans are to extend our STP plans further during 2016-17 to work collaboratively across a wider number of strategic priorities as follows:

Primary Care

Our approach to primary care development in Walsall is set out in **Section 2.3.3** below and it can be seen that during the last 12 months we have been actively developing our plans to develop Primary Care at scale. We now have two well established Federations of GPs working together to deliver a range of services at scale. The Federations have enjoyed some early success by working with the CCG to extend Primary Care opening hours including over weekends and Bank Holidays and we have plans to enhance this across a larger number of practices during this year.

The Black Country STP provides us with some exciting opportunities to work with Dudley CCG to learn the early lessons emerging from their national Vanguard programme and where appropriate we will use this to accelerate further developments within Walsall.

We have also worked successfully with NHS England to secure full delegation of Primary Care and intend to use this opportunity to enhance our strategic programme to bring care closer to home. We will therefore plan to further integrate our primary care services with our community services and have a number of exciting plans to develop and commission new models of care as part of our local transformation plans in Walsall. Within this context, we are currently exploring the potential to develop an Accountable Care Organisation type model across a range of Primary Care, Community Services and Adults Social services.

Mental Health

During the course of this year we have been working as part of a collaborative arrangement to commissioning some mental health services on a wider Black Country footprint. We have commenced with developing our Tier Three services in CAMHS and hope to use this to test further joint opportunities.

The recent collaboration between the two main Mental Health providers in the Black Country, Dudley and Walsall Mental Health Partnership NHS Trust and the Black Country Foundation Partnership Trust provides further opportunities to commission further mental health services on a wider footprint as

well as integrate Physical and Mental Health services e.g. Learning Disabilities. The recently established MERIT networks collaborating across a greater number of Mental Health Trusts across the Black Country present further opportunities to develop new models of care as well as explore greater efficiencies.

This approach will again build on the strategy we have already adopting to the improvement of mental health services in Walsall.

2.3.3 Primary Care

2.3.3.1 Developing Primary Care at Scale

Walsall CCGs Strategic Plan assumes primary care will be better placed to offer an extended range of services in the future through maximising opportunities for practices to work together, co-location/integration of community services and opportunities for embedding the voluntary sector as part of the primary care provision. The CCG has commenced this work with its member practices and in discussion with the Local Medical Committee. This work is in parallel to other work the CCG is undertaking around improving the quality of primary care.

The CCG has worked with general practices in Walsall to take forward the primary care transformation agenda to support sustainability through collaborative working to provide primary care at scale and invest in primary care infrastructure to create the right environment for the development of new care models in Walsall.

Key developments are as follows:

- GP Federations - Two GP Federations have formed in Walsall and a primary care transformation fund has been made available to support their set up. Significant investment has already been made in providing EMIS to all GP practices, which is fundamental to moving towards record sharing across GP practices. To move this forward the CCG has been working with one of the Federations to test out an extended GP service during bank holidays. Two hubs have been set up to complement the newly commissioned urgent care service and data sharing agreements have been signed by over 50% of Walsall GP practices to share their records with the pilot hubs: work is underway to get the remaining practices to sign up to share patient records for the Easter bank holidays. This work will support rapid implementation of enhanced access to primary care in the evenings and weekends and increased use of technology and data sharing across general practice to improve the quality of care provided to patients. Additional funding would support the roll out of this area of work.
- Community Education Pilot - One of the GP Federations in Walsall was successful in securing HEWM Community Education Pilot Network (CEPN) to take forward the 'grow your own' approach for training and employment of nurses, GPs and other health professions. The CCG is supporting the Federation with this work. In addition, the CCG is working with the LMC to host a Primary Care Job Fayre to support general practice to attract new healthcare professionals to join the primary care workforce in Walsall.
- Skill-mix - Walsall CCG has been successful in increasing the skill-mix in general practice with the introduction of pharmacists working in general practice which has delivered medicine optimisation benefits, increased detection and improvement in medicines adherence, contributing to improved morbidity and impact on health inequalities. Utilising the skills of pharmacist independent prescribers has improved management of patients with long term conditions such as hypertension and diabetes to improve patient quality of life, reduce long-term cardiovascular complications such as strokes and the on-going disability associated with these conditions. This initiative frees up GP

and nursing capacity to manage other patients, improve patient safety and reduce waiting time for GP appointments.

- Pharmacy technicians - Walsall CCG is working with a GP practice to pilot a pharmacy technician working in practice to address prescription issues currently passed by the receptionist to the GP which could be resolved by the technician; more effective utilisation of the primary care workforce and saving GP time to spend on more complex patients.
- Primary Care Commissioning CIC - The CCG is working with Primary Care Commissioning CIC to offer further support to GP Federations in understanding opportunities MCPs and PACS can bring.
- Use of Technology - To support improved general practice productivity and efficiency the CCG has worked with GP practices to showcase and encourage adoption and investment in increased use of technology in general practice which has included 'GP Access' telephone triage, 'Ask my GP', MJOG, use of Health Monitors, Productive General Practice and web consultations. Funding has been made available to pilot eConsult web based patient triaging platform as an alternative solution to the standard GP delivery model.
- Diabetes - The CCGs Diabetes clinical lead has been successful in securing the RCGP QI Diabetes Model and is working with a number of GP practices in Walsall to take this work forward.
- Estates Strategy - An interim primary care estates strategy has been designed to support the CCGs objectives and vision for primary care. Work has been undertaken to understand local primary care estates, identify areas requiring investment and opportunities for rationalisation and change. The strategy will be used to support any bids managed by the CCG bids to access funds from the Primary Care Transformation Fund (PCTF). The final estates strategy will consider estates in Walsall Healthcare NHS Trust, Dudley and Walsall Mental Health Partnership NHS Trust, urgent care services, out of hospital services and will incorporate joint estates planning with the Local Authority. The strategy is underpinned by the CCGs Operational plan and NHS England's Five Year Forward View. It considers population growth, estates development and maximising effective utilisation with an aim to reduce void areas.
- Mental health - Improving access to both primary and secondary care based mental health assessment, treatment and support by developing integrated community pathways and models of care including improved access to advice from secondary care for GPs when managing patients with mental health and emotional problems.

We believe that these initiatives, together with the delegated commissioning of primary care services will make a significant contribution to ensuring that the CCG complies with '**must do' no 3.**

2.3.3.2 Delegated commissioning of Primary Medical Services

Primary care co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. Our application for fully delegated commissioning has been approved by NHSE. Our aim is to use this as a vehicle to support the development of integrated out-of-hospital services based around the needs of local people. It is part of our wider strategy to join up care in and out of hospital and could lead to a number of benefits for patients and the public including:

- Improved access to primary care and wider out-of-hospitals services with more services available closer to home.
- High quality out-of-hospital care.
- Improved health outcomes, better access to services and reduced health inequalities.
- A better patient experience through more joined up services.
- Parity of esteem for mental health with integrated, seamless assessment, treatment and support to address physical and mental health needs.

Since 1 April 2015 the CCG has jointly commissioned primary care with NHS England and had always planned that it would move to full delegation with effect from 1 April 2016. This is because Full

Delegation offers more opportunities to deliver strategic transformational change in response to the drivers highlighted in the Forward view – demographic, Quality and Financial and local needs assessment.

Our objectives which are over and above our existing joint commissioning approach are:

- To improve primary care services for the benefit of patients and local communities.
- To improve integrated working: our recent redesign of the urgent care pathway in Walsall can be further enhanced and strengthened through fully delegated commissioning which can bring about a higher level of integrated working between GP practices, NHS 111, GP out of hours, Urgent Care Centres and other emergency services.
- To enable clinically led, optimal local solutions to meet local needs.
- To enable commissioning and service design across the whole patient pathway.
- To give greater control over local decisions affecting primary care informed by local knowledge of services and practices.
- To enable the CCG to shift investment from acute to primary and community services.
- To enable development of seamless integrated out-of-hospital services.
- To enable the development of seamless, integrated models of physical and mental health care.
- To ensure early mental health diagnosis and intervention.
- To provide an opportunity for the CCG to design local incentive schemes as an alternative to Quality and Outcomes Framework (QOF) or Directed Enhanced Services (DESs).
- To give accelerated focus on outcomes based commissioning in primary care by aligning outcome measures and incentives used in PC.
- To enable a more local focus and in depth understanding of local issues whereas NHSE local teams now cover a large geographical patch, manage all independent contractors (GP practices, dental, optometry, Pharmacy) and have had to achieve reductions in their staff budgets
- To give the CCG the ability to have more focus on primary care: Re-structuring of NHS England teams to cover larger areas and reduce running costs will mean limited ability to focus on primary care quality improvement and service design.
- To consider and make decisions about practice mergers under delegated commissioning.

We know fully delegated commissioning will be challenging but it is an important enabler to support our local strategic transformation plan which is aimed at delivering more sustainable health care system which relies more on "upstream" care and much less reliance on hospital treatment services.

Delivery of our vision and strategic objectives and a transformed health care system is reliant on a strong primary and community care system which enables us to move from a model of predominantly reactive care to one of proactive care, eliminating hospital admissions as a default for people who are not acutely unwell but need help and support. Full Delegation will be a key enabler in delivering this aspect of our local strategic transformation plan.

The interface between primary care and hospitals will change significantly, with many of the existing obstacles to quick responsive care removed. Planned care will be delivered in a more effective and sustainable way and across a wider planning footprint, reducing administrative complexity for professionals and patients, whilst reinvigorating working relationships and dialogue between primary and secondary care clinicians.

Our strategic transformation plan will support and facilitate change across our health system and in collaboration with other CCGs across the Black Country and fully delegated commissioning will be an important lever to support and enable changes that are needed to get to where we need to be.

Our engagement and consultation with local people via our urgent care strategy development and our patient engagement agenda has identified a number of themes that patients would like to see in how primary care should be delivered and these include:

- Improving the quality of consultation at the GP practice and out of hours.
- Improving the overall care received at the surgery.
- Improving access in primary care.
- Improve patient GP survey indicators and Friends and Family test.
- Improving satisfaction with locally commissioned practice based services.

Another key element of our current Primary care strategy is to improve the quality and performance of primary care delivery. Key features of this include:

- Outcomes based commissioning.
- Parity of esteem for mental health patients.
- Supporting GP federations and super partnerships within Walsall – these are important vehicles for delivery which the CCG needs to forge close relationships with.
- Increase uptake and use of technology for access and care.
- Implementation of 7 day services.

Primary care will not only become an integral part of joined up care for people, it will become the central point at which people predominantly access the care they need. Our vision is that primary care is the focal point and default for excellent NHS care. GPs will take a leading role in coordinating joined up services, centred on the needs of the people that we serve, not the needs of organisations. The health benefits and far reaching impact of primary care at the helm of care coordination will greatly diminish the inequalities in lifespan and illnesses that exist in our area. People who live in economically deprived areas will be able to maximise their health potential as fully as their more affluent neighbours.

The CCG envisages that the delegated commissioning arrangements will also allow better coordination of arrangements across primary and secondary care, and so will facilitate a greater acceleration towards CCG objectives for continuously improving quality and safety in primary care including:

- Patient Experience and engagement - The CCG will directly engage with patients and the public regarding primary care services. Delegation will also provide an opportunity for the CCG to be more involved with the complaints management process enabling more focus on embedding learning from complaints across Primary Care. In addition the CCG will strengthen relationships and PPGs.
- Sustainability and quality improvement – As indicated in **Section 2.2.4**, the CCG will take stock of sustainability and quality of GP practices in Walsall building upon the work of the CCG Quality Improvement Sub-Group and working with GP federations to improve under-performing practices. We will work closely with the NHS England Hub to provide additional expertise and capacity to support sustainable GP practices in Walsall.
- Primary Care Contracting/Management - The CCG will have greater influence in improving primary care via commissioning , contracting and monitoring processes and control in how its manages and supports member practices with an increased focus on quality improvement.
- Primary Care workforce – The CCG will support the development of a sustainable primary care workforce to enable the delivery of quality primary care by identifying and understanding the issues and helping member practices to develop their workforce. One of our larger practices is developing a strategy for better use of primary care clinical skills and the CCG in its full delegation role would be keen to support the spread of new and innovative primary care workforce solutions to meet the current and future workforce challenge.

- Information technology and systems - Walsall CCG IT strategy will include a digital roadmap aligned with national policy leading to a health economy that is 'paper free at the point of care' by 2020. The information revolution will be harnessed as a key enabler with a strategic roadmap ensuring that by 2020 all electronic health records are fully interoperable enabling patient records to be paperless. this will also ensure that the information captured within clinical care settings is appropriately and securely shared not only to enhance care but also to provide management information to support secondary usage such as commissioning and public health activities. Fully delegated commissioning will enable the CCG to work at a local level to ensure delivery of these aims and support Practices to complete this transformation.
- Estates strategy – Our work towards improving the primary care estate as set out above will b enhanced by delegated commissioning. It will help us to develop improved relationships with primary care contractors and, moving forwards, with other primary and community care providers, obtaining a deeper understanding of potential innovations that are possible including accommodation configurations that support integrated service provision and working together that support delivery of our strategic objectives.
- Localities and member practice engagement – We can use the well-established arrangements with our localities and member practices to make best use of full delegation responsibilities, for example the development of new collaborative models of care that are population based and focussed on outcomes improvement. We will also be able to accelerate the integration of Primary care with wider out of hospital services eg community nursing, therapy, Rapid Access Teams, support to PNHs and social care.

We are working collaboratively with NHS England to ensure that the transition period is managed coherently and sensitively. Arrangements are being taken forward for utilising a 'hub' of NHS England primary care contracting staff to ensure business continuity and minimal disruption to staff. It is anticipated that this "hub" offer will be in place until March 2017. In addition the CCG has retained a number of staff from previous organisations who have experience and competencies to support primary care contracting not only for GP services but also community pharmacy and dental contractors. The CCG is looking to use these staff in a matrix working manner to manage the additional responsibilities that delegated arrangements will entail.

The CCG has reviewed and updated its governance structure, which includes a revised constitution and Primary Care Commissioning Committee terms of reference to incorporate primary care commissioning responsibilities.

2.3.4 Mental Health Services

During 2015-16 a number of improvements to mental health services been made in partnership with key organizations, people with mental health problems and their carers and the local communities. In particular, progress has been made towards achievement of the key priorities for improvement identified in the first year of this 2 year (2015-17) year operational plan as follows:

- The targets set in the previous year for dementia diagnosis were achieved with 68 % of those expected to have a dementia diagnosis recorded on GP registers. An in-year adjustment to the estimated number of people thought to have dementia in the area meant that the diagnosis rate temporarily dipped below the target of 67%. However, remedial action was taken to address this and it is likely that this target will have been exceeded by the end of the financial year.
- Progress has been made towards achievement of the national target for recovery for the Improving Access to Psychological Therapies (IAPT) services provided by Dudley and Walsall Mental Health Trust. Performance has improved since December 2015 (47%) with data for January 2016 (48.3%), and projections going forward for Feb (49.3%) and March (50.4%). The provider is now

undertaking frequent and timely data cleansing as well as seeking to report only those users within clusters 1-4. This will more accurately reflect national standards. It is anticipated that the service will continue to achieve national targets from 1 April 2016. Commissioners will work with them to monitor performance and address any discrepancies that may arise.

- The front end of the MH Crisis Intervention Pathway has been strengthened with housing of the Adult and Older People's Mental Health Liaison teams in WHT, commissioning of the Mental Health Crisis Car in partnership with Dudley and the other Black Country CCGs. The Psychiatric Liaison Service was extended for an initial 6 months from December 2015 to June 2016 to provide basic crisis response from 11.00pm to 8.00 am for children, adults and older adults 7 days per week i.e. providing a service 24/7.

In addition to the above, WCCG has led the development of a Mental Health and Wellbeing Strategy for Children and Young People, working in partnership with Walsall Council, Children's Services, Education, Public Health, current service providers and children and young people and their families. The Strategy reflects and addresses feedback from children and young people about what they would like to see in place to help them with their mental health and wellbeing needs, and includes the Walsall Children and Young People's Mental Health and Wellbeing Transformation Plan 2015-2020. This meets the recommendations for future commissioning and provision of mental health and wellbeing services for children and young people, as laid out in "Future in Mind, Promoting, protecting and improving our children and young people's mental health and wellbeing: 2015" will support achievement of the priorities identified in the Strategy. There has been some additional national investment to support delivery of the Plan and implementation has already started. Progress will be reviewed regularly both locally, regionally and nationally to give assurance that we are putting the actions in place.

The Mental Health Taskforce will shortly report on its engagement with stakeholders in mental health services undertaken during the first half of 2015-16. This will inform the new five-year all age National Mental Health Strategy 2016-2021. The Strategy will specify the action needed to ensure parity of esteem for mental health and will align mental health services with the vision and priorities in the Five Year Forward View. It will address all aspects of mental health care for children and young people, adults and older people as follows:

- Prevention.
- First contact with services.
- Diagnosis.
- Treatment.
- Optimising quality of life and support for those with complex and longer term mental health conditions.

and will:

- Address the mental health needs of at risk groups including those experiencing co-morbidity of mental health problems with long term conditions and dementia.
- Address equality and human rights commitments relating to mental health.
- Ensure cross-system leadership in the implementation of the strategy.
- Identify the data required to support implementation including monitoring of improvement to outcomes and delivery.
- Provide an assessment of the priorities, costs and benefits of the strategy.
- Take account of strategic and directional risks and issues and propose actions to address these.
- Propose an approach to ensuring that people with experience of mental health problems, their families and carers and wider stakeholders are engaged appropriately and consistently in the delivery, monitoring and governance of the strategy.

The following priorities for improvement were identified in the Public Engagement undertaken in the first half of 2015-16:

- Prevention and stigma.
- Access and choice.
- Quality and experience.

It is anticipated that these will constitute the main priorities in the forthcoming Strategy.

The CCG is committed to achieving parity of esteem for mental health, and therefore to delivering the targets and improvements that will be identified in the new Strategy. In order to do this, it will build on the work to improve the mental health and emotional wellbeing of people of all ages living in Walsall undertake in previous years, including the Walsall Mental Health and Wellbeing Strategy for Children and Young People and Children and Young People's Transformation Plan, progress current plans for the improvement of mental health services for adults and older people, many of which are likely to be in line with, and support the recommendations in the National Strategy, and review and progress the work already commissioned jointly with WMBC to develop a joint all age 5 year Mental Health Strategy for Walsall, working with all partners, including service users, their families and carers, and local communities.

In order to ensure that the Walsall Mental Health Strategy is robust, there will be a full engagement process with all stakeholders. On completion, if the plans require it, formal consultation will also be carried out. The intention is to complete the strategy during the summer of 2016 with consultation in the latter part of the year if necessary.

The NHS Mandate for 2016/17 and '**must-do" no 7** in the latest Planning Guidance already identifies specific targets for improvement of access and waiting time standards for people with mental health problems. WCCG is committed to achievement of these as early in 2016-17. The new targets include specific standards for 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 is already meeting these targets and is committed to ensuring that they continue to be met. The CCG also expects to meet the 50% recovery targets in future months. WCCG also anticipates that DWMHT will be able to achieve the new 2 week access to treatment times for Early Intervention in Psychosis services.

WCCG will agree a service development and improvement plans (SDIP) within the 2016/17 contract with the prime mental health provider. This 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 reducing the distress experienced by individuals and their families. The actions we take are intended to deliver the following outcomes:

- Improve prevention, mental health and emotional wellbeing.
- Reduce stigma and improve awareness and understanding of mental health problems.
- Ensure easier access to information, advice and sign posting and access to mental health assessment and treatment when needed.

- Provide more community based care, with admission to inpatient care only when chosen or necessary and fewer re-admissions.
- Improve response to mental health crises.
- Reduce the need for secondary mental health assessment and treatment by ensuring early diagnosis and therefore intervention and support earlier in the course of a mental illness.
- Ensure access to specialist, evidence based assessment, treatment and support when needed.
- Support recovery by improving both experience and outcomes from mental health assessment and treatment, including ensuring that care is individualised and person centred, that individuals have increased access to information and advice and choice and control over their illness and treatment and that they are supported to achieve greater independence through the ability to develop and maintain meaningful relationships and occupation, including employment, and to participate as actively citizens in the communities in which they live.
- Improve support for carers of people with mental health problems to continue to care where they wish to do so.
- Co-produce mental health services, involving people with mental health problems, their carers and families fully in service improvement.

Dementia

We have developed an integrated dementia strategy that includes work to increase early diagnosis by GPs. dementia cafes and community support pathways, including for those in crisis or who need intensive treatment and support, and support for older people with mental health difficulties admitted to the hospital.

It should be noted that with regard to the early diagnosis target Walsall reached the national target of 67% of those estimated to have dementia in 2014 ahead of target, however, the percentage of people diagnosed with dementia has recently decreased falling below the 67% target due to changes in the prevalence data. A Remedial Action Plan has been put in place and it is likely that the 67% target will be reached by March 2016.

2.4 Priority No 4 – Maximise Value and Secure Financial Balance through RightCare

Given the scale of the financial challenge faced in Walsall, a radical approach needs to be adopted whereby service transformation will drive improved efficiencies. This section sets out a number of initiatives including the Right Care approach, our financial plan and QIPP programme, our use of the Better Care Fund, improvements in community services, 7 day working and medicines management which together will promote integrated services, drive service transformation and deliver efficiency improvements.

2.4.1 Committed to right Care: Realising our Value Opportunities

As part of our systematic opportunity searching Walsall CCG is also using the RightCare approach to review data to highlight our top priorities and opportunities for transformation and improvement locally so that we can better address unwarranted variation of care. This has the buy-in of our Governing Body and is to become our programme for delivery of change.

Using Rightcare we will address our priority issues and value opportunities. This will be through agreement in partnership with key stakeholders, identifying what we need to do and where we need to focus. The “how and who will do this” will be agreed and monitored through our new RightCare delivery process.

This approach is set out in in **Figure 16.**

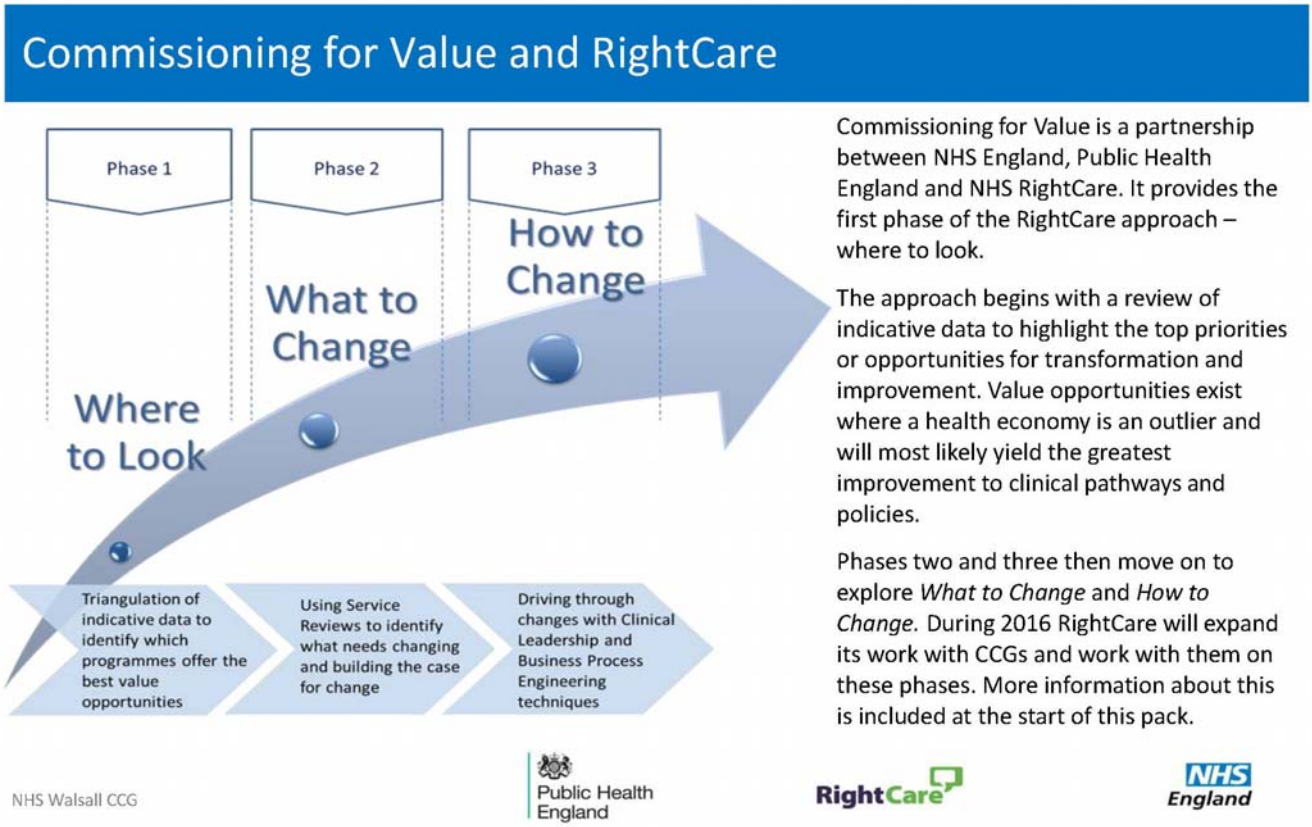


Figure 16 – The RightCare Methodology

This approach has already identified the opportunity areas as illustrated in **Figure 17** and this will help embellish those opportunities already identified within our QIPP programme set out in **Section 2.4.2.**

Figure 17 – RightCare Opportunities for Walsall

2.4.2 Our Financial Plan and QIPP Programme

The CCG's Financial plan takes the 2016/17 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 2016/17 National Tariff Payment System document. This includes an uplift of 0.3% in 2016/17 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 2016/17.
- 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 2016/17" document in conjunction with the draft rules for the adoption of the tariff as outlined in the 2016/17 National Tariff Payment System document.

Our financial plan details the modelling work and QIPP plans for 2016/17. A summary of QIPP plans are given below and this shows the effect of our proposed QIPP programme on our 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 the implementation of the schemes set out in this Operational Plan.

Plans agreed by Walsall CCG to deliver the QIPP challenge are summarised in the **Table 5.**

Programme	2016/17 CCG Savings
Identified schemes	£ 10m
Prescribing	£ 2.0m
Primary care, LTCs and Community	£ 2.9m
Mental Health	£ 2.6 m
Unscheduled Care	£ 2.3 m
Planned Care	£ 2.5m
Learning disabilities	
Grand Total	**£ 22m**

Table 5– High Level QIPP

The QIPP challenge will see WCCG plan for savings of approximately £22 million in 2016/17 to ensure the delivery of £17 million savings in that financial year. This takes account of the potential risks to delivery of the identified QIPP i.e. there is a potential high risk that the full value of the QIPP programme may not be delivered. The risks include implementation problems, slippage, and also the recognition that secondary care related schemes need to be negotiated during the 2016/17 contracting round.

The detail of the QIPP scheme development is currently being developed with schemes in the region of £10 million so far identified. The process is being led by the CCGs Improving Outcomes Committee. Programmes which report to this committee have been tasked with developing transformation schemes that deliver this challenging financial target. The IOC has agreed that the QIPP delivery arrangements will reflect the following principles and parameters:

- QIPP schemes will be across the whole commissioning portfolio
- Clinical leadership will the key driver behind changes with commissioning support
- Schemes are evidence based
- Need clear accountability arrangements
- Look across the demand side and ensure the priorities are capable of being delivered
- Understand the impact of the schemes proposed

- Need to consider save to invest proposals
- Schemes needing NR investment need to resourced fairly
- Evaluation of the time to fruition/Do ability is required
- Strong Governance arrangements for each scheme with agreement on who is delivering schemes, how are they going to be made accountable, all schemes are clinically led and owned with allocated clinical leads
- In consideration of the commissioning support available and risks arising from taking forward multiple QIPP schemes there should be small number of big schemes rather than a long list of small schemes
- Assurance of QIPP delivery will continue to operate via a centrally coordinated Programme Management Office (PMO) and the planning of current and 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 2015/16 which saw the successful delivery of QIPP targets.

WCCG QIPP 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 6.** This approach mirrors the RightCare methodology set out in **Section 2.4.1** and provides a solid foundation for the CCG to move forward with the RightCare approach.

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 6 – 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 7.**

Source	Reason	Latest Data	Metric
West Midlands Estimate of Potential	Above demographic predictions for the	2014/15	Para-suicide and self-harm admissions
			Sexual health related admissions
			Surgical interventions resulting from poor LTC mgt

Source	Reason	Latest Data	Metric
Savings	last 4 years		Complications following surgery
			Zero day Length of stay emergency admissions without procedure and discharged home
			Minor A&E attendances
			Minor A&E attendances out of hours
			Consultant to consultant outpatient referrals
			Rescheduled out-patient attendances
Spend and Outcome Tool	Higher spend In the right hand side of the quadrant analysis for the last 3 years	2013/14	Maternity and Reproductive Health
			Other
	Highest count of SPOT Potential Savings in each POD		Circulation
			Respiratory
			Gastro Intestinal
	SPOT Potential Savings per Programme Budget Category		Mental Health
			Maternity and Reproductive Health
			Neurology
Commissioning for Value - Pathways	First year of analysis shows significant difference from prevalence peers.	2012/13	Musculoskeletal
			COPD
			Heart Disease
			Renal
			Lower Gastrointestinal
NHS Atlas of Variation	First year of current analysis shows improvement opportunity. Update to most up to date data shows no improvement.	2013	Map 2: Percentage of all antibiotic prescription items in primary care that were for key antibiotics
		2012/13	Map 14: Rate of epilepsy emergency admissions to hospital in people aged 18 years and over per 100,000 population
		2012/13	Map 22: Rate of COPD emergency admissions to hospital per 100,000 population
		2013/14	Map 32: Total net ingredient cost of anti-diabetic items per person on GP diabetes registers
		2012/13	Map 58: Mean length of stay (days) for emergency admission to hospital for fractured neck of femur (FNOF)
		2012/13	Map 61: Rate of emergency admission to hospital for people aged 75 years and over with a length of stay of less than 24 hours per 100,000 population
		2012/13	Map 75: Rate of emergency admissions to hospital of babies within 14 days of being born per 1,000 deliveries
		2010/11 - 2012/13	Map 79: Rate of admission to hospital for dental caries in children aged 1-4 years per 100,000 population
		2012/13	Map 84: Mean length of stay (days) for asthma in children aged 0-18 years
		2012/13	Map 88: Rate of elective admission to hospital for tonsillectomy in children aged 0-17 years per 100,000 population
		2012/13	Map 95: Rate of emergency admission to hospital for ambulatory care-sensitive conditions per 100,000 population

Table 7 – Areas of Concern

2.4.3 Better Care Fund and integrated care

Walsall's whole system plan for the BCF in 2016/17 is to consolidate the commissioning programme which was established during 2014/15 and 2015/16 and is a key enabler to bring about transformational change, drive efficiencies and improve productivity. We have agreed a clear vision for a transformation of our system from an over reliance upon institutional and hospital based care to one of supporting older people to remain safely in their own homes. This is represented in the **Figure 18** below where there is an emphasis upon prevention and integration of service provision:

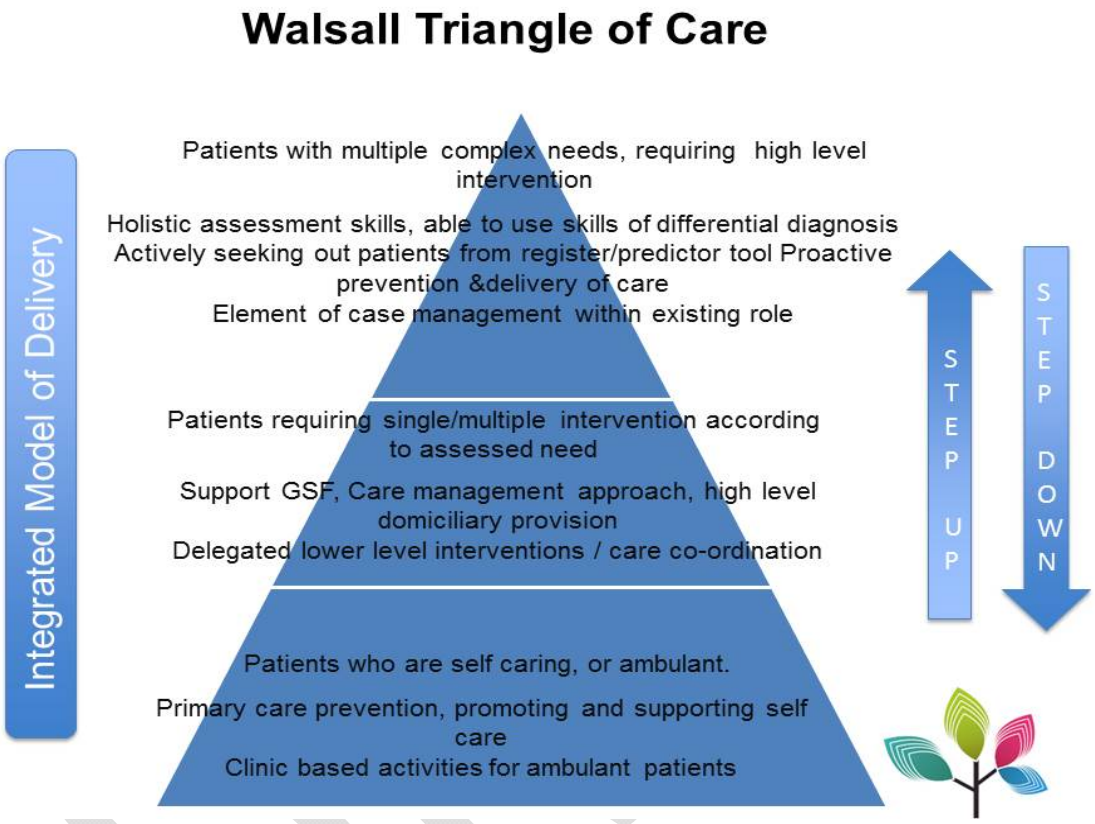


Figure 18 – Triangle of care

There is no additional funding placed in the pooled budget for 2016/17, which is hosted by Walsall Council as specified in our local Section 75 agreement (National Health Act 2006). We will continue to identify aligned funding that can be used to enlarge the pooled budget from April 2017, for instance funding for community health services, commissioning budgets in the Council, or funding for Older People Mental Health Services with Dudley Walsall Mental Health Trust. There will be a need to clarify QIPP targets associated with this funding prior to agreement to pooling, and also savings targets associated with Council funding. Details and plans for each of the financial schemes in the Better Care Fund.

We have agreement to the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate, working in partnership with providers within financial constraints in a way that also aligns with our overall vision for providing care closer to home.

All of our information systems currently use the patient NHS number as an identifier. We are currently revising information sharing governance arrangements and plan to have them updated and agreed across the health and social care system by end of June 2016. Our plans for interoperability between data systems are based upon identification of the necessary investment in mobile working providing

the work force with the necessary technology at the front line for immediate and real time data sharing. Community health teams currently do not have access to mobile working technology and there is a need to address this as part of the overall plans for mobile working. This will be in recognition that integrated planning and delivery of the enabling information technology (including access to integrated digital records) is a vital part of the infrastructure to support improved operational performance on a number of areas that are a core focus of the Better Care Fund. We will be developing a local digital roadmap across our health and social care system during 2016/17. We also plan to conduct patient engagement and communications around data sharing in line with the recommendations from the National Data Guardian review. This will be part of a broader programme of patient engagement focusing upon more effective self-care and prevention, as well as how patients can expect to be supported closer to home with joint case management and new services such as Rapid Response.

Community Health Services have implemented risk stratification for frequent flyers and those at high risk of admission since summer 2014, analysing data each month for patients who have been readmitted 4 or more times in the previous 12 months. This work has been on-going until June 2015 when the sample was changed to patients who had been readmitted 2 or more times in the previous 3 months. The 4 or more admission work proved very useful and has helped to reduce avoidable readmissions for this cohort and also identified a population of patients whom despite intervention require frequent acute intervention. Social care will be integrated with community health locality teams by end of March 2016 with an agreed approach to the appointment of a nominated lead professional.

Our plan for the transformation of the health and social care system, which is based on a greater level of integration of service delivery, has been developed under the auspice of the Healthy Walsall Partnership Board (see section 1.3 above) with joint working between commissioners and providers as a key principle to guide the work. The CCG will be setting QIPP targets and the Council will be setting savings targets for some parts of the financial profile of the Better Care Fund, and these will be signed off at the Healthy Walsall Partnership Board.

Our plan for investment in out of hospital services is to continue with our current investments in these services. The majority of the programme is commissioning out of hospital services in the form of community health services, intermediate care, and social care reablement services, with additional elements for primary care case management of over 75 year olds, assistive technology, mental health support to urgent care, and support to carers. The national condition of protecting social care services is achieved by an investment in the BCF for Council commissioned residential placements and care packages. This is in line with the requirement that each local area uses its share of the fund previously linked to the performance framework to deliver investment or value to the NHS.

Our risk sharing arrangements are governed by an agreed Joint Accountability Framework through which is reported the finance, activity and performance of each scheme in the Better Care Fund so that all agencies are party to the same level of information on every scheme, no matter who is the provider. We set out our approach to risk sharing in our December 2014 submission, and have maintained these arrangements since then.

Our focus around Delayed Transfers of Care is upon reducing the overall numbers and lengths of stay of the whole of the clinically stable cohort of patients in the hospital, of which those who are agreed as Delayed Transfer in line with the revised guidance are a sub set. There has recently been an adjustment to our reported level of delays following revisions to ensure that data reporting is in line with the revised guidance issued in summer 2015. We will continue to recalibrate this data reporting as we continue to embed the SAFER bundle to improve flow management in the hospital as part of our Recovery Plan under the System Resilience Group as set out in section 2.1.1 above. The 10 key actions to address the A&E 4 hour wait performance will be aligned with more strategic change programmes set out in our plan for the BCF including:

- Investments - In 2015/16 there was a £1.5 million investment in discharge to assess beds in nursing homes in order to free up bed capacity in the acute hospital by reducing the number of clinically stable patients, and the length of stay in hospital of clinically stable patients. During 2016/17 we will reinvest half of this funding in to social care reablement in order to support a model of discharge to assess in the home, instead of in a care home following a hospital discharge. This service will then also be able to support older people to remain in their own homes and avoid a hospital admission. The impact of this change will be to reduce admissions to hospital, and to reduce the number and length of stay of patients on the clinically stable list.
- Admissions to residential care - The number of admissions to residential care increased during the year 2015/16 compared to financial year 2014/15, in contrast to a targeted reduction in the number of placements (current projected out-turn is between 310 and 320 placements compared to a target figure of 232). We have agreed a revised target for this metric of between 305 and 315 depending upon the actual out-turn, based on a percentage reduction on the level of placements in 2015/16.
- Reablement services - We have agreed that during 2016/17 we will incorporate health intermediate care services in to the reablement metric, which currently only measures social care reablement services. This will mean that this metric provides a more comprehensive reflection of the success of reablement and intermediate care interventions designed to prevent hospital admission, or support hospital discharge. We have achieved our target figure of 80% or more people remaining at home 91 days after the episode of intermediate care or reablement for those people supported at home. The percentage is less than 80% for those supported in step down beds and this has caused us to look at changing the model of these services as described above. As a result we will set a slightly higher target for this metric in 2016/1 of 81%.
- Delayed transfers of care - We have agreed a target for Delayed Transfers of Care (DToC) at 2.5% and the range of services commissioned via the BCF are aligned with our plans for investment in out of hospital services as described above.
- Diagnosis of dementia - At the end of March 2015, Walsall had achieved the national ambition for a dementia diagnosis rate of 67% and achieved 68%. From April 1st 2015, NHS England introduced a new methodology for calculating prevalence that increased the Walsall figure by 3%. Walsall's dementia diagnosis rate for December was 65.8%. This reduction was due to the increase in prevalence, deaths from the dementia registers and Memory Assessment Service performance. Since April 1st, 130 people have been diagnosed with dementia and 106 have been removed from the registers due to death or moving out of area. Commissioners have met with all four GP localities and encouraged them to use the tools provided to increase the diagnosis rate and specialist dementia support workers work with care homes to improve dementia care, end of life care with a view to reducing acute hospital admissions. Hospital dementia support workers continue to support care improvements in the acute hospital and the dementia cafés support carers to reduce the strain of caring which can often lead to acute admissions. The national target remains at 67% and the Better Care Fund target at 70%. If the prevalence had not altered, a 70% diagnosis rate would have been achieved by August 2015.
- Patient Satisfaction - A satisfaction survey of people who have used integrated intermediate care services has been established and will form the basis for a measurement of satisfaction during 2015/16. This will be continued during 2016/17.

2.4.4 Community Services

Our Plan in 2016/17 and beyond is committing the CCG 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 the CCG 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 the Health and Well-Being Board, with integrated commissioning well established between the Council and the CCG, and integrated service models with NHS and other providers under development.

Key components of our proposed changes in community services for 2016-17 are as follows:

- 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 that 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.

The re-designing of community services will focus on 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.

Within this Agenda we will be prioritising improved self-care and long term conditions with a focus on diabetes and respiratory and neurological conditions and CVD, 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 – Key parts of our approach to improving diabetes services include:
  - Working with Public Health, Walsall MBC on developing and commissioning lifestyle and preventive services that help to reduce obesity, including childhood obesity and to enable patients who are at risk of developing diabetes, to access educational sessions so as to prevent or delay onset. 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. The CCG is participating in a quality improvement project that the Royal College of General Practitioners (RCGP) is sponsoring until May 2016. The aim is to try to improve care of people with diabetes by working with 6 practices nationally where there is room for improvement, using quality improvement methodology. There are four pilot sites nationally 3 in England, 1 in Wales. The project is intended to lead to the development of a guide to be used nationally. The CCG in conjunction with WHT, have launched the new Walsall 'Diabetes and Me' educational programme for Type 2 including an app for android phones and televised sessions with Sky Akaal Channel Sky 843 which is available on You Tube. The CCG have also launched specific educational events for non-English speaking type 2 diabetic patients and their families which will continue throughout 2016/17
  - The CCG have hosted a primary care education event with a second event in February 2016, with the intention to hold this twice yearly.
  - The CCG are intending to relook at procuring the type 2 and 3 LCS services with primary care given the opportunities with Federating practices to enable more patients to access insulin management including initiation in primary care
  - In 2016/17 the CCG will be focusing on tackling the increasing rate of diabetic related amputations jointly with Dudley collaboratively with Diabetes UK. The NDA audit results will give the T&F group areas to focus on for 2016/17 onwards.
- Neurological Conditions – The CCG have contracted NHiS to undertake a review of the delivery of neurological services. NHiS have an established reputation working with multiple partners across England since 2008 including with NHS Strategic Clinical Networks and other CCG's. The CCG has specifically commissioned NHiS to undertake the following as Phase 1 of the project:
  - To provide a Neurowatch data intelligence report highlighting four years of activity (2010/11-2013/14) for NHS Walsall CCG for the top 5 spends to identify specially:
  - Admissions – primary and secondary, elective and non-elective
  - Costs
  - Co-morbidities
  - Length of stay

- Bed days
- Excess bed days
- Zero day admissions
- Showing trends over relevant years
- Speciality that patient was treated by once admitted i.e. neurology, care of the elderly and general medicine
- Outpatient activity across neurology, geriatric medicine and general medicine for previous four years.
- Organise a meeting with key internal stakeholders, including clinicians, to review and examine the data to identify any priority areas and opportunities and develop an action plan for:
  - Improving patient outcomes
  - Increasing efficiency
  - Providing further patient satisfaction
  - Greater clinical effectiveness
  - Enhanced staff satisfaction
  - Service development to fit with best practice guidelines

This work is due to be completed by March 2016 and will enable the CCG to have clarity of the current challenges to the service and future procurement opportunities moving forward.

- CVD including Stroke – The CCG are currently working with Staffordshire CCG with regard to the Stroke pathway for patients in the Burton and Lichfield Borough areas following Burton Hospitals decision to cease providing Acute Stroke Unit services.
- Heart Failure Left Ventricular Systolic Dysfunction The CCG have recently specified Multi-disciplinary Specialist Community Service - Heart Failure Left Ventricular Systolic Dysfunction (LVSD) with the intention to ensure that people with chronic heart failure are cared for by a multidisciplinary heart failure team led by a specialist and consisting of professionals with appropriate competencies with a single point of contact for the team in order to deliver the following outcomes:
  - Reduction in acute admissions;
  - Reduction in acute outpatient appointments;
  - Accurate GP records identifying HF patients;
  - Improved identification of HF patients;
  - Reductions in length of stay (in line with integrated pathways between primary and secondary
  - care services)
  - Improved quality of life indicators; and
  - Improvement in the GSF objectives including preferred place of death.
- Improves use of technology - Develop the use of technology especially around LTC's in general practice following the early implementer site at Sycamore House Medical Centre where patients can:
  - Access information on self-care.
  - 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.

2.4.5 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 2016/17 are included within the provider Service Development and Improvement Plans (SDIP).

Standards 1 to 5 were prioritised for joint review in the summer 2015 between the CCG and Walsall Healthcare NHS Trust and a summary of the conclusions was as follows:

- Standard 1 Patient Experience: Patient involvement is evidenced in the Net Promoter Scores (NPS). Real-time feedback is not available and the trust has a performance display that includes partial evidence of what is required by the standard. The CQC Inspection conducted in September 2015 found that "Patients reported being involved in their care across the majority of services, with more work required in maternity services and the emergency department because with increased activity there was a decline in patient involvement". Further work to assure that differences between weekday and weekend are understood is underway.
- Standard 2 Time to First Consultant Review: This is referred locally as the Early Senior Review and is operational from 8.00am to 22.00pm M to F and 8.00am to 14.00pm Sat/Sun. This mirrors the consultant on site presence within A&E. Our plan for coverage 24 hours 7 days is to establish the Early Senior Review Model with middle grades within the limited space available to have a dedicated area. There are no current plans to extend consultant cover within A&E.
- Standard 3 Multi-disciplinary Team Review: a multi-disciplinary team ward and board round processes are embedded at ward level, particularly in the MAU and medical wards, with social care input included. These take place on Saturdays, but currently not on Sundays.
- Standard 4 Shift Handovers: An electronic handover process is in existence. Handovers take place twice per day, and utilise the electronic spread sheet and data from clinical systems. Further work is needed to standardise across 7 days per week.
- Standard 5 Diagnostics: 7 day diagnostics are available for the majority of diagnostic services. Exceptions such as Endoscopy are due to resource constraints.

On-going review of progress against the 7 day working standards is built in to the contractual arrangements with WHT. The Trust has completed the self-assessment tool on the 7 Day Standards website, and further progress will be added in to the self-assessment following a further review during March 2016. This review will include progress with Standard 9.

2.4.6 Medicines Management

WCCG recognises that medicines management will continue to play a key role in service quality and efficiency improvement and in tackling unwarranted variation and will progress the following key initiatives in 2016-17:

- 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.
- Antimicrobial prescribing - The prescribing incentive scheme for GPs includes the volume of antimicrobial prescribing as well the prescribing of high risk of C-diff antibiotics. All Walsall GP practices have received therapeutic detailing via the IMPACT team on antimicrobial prescribing as well the prescribing of high risk of C-diff antibiotics. Educational work is ongoing in local care homes regarding staff training, the importance of medicine compliance and missed doses.
- Guidance and formulary updates - Medicines management team also issue guidance and formulary updates to ensure prescribers are enabled to issue the right drugs responsibly. This is supported again by the IMPACT campaign and the work that is undertaken by the practice pharmacist team. Monitoring is undertaken through the prescribing incentive scheme, as well as using data from Keele, antimicrobial data from WHT and EPACT.
- QIPP Schemes - The medicines management team have drawn up and will be delivering an extensive QIPP plan for 2016/17 with the overall aim of saving 2 million pounds in the financial year. This is a 3.7% saving on the drug budget. This plan is based on both switching of drugs as appropriate to a cost effective option, adherence to local formulary and the monitoring of expensive items such as 'specials' i.e. unlicensed medicines, dressings and enteral nutrition. The monitoring will be undertaken through audits and reports on the work plan during this financial year. This data will be triangulated within information from Keele University, PrescQIPP and EPACT data downloads. This QIPP plan will help to support efficiencies that need to be made but also address safety and antibiotic prescribing.

2.4.7 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 Programme Director for Contracting, Procurement and QIPP being 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 WCCG's Contracting and Procurement Strategy is based on a published academic study conducted by WCCG's Programme Director for Contracting, Procurement and QIPP 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 WCCG has recently 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 2016-17.

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.

The West Midland Academic Health & Science Network (WMAHSN) has a seven point Health and Wealth Growth Plan . While all the actions will benefit the West Midlands, twoactions to highlight here in the context of WCCGs strategic and operational plan obectives, are the commitment to enabling the adoption and diffusion of innovation to benefit patients and reduce bureaucracy (and therefore costs) and working at a system level in the adoption of innovation and best practice, to improve productivity, and in turn empowering local health systems to deliver more health benefit from its commissioning allocation.

As described earlier in this plan the Five Year Forward view and the challenges set out requires the CCG to take action on a number of fronts. The WMAHSN is a vehicle that WCCG will connect to and is already participating in. Our connection with this network will help to embed innovation and accelerate transformation in the services we commission. This will be particularly important in enabling WCCG and system partners deliver a vision of a sustainable and integrated health care system in the future.

There are a number of other WMAHSN work programmes WCCG planning programmes will consider connecting to to support transformation locally. These include Long Term Conditions where the aim to share good practice using a "push" and "pull" approach to disseminating and focussing on areas where innovation is needed. WCCG will connect to other work programmes to explore potential areas that can help transfromation locally , including Mental Health, Drug Safety and Medicines Optimisation, Patient Safety, Education and Training (through Health Education West Midlands), Integrated Care and Digital Health.

All our clinical leads and their support managers will seek to proactively engage with the leads for the WMAHSN work programmes to explore the opportunities and benefits of enagement in specific work areas. One example of a project area WCCG is laready enaged in concerns long term condions, specifically diabetes, where we are enaged in a work programe called "Making a difference to people with diabetes".

The aim of this WMAHSN project is to deliver 1,000 differences to people with diabetes with 500 difference makers through helping people to think in a solution focused way by December 2015. This is a joint project involving industry providers, CCGs and other stakeholders as well as health and lifestyle professionals with the aim of making positive changes to improve the delivery of healthcare to people

with diabetes and by sharing ideas and enthusiasm to make a significant impact. There are already a range of differences in diabetes care and the aim is to try to transform care. In the case of WCCG our involvement in the work steam is with the aim of improving the detection, coding and management of micro albuminuria in people with diabetes in Walsall an is being led by Dr Andrew Askey a local GP.

2.4.8 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 19** below. 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 specifications; having a high level of public, patient and clinical engagement; embracing suppler relationship management; and having appropriate skills and competence.

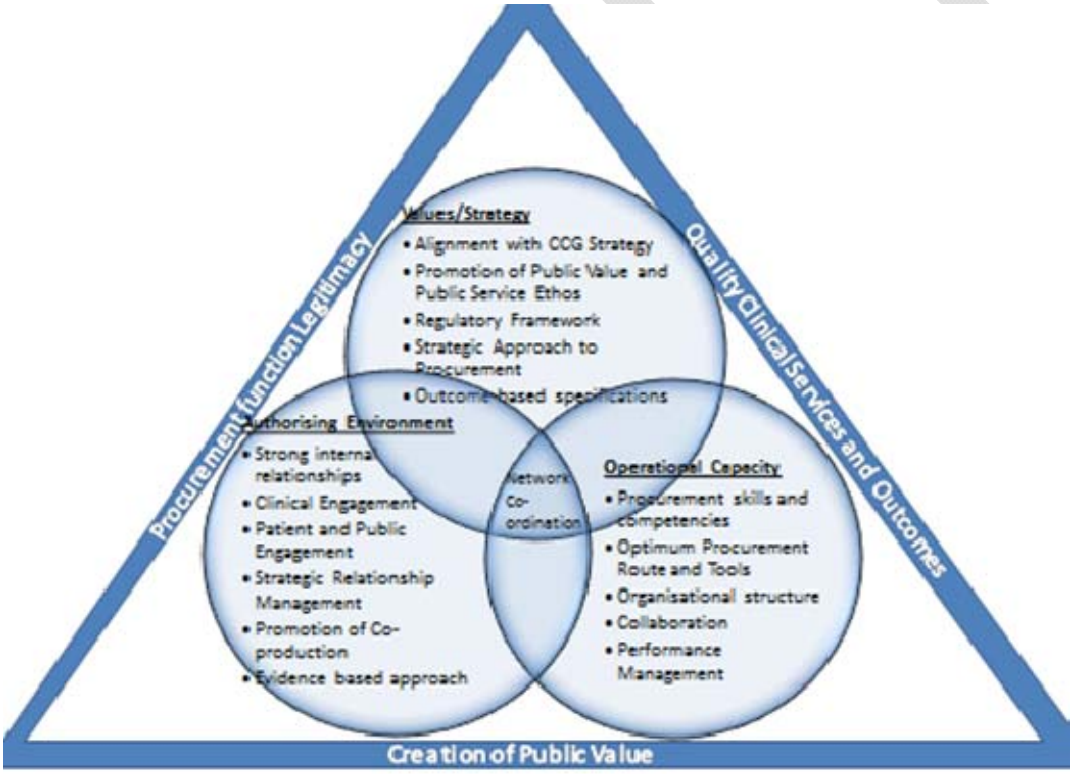


Figure 19– Walsall CCG Contracting and Procurement Strategy

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 now embedded within the CCG's procurement and contracting activities in the following ways:

- As part of tender exercises, at PQQ stage bidders are asked to demonstrate that their organisational mission values are compatible and supportive of the NHS constitution and the CCG's mission and

values. With those of the CCG and with the NHS Constitution and whether they have in place policies relating to social and economic issues and have taken actions in support of these.

- At the ITT stage of procurement exercises, providers are asked to identify the specific actions that they intend to take in providing the service that will contribute to the well-being of the community in terms of economic, social and environmental benefits. For example, a recent tender exercise revealed that private and public sector providers alike already had in place, or had plans for, a whole range of schemes including: paying the living wage; engaging local labour; operating apprenticeship and graduate schemes; supporting national and local charities including through salary sacrifice schemes or staff volunteer days; sourcing goods and services locally, inviting a proportion of their "surplus" or profit in the local community, and implementing carbon reduction schemes including encouraging staff to use public transport or cycle to work.
- Within all contracts, providers are required to provide an annual Public Value Account, as well as their Quality Account, which sets out the wider community benefits they have provided. Initial Public Value Accounts have been submitted. This approach has been piloted by St Giles Hospice, the provider of in-patient palliative care facilities, and their initial Public Value Account highlights: the use of volunteers and promoting community engagement; undertaking numerous local fundraising events; opening and operating local shops which employ local people and operating recycling centres.
- Working in partnership with the local third and SME sectors including: helping them to improve their capacity and capability including their ability to respond to tendering opportunities; developing their services so that are actively support the delivery of the Walsall health and well-being strategy, and signposting patients and carers to appropriate services. The latter has recently been piloted by the Community Partners Scheme operated by Age Concern whereby patients that would benefit from health and non-health services offered by the voluntary sector were identified by GPs and signposted to appropriate services. This is already increasing the awareness of providers that they can make a real contribution to their local communities beyond the delivery of excellent services.

This activity ensures that the CCG is not only compliant with its obligations under the Public Services (Social Value) Act to consider social, economic and environmental issues when conducting procurements but that it goes a step further in ensuring that these areas are at the forefront of all contracting and procurement activity with a focus on ensuring delivery of real benefits. Indeed, there is evidence that this approach is already increasing the awareness of providers that they can make a real contribution to their local communities beyond the delivery of excellent services. In doing so the CCG has gained a reputation for being a leader in this field.

In 2016-17, Walsall CCG intends to build on these strong foundations with key initiatives being:

- To receive and publish Public Value Accounts from all providers and where possible, quantify the benefits delivered.
- To adopt a joined up public value/social value approach with Walsall Council and other public sector organizations to ensure a consistent approach and, where applicable, adopting specific social, economic and environmental policies.
- To support Walsall Council in developing a strategy for the development and implementation of the voluntary/third sector in Walsall.

As the number of Public Value 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 3
Performance Management

3.1 Governance arrangements

There is a robust performance management framework in place which includes 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.
- System resilience and meeting NHS Constitution targets

An exception report highlights areas where performance is of concern 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 over the page. 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.

3.2 Plans for Performance Management & Quality

WCCG is in the process of reviewing the Performance Management Framework for 2016/17. The proposed approach comprises:

- Review and update the outcome indicators to show the planned improvements to outcomes for 2016/17 including:
  - "Five Year Forward View" & "The Forward View into Action: Planning for 2016/17 to 20/21".
  - QIPP outcome indicators showing the planned changes for 2016/17. and 2016/17.

- CQUIN objectives, following agreement through the 2016/17 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.

3.3 Commissioning for Quality and Innovation (CQUINs)

2016/17 CQUINS are in the process of being discussed with our providers and are awaiting national guidance but it is anticipated that CQUIN schemes will align with the priorities set out in this Operational Plan with schemes anticipated identified in the **Tables 8 & 9** below.

Scheme Name	National or Local	Proposed Overall %
TBC		
TBC		

Table 8 – Acute CQUINS

Scheme Name	National or Local	Proposed Overall %
TBC		
TBC		

Table 9 – Mental Health CQUINS

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.

3.4 Outcomes Measures

The following section sets out our overall approach to meeting a number of key patient safety and quality measures in 2016/17.

Improvement against NHS Outcomes Framework ambitions are in **Table 10.**

Outcome Ambition	Measure Used	CCG Ambition	
		2016/17	2017/18
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.	2,619	2,612
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		
	Dementia diagnosis rate per 100 population		
	IAPT access proportion per quarter		
	IAPT recovery rate per 100 people		
	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		
	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		
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.	975.8	984.0
	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s per 100,000 population.	293.4	275.6
	Emergency admissions for acute conditions that should not usually require hospital admission per 100,000 population.	1,169	1,092
	Emergency admissions for children with lower respiratory tract infections per 100,000 population.	338.5	321.4
Increasing the number of people having a positive experience of hospital care	Patient experience of inpatient care per 100 patients		
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.		
	GP out of hours per 100 patients.		
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	MRSA		
	CDiff for WCCG		
	CDiff for WHNHST		
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		
	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		

Outcome Ambition	Measure Used	CCG Ambition	
		2016/17	2017/18
	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 10 – Outcome Ambitions

The outcomes indicators in **Table11** 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	
		2016/17	2017/18
Domain 1 – Preventing people from dying prematurely	Potential years of life lost (PYLL) from causes considered amenable to healthcare per 100,000 population.	2,619	2,612
	Under 75 mortality rate from cardiovascular disease per 100,000 population.	68.9	68.0
	Under 75 mortality rate from respiratory disease per 100,000 population.	22.0	21.7
	(Proxy indicator) Emergency admissions for alcohol related liver disease per 100,000 population.	32.5	33.5
	Under 75 mortality rate from cancer per 100,000 population.	131.3	135.0
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	0.760	0.775
	Proportion of people feeling supported to manage their condition	66%	66%
	Unplanned hospitalisation for chronic ambulatory sensitive conditions (adults)	975.8	984.0
	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	293.4	275.6
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.	1,169	1,092
	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	11.2	11.0
	Emergency admissions for children with lower respiratory tract infections per 100,000 population.	338.5	321.4
Domain 4 – Ensuring that people have a positive experience of care	Patient experience of GP services per 100 patients.		
	Patient experience of GP out of hours services per 100 patients.		
Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm	MRSA		
	CDiff for WCCG		
	CDiff for WHNHST		

Table 11 – Domain Measures

Direct commissioning – Primary Care Measures are in **Table12** below:

Domain	Measure Used	Ambition	
		2016/17	2017/18
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 12 – Primary Care Measures

3.5 NHS Constitution Measures

NHS Constitution measures are in **Table 13.**

Constitution Measure	Measure Used	Ambition	
		2016/17	2017/18
Referral To Treatment waiting times for non-urgent consultant-led treatment	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%	92%	
Diagnostic test waiting times	Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 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%	
Cancer waits – 2 week wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%	93.1%	
	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%	93.7%	
Cancer waits – 31 days	Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96%	96.4%	
	Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%	96.0%	
	Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%	100%	
	Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%	945.2%	
Cancer waits – 62 days	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%	83.4%	
	Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%	95.1%	
	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	92.3%	
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%	
	Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 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.	0	
	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 13 – NHS Constitution Measures

3.6 Better Care Fund Measures

BCF measures are in **Table 14** below:

Measure	Measure Used	Ambition 2016/17
Transfers	Delayed transfers of care	685
Admissions	Reduction in emergency admissions	To be advised by NHS England before 16/3/16
	Admissions to residential and nursing care	301
Reablement	Effectiveness of reablement	81%
	Reduction in expenditure on social care packages and residential placements for older people	No Measure
Experience	Patient / service user experience	92%
	Bed Days	Not applicable
Local Measure	Dementia Diagnosis Rate	67%

Table 14 – Better Care Fund Measures

In relation to the measures in Section 4.4 to 4.6 these will be achieved via the commissioning interventions shown in Section 7 of the Operational Plan, Better Care Fund 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 4

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. The priorities of these programmes may change in the light of the development work on the STP for the Black Country and West Birmingham and also integrated Commissioning within Walsall itself. The current commissioning programmes are as follows:

- Elective Care.
- Urgent Care.
- Mental Health.
- Disabilities and Carers.
- Primary Care & Community Care.
- 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 Appendix 4.

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 2016/17 WCCG expects that the transformation programmes will impact positively on the measures as detailed in Section 4 of this plan and deliver the range of savings required to achieve sustainability of the health care system.

The Change Programme Template on page 76 explains the content of the change programme for Elective Care, Urgent Care, Mental Health, Disabilities and Carers, Primary Care & Community Care, 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 (these are to be confirmed within the 2 March and 11 April submissions).

CCG Planning structure is shown in **Figure 20** on the next page.

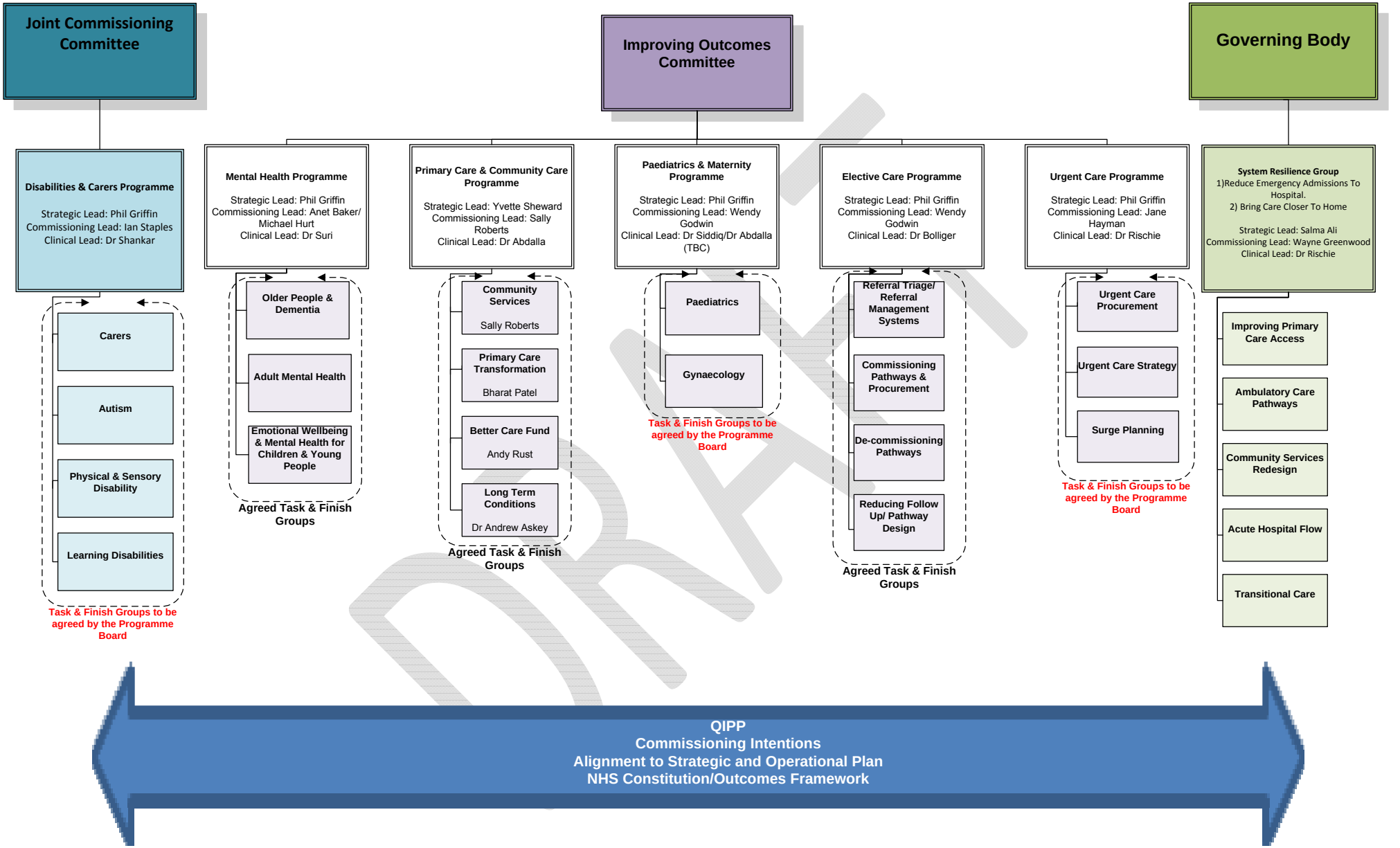


Figure 20 – WCCG Planning Structure

Format of the Change Programme: Template explanation

Why is change needed?

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

Description	WCCG 2013/14	Best CCG's in England 2016/17	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 2016/17	The difference between the 2 metrics

WCCG Outcome Indicator Set Trajectories	2013/14	2014/15	2015/16	2016/17	2017/18
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	National Guidance
The corporate objectives the T&F works to	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	16/17	17/18	Investment £k +	Investment £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 2** 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 3** 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

4.1 Elective Care Programme

4.1.1 Trauma & Orthopaedics, Rheumatology and Pain Management, ENT, Urology, Dermatology and Ophthalmology

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 2013/14	Best CCG's in England 2016/17	Opportunity for Saving / Outcome
£ per head of population – Musculoskeletal System	£88.23	£85.66	£2.57
Total Expenditure £ – Musculoskeletal System	£24,773,221	£24,052,642	£720,578
£ per head of population – Trauma & Injuries	£46.21	£56.73	(£10.52)
Total Expenditure £ – Trauma & Injuries	£12,975,760	£15,929,981	(£2,954,220)
% 75yr+ with fragility fracture and treated (OST003 / OST03)	75.80%	82.19%	6.39%
% fragility fracture, DXA confirmed and treated (OST002 / OST02)	98.04%	95.42%	(2.61%)
% RA aged 30-84 with CVD risk assessment (RA003)	94.25%	93.31%	(0.93%)
% RA aged 50-90 with fracture risk assessment (RA004)	91.53%	90.08%	(1.46%)
% RA with review (RA002)	92.49%	90.31%	(2.18%)
Hip fracture: % recovering to previous levels of mobility at 120 days	0.00%	49.34%	49.34%
Hip fracture: % recovering to previous levels of mobility at 30 days	0.00%	24.99%	24.99%
Hip fracture: collaborative orthogeriatric care	88.00%	93.69%	5.69%
Hip fracture: incidence	470.10	439.40	(30.70)
Hip fracture: multifactorial risk assessment	99.20%	96.93%	(2.27%)
Hip fracture: timely surgery	65.80%	74.23%	8.43%
Register of fragility fracture (OST001 / OST01)	0.42%	0.39%	(0.02%)
Register of rheumatoid arthritis (RA001)	1.03%	0.74%	(0.29%)

WCCG Outcome Indicator Set Trajectories	2013/14	2014/15	2015/16	2016/17	2017/18
Patient reported outcome measures for elective procedures - knee replacement	-	0.433	0.443	0.454	0.466
Patient reported outcome measures for elective procedures - groin hernia	-	0.320	0.326	0.333	0.340

Strategic Objectives and Priority

- See Section 1.4 of this plan

National Guidance

- See references at **Appendix 4**

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	16/17	17/18	Investment £k +	Investment £k -
o Referral Management Pathways including single point of access	✓	✓		
o Primary Care Direct Access for Orthotics	✓	✓		
o Review of the commissioning of Rheumatology Services as part of the BCA	✓	✓		
o Review of Acute and Community Physiotherapy Services	✓	✓		
o Procurement of Community Chronic Pain Services				
o Procurement of Community ENT service				

o Policy development for Tibial Nerve Stimulation as an alternative to bladder reconstruction				
o Policy development for testicular sperm retrieval				
o Evaluation of IQudos Project				
o Evaluation of teledermatology pilot				
o Monitoring impact of re-procured Ophthalmology services for: ▪ Pre and post operative cataracts ▪ PEARS ▪ IOP				

How we will measure success

- Performance against agreed measures as detailed in Appendix 2

What KPI's will we use to monitor progress?

- Operational plan, Local and contractual measures as detailed in Appendix 3

Risks and Mitigating Actions

RISKS	MITIGATING ACTIONS

4.1.2 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 2013/14	Best CCG's in England 2016/17	Opportunity for Saving / Outcome
£ per head of population	£43.43	£48.99	(£5.55)
Total Expenditure £	£12,195,391	£13,754,321	(£1,558,930)
% cancer with review (CAN002 / CANCER03)	92.50%	91.54%	(0.95%)
% cancers detected at stage 1 and 2	32.10%	40.22%	8.12%
% One-year survival from all cancers	67.70%	67.74%	0.04%
% One-year survival from breast, lung and colorectal cancer	70.08%	69.25%	(0.83%)
% Record of lung cancer stage at decision to treat	97.20%	92.53%	(4.67%)
% Record of stage of cancer at diagnosis	49.50%	58.20%	8.70%
DSR (PYLL) from Neoplasms amenable to healthcare	646.50	625.82	(20.68)
Mortality from breast cancer in females	36.80	34.81	(1.99)
Under 75 mortality from cancer (per 100,000 females)	118.50	115.24	(3.26)
Under 75 mortality from cancer (per 100,000 males)	155.70	131.67	(24.03)
Mortality from all cancers: Under 75 DSR	137.10	123.45	(13.65)
Patients on Cancer Register since 1/4/2003	1.91%	2.11%	0.20%
Rate of potential years of life lost per 100,000 - Neoplasms	646.50	625.82	(20.68)

WCCG Outcome Indicator Set Trajectories	2013/14	2014/15	2015/16	2016/17	2017/18

Strategic Objectives & priority

- See Section 1.4 of this plan

National Guidance

- See references at Appendix 4

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	16/17	17/18	Investment £k +	Investment £k -
o EOL care for patients with dementia	✓	✓		
o local EPaCCS implementation	✓	✓		
o Improving Cancer survivorship e.g bowel screening project	✓	✓		
o Implementation of Transform and Amber Care Bundles	✓	✓		
o Rapid Discharge Home to Die Pathway	✓	✓		
o Improving EOL transition for children and young people	✓	✓		

How we will measure success

- Performance against agreed measures as detailed in Appendix 2

What KPI's will we use to monitor progress?

- Operational plan, Local and contractual measures as detailed in Appendix 3

Risks and Mitigating Actions

RISKS	MITIGATING ACTIONS

4.1.3 Elective Care – Other

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 2013/14	Best CCG's in England 2016/17	Opportunity for Saving / Outcome

WCCG Outcome Indicator Set Trajectories	2013/14	2014/15	2015/16	2016/17	2017/18

Strategic Objectives & priority

- See Section 1.4 of this plan

National Guidance

- See references at Appendix 4

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	16/17	17/18	Investment £k +	Investment £k -
o Management of Urology Follow-up appointments & PSA management	✓	✓		
o Referral Triage/ Referral Management Systems: Urology	✓	✓		
o Community audiology procurement / reprocurement / contract variation	✓	✓		
o Community MSK/Physio procurement / reprocurement / contract variation	✓	✓		
o Bereavement procurement / reprocurement / contract variation	✓	✓		
o COPD procurement / reprocurement / contract variation	✓	✓		
o Paediatric Consultants procurement / reprocurement / contract variation	✓	✓		
o Psychology procurement / reprocurement / contract variation	✓	✓		
o Continence specification procurement / reprocurement / contract variation	✓	✓		
o Enuresis procurement / reprocurement / contract variation	✓	✓		
o Diabetes procurement / reprocurement / contract variation	✓	✓		
o Diatetics procurement / reprocurement / contract variation	✓	✓		
o Looked After Children procurement / reprocurement / contract variation	✓	✓		
o Commissioning Pathways & Procurement: Orthotic Pathways	✓	✓		
o PoLCV - Aesthetics	✓	✓		
o Improvement in Referral to Treatment Times (RTT) and achievement of national standard as per agreed RTT Recovery Plan	✓	✓		
o Early Pregnancy Unit	✓	✓		

How we will measure success

- Performance against agreed measures as detailed in Appendix 2

What KPI's will we use to monitor progress?

- Operational plan, Local and contractual measures as detailed in Appendix 3

Risks and Mitigating Actions

RISKS	MITIGATING ACTIONS

4.2 Paediatrics & Maternity Programme

4.2.1 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 2013/14	Best CCG's in England 2016/17	Opportunity for Saving / Outcome
£ per head of population	£0.93	£3.71	(£2.78)
Total Expenditure £	£259,744	£1,041,637	(£781,893)
Infant mortality	7.21	4.01	-3.20
Neonatal mortality and stillbirths rate	8.30	7.21	-1.09

WCCG Outcome Indicator Set Trajectories	2013/14	2014/15	2015/16	2016/17	2017/18
Maternal Smoking at Delivery	14.70%	13.80%	14.10%	10.41%	12.12%

Strategic Objectives and priority

- See Section 1.4 of this plan

National Guidance

- See references at Appendix 4

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	16/17	17/18	Investment £k +	Investment £k -
o Shared Action plan with Public Health and WHNHST. Implement and monitor joint action plan	✓	✓		

How we will measure success

- Performance against agreed measures as detailed in Appendix 2

What KPI's will we use to monitor progress?

- Operational plan, Local and contractual measures as detailed in Appendix 3

Risks and Mitigating Actions

RISKS	MITIGATING ACTIONS
Adoption of new Maternity Dashboard	

4.2.2 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 2013/14	Best CCG's in England 2016/17	Opportunity for Saving / Outcome
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	2013/14	2014/15	2015/16	2016/17	2017/18
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 4

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	16/17	17/18	Investment £k +	Investment £k -
o Look at local implementation of 'Your Welcome' with Primary care	✓	✓		
o Reducing Emergency admissions for children with respiratory tract infections (NHS of 3.2)	✓	✓		
o Evaluation and on going support of the 'George Coller' sponsored Asthma CNS	✓	✓		
o Monitoring the KPIs related to the Childrens Community Nursing Service in relation to addressing:	✓	✓		
o Preventing lower respiratory tract infections in children becoming serious o Reducing time spent in hospital by people with long term conditions o Reduce Unplanned Hospitalisation for asthma and epilepsy in the under 19's (NHS 2.3i)	✓	✓		
o Impact of transference of commissioning responsibility of critically ill children from NHSE to CCG	✓	✓		
o Development of a service specification and local tariff for PAU	✓	✓		

How we will measure success

- Performance against agreed measures as detailed in Appendix 2

What KPI's will we use to monitor progress?

- Operational plan, Local and contractual measures as detailed in Appendix 3

Risks and Mitigating Actions	
RISKS	**MITIGATING ACTIONS**

4.3 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 2013/14	Best CCG's in England 2016/17	Opportunity for Saving / Outcome

WCCG Outcome Indicator Set Trajectories	2013/14	2014/15	2015/16	2016/17	2017/18
Emergency admissions for alcohol related liver disease	44	44	32	32.5	33.5
Unplanned hospitalisation for chronic ambulatory sensitive conditions (adults)	1,087	1,126	968	975.8	984.0
Emergency admissions for acute conditions that should not usually require hospital admission	1,399	1,451	1,245	1,169	1,092
Emergency readmissions within 30 days of discharge from hospital		11	11	11.2	11.0

Strategic Objectives and priority

- See Section 1.4 of this plan

National Guidance

- See references at Appendix 4

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	16/17	17/18	Investment £k +	Investment £k -
o WMAS	✓	✓		
o NHS 111	✓	✓		
o Achieve A&E 4 hour wait target	✓	✓		
o Seven Day Working Standards	✓	✓		
o Reduction in emergency admissions	✓	✓		
o Getting Home Quickly and Safely	✓	✓		
o Minimise Level of Readmissions	✓	✓		
o Specification for Emergency Department	✓			
o Locality Extended GP Urgent Access Model	✓			

How we will measure success

- Performance against agreed measures as detailed in Appendix 2

What KPI's will we use to monitor progress?

- Operational plan, Local and contractual measures as detailed in Appendix 3

Risks and Mitigating Actions

RISKS	MITIGATING ACTIONS

4.4 Mental Health Programme

4.4.1 Mental Health Programme– 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 2013/14	Best CCG's in England 2016/17	Opportunity for Saving / Outcome
% dementia whose care has been reviewed (DEM002 / DEM02)	81.83%	84.08%	2.25%
% new dementia with tests (DEM003 / DEM03/04)	79.29%	80.03%	0.73%
% older MH with total cholesterol:hdl ratio (MH004 / MH14/19)	83.29%	80.40%	-2.89%
% older MH with blood glucose or HbA1c (MH005 / MH15/20)	89.02%	85.83%	-3.20%

WCCG Outcome Indicator Set Trajectories	2013/14	2014/15	2015/16	2016/17	2017/18
Patient experience of community mental health services					
Dementia diagnosis rate					

Strategic Objectives and Priority

- See Section 1.4 of this plan

National Guidance

- See references at Appendix 4

Where we want to be

- Prime Minister's Challenge on dementia 2020 is implemented; An integrated tiered approach to mental health and dementia is developed across the whole healthcare system; There is far greater understanding about how to maintain mental health, wellbeing and challenge the stigma attached to having mental health problems and dementia amongst Walsall residents.
- 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 and/or 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
- A review of older people's mental health services has been completed and is incorporated into a Joint Strategy for Mental Health and Wellbeing of People of All Ages Living in Walsall which is agreed with all partners.
- Mental health achieves parity of esteem with physical health; High quality post diagnosis community based support is provided;Service are responsive, individualised and person centred.

Our plans	16/17	17/18	Investment £k +	Investment £k -
o Older Peoples MH & dementia 7 day intensive support/crisis team	✓	✓		
o Continue the rollout of specialist Dementia Support Workers	✓	✓		
o Develop Primary Care Liaison Nurses to support localities	✓	✓		
o Support the development of challenging behaviour facilities	✓	✓		
o Improved activity in care homes & community groups with the use of assistive technology	✓	✓		
o OPMH acute hospital liaison team to 7 days instead of 5 days a week	✓	✓		
o Review of the Memory Assessment Service and future ways of diagnosing dementia	✓	✓		
o Support for care homes, particularly around improved dementia care and end of life care	✓	✓		
o Continue to provide Mind Matters café and encourage the voluntary sector to provide others	✓	✓		
o Continue to provide Dementia Cafes and encourage the voluntary sector to provide others	✓	✓		
o Older Peoples MH & dementia 7 day intensive support/crisis team	✓	✓		

How we will measure success

- Performance against agreed measures as detailed in Appendix 2

What KPI's will we use to monitor progress?

- Operational plan, Local and contractual measures as detailed in Appendix 3

Risks and Mitigating Actions

RISKS	MITIGATING ACTIONS

4.4.2 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 2013/14	Best CCG's in England 2016/17	Opportunity for Saving / Outcome
£ per head of population			
Total Expenditure £			
% adults in contact with secondary MH services in employment	2.90%	6.49%	3.59%
% female MH with cervical screening (MH008 / MH16)	90.20%	89.61%	-0.59%
% lithium therapy with therapeutic levels (MH010 / MH18)	93.38%	88.70%	-4.69%
% MH with alcohol consumption record (MH007 / MH11)	92.46%	88.91%	-3.55%
% MH with blood pressure record (MH003 / MH13)	93.71%	91.30%	-2.41%
% MH with BMI record (MH006 / MH12)	92.01%	88.31%	-3.70%
% MH with comprehensive care plan (MH002 / MH10)	90.58%	86.23%	-4.36%
% new depression with assessment of severity (DEP001 / DEP04/06)	89.33%	90.19%	0.86%
% new depression with further assessment of severity (DEP002 / DEP05/07)	79.01%	78.17%	-0.84%
% on lithium therapy with creatinine/TSH (MH009 / MH17)	96.45%	96.15%	-0.31%
Access to community mental health services (all groups), crude rates per 100,000 population	3033.90	3348.30	314.40
Access to IAPT services	23.10%	12.72%	-10.38%
Excess under 75 mortality rate in adults with serious mental illness	254.40	350.96	96.56
Health-related quality of life for people with a long-term mental health condition	0.47	0.53	0.06
IAPT recovery	47.22%	44.97%	-2.25%
Mental Health Service users with crisis plans	33.85%	21.75%	-12.10%
People in contact with Adult Mental Health services	2014.15	2267.00	252.84
People on Care Programme Approach	648.18	527.40	-120.77
Register of schizophrenia, bipolar disorder + (MH001 / MH08)	0.85%	0.85%	0.00%
Unplanned MH readmissions within 30 days of MH IP discharge 17+yrs	80.30	93.04	12.74

WCCG Outcome Indicator Set Trajectories	2013/14	2014/15	2015/16	2016/17	2017/18
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 4

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.
- Improve the offer and ensure access to services that respond, and navigate systems quickly to deliver the treatment and support required efficiently.
- Ensure that services users, carers and partners have a voice and can be heard so that quality concerns are addressed and are fully involved in shaping future service design with commissioners.
- 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.
- A fully integrated model of mental health care with robust pathways with all partners working in effectively together is in place.
- Have a thriving and competitive independent sector that delivers a range of service that are of high quality and value for money with sufficient capacity.
- High quality care and support for people who become acutely mentally ill and need specialist in-patient and community based services (specialist or generic services) are provided.
- Mental health achieves parity of esteem with physical health.
- Those requiring mental health services receive timely and appropriate support, whether it is in response to need routinely, urgently or in a crisis.
- Improvement to the mental health offer including responding to a wider range of needs e.g. disorders on the autistic spectrum and personality disorder.
- A review of mental health services for adults has been completed and a Joint Strategy for Mental Health and Wellbeing of People of All Ages Living in Walsall which is agreed with all partners.

Our plans	16/17	17/18	Investment £k +	Investment £k -

o Develop a rehabilitation contract framework and reduce the need for out of area residential and nursing home placements	✓	✓		
o Redesign access, crisis and psychiatric liaison services and review the Crisis Car service	✓	✓		
o Review and improve community and acute care pathways and services	✓	✓		
o Initiate projects that will continue to promote and prevent mental health and wellbeing and reduce stigma	✓	✓		
o Improve recovery and outcomes from mental health problems	✓	✓		
o Support primary care to assess, treat and support people with mental health problems	✓	✓		
o Ensure that the best use is made of secondary care mental health services and ensure that support is given to primary care when needed	✓	✓		
o Improve maternal mental health care	✓	✓		
o Address the interaction between mental health, alcohol & frequent fliers	✓	✓		
o Increase access to IAPT services for Older People	✓	✓		
o Continue to work with partners and deliver the improvements outlined in the Mental Health Concordat	✓	✓		
o Meet new performance targets for IAPT and EIP	✓	✓		
o Increase the range of counselling services provided including considering commissioning DBT for people with a personality disorder	✓	✓		
o Ensure that the physical health care needs of people with mental health problems are addressed	✓	✓		
o Continue to ensure that services are personalised and that there is access to individual personal health budgets for continuing health care needs o Continue to develop the market and seek to increase capacity and competiveness within the independent sector o Ensure that services are effective and efficient, achieving challenging QIPP targets	✓	✓		
o Develop a rehabilitation contract framework and reduce the need for out of area residential and nursing home placements	✓	✓		

How we will measure success

- Performance against agreed measures as detailed in Appendix 2

What KPI's will we use to monitor progress?

- Operational plan, Local and contractual measures as detailed in Appendix 3

Risks and Mitigating Actions

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

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

Why is change needed?

- Guidance published in 2015 'Future in Mind', outlines a national agenda to improve access to mental health and wellbeing support for children and young people. This document is linked to additional transformation funds during 2015 to 2020 for each CCG to bring about transformation.
- An estimated 9.6% or around 4,380 children aged between 5-16 overall are estimated to have an emotional health and wellbeing problem, of which 3.3% are likely to have an anxiety disorder; 0.9% depression, 5.8% conduct disorder and 1.5% a severe hyperkinetic condition.
- Based on national modelling we estimated that in Walsall, approximately 2,970 preschool children are likely to have a mental health disorder and 4,380 school-age children (5-16 years). Boys (11.4%) are more likely to have experienced or be experiencing a mental health problem than girls (7.8%), but young men 15-17 years and young people from black and minority ethnic groups are least likely to access mental health support services.
- Hospital admissions as a result of self-harm in Walsall have increased in recent years, especially in young women.

Description	WCCG 2013/14	Best CCG's in England 2016/17	Opportunity for Saving / Outcome
£ per head of population			
Total Expenditure £			

WCCG Outcome Indicator Set Trajectories	2013/14	2014/15	2015/16	2016/17	2017/18
Patient experience of community mental health services					

Strategic Objectives and priority

- See Section 1.4 of this plan

National Guidance

- See references at Appendix 4

Where we want to be

- The recommendations identified in the 2015 Walsall Public Health Children and Young People's Emotional Wellbeing and Mental Health Needs Assessment, the principles and priorities and actions in the Walsall Children and Young People Mental Health and Wellbeing Strategy and Transformation Plan are implemented through a planned timescale to bring about transformation of children and young people's mental health and wellbeing services.
- The Walsall Children and Young People Mental Health and Wellbeing Strategy and Transformation Plan have been incorporated into a Joint Strategy for Mental Health and Wellbeing of People of All Ages Living in Walsall which is agreed with all partners.
- An integrated tiered approach to mental health across the whole health and social care system is implemented.
- Understanding about how to maintain good mental health and wellbeing and challenge the stigma attached to having mental health problems is improved across the population.
- 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.
- 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) is provided in partnership with NHS England.
- Children and young people with mental health problems remain in or as near to Walsall as they wish in a genuinely safe placement with support to access education and relevant social activities.
- A fully integrated model of mental health care with robust pathways with all partners working effectively together is implemented for children and young people.

Our plans	16/17	17/18	Investment £k +	Investment £k -
o Implement the actions in the Children and Young People's Mental Health and Wellbeing Transformation Plan including:	✓	✓		
o Develop performance data sets	✓	✓		
o Develop a single point of access	✓	✓		
o Increase capacity in specialist services to reduce waiting times and give timely access to support	✓	✓		
o Identify how to support partners around assessing and referring young people appropriately	✓	✓		

How we will measure success

- Performance against agreed measures as detailed in Appendix 2

What KPI's will we use to monitor progress?

- Operational plan, Local and Contractual measures as detailed in Appendix 3

Risks and Mitigating Actions

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

4.5 Disabilities and Carers Programme

Why is change needed?

- Transforming Care Programme
- Gain best value of placements
- Ensure parity of esteem and reduce health inequalities
- Support carers to continue caring

Description	WCCG 2013/14	Best CCG's in England 2016/17	Opportunity for Saving / Outcome
£ per head of population	£36.85	£21.14	£15.71
Total Expenditure £	£10,347,876	£5,935,820	£4,412,055
% LD with Down's Syndrome with TSH (LD002 / LD02)	91.38%	90.79%	-0.59%

WCCG Outcome Indicator Set Trajectories	2013/14	2014/15	2015/16	2016/17	2017/18

Strategic Objectives and Priority

- See Section 1.4 of this plan

National Guidance

- See references at Appendix 4

Where we want to be

Telecare, Disabilities, Health and Well Being

- 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
- An integrated Joint Funding protocol and policy
- 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
- 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

Transforming Care

- Reduce the number of people with learning disabilities and autism in Assessment and Treatment and Rehabilitation hospitals. In 16/17 this will equate to halving our 15/16 provision to 5 inpatient beds being utilised at any one time across all providers and 3 inpatient beds being utilised at any one time in 17/18.
- Further develop community provision that supports people with behaviours which challenge and complex health care in the community and prevents inpatient admissions and care breakdown. This will be developed and delivered over a 3 year period in partnership with Black Country colleagues and as approved by NHS England

- Review all health community services including nursing, therapies and medical to support hospital avoidance, early intervention and signposting to ensure people's needs are met within the community
- Decommission any remaining block arrangements in order that all inpatient beds are spot purchased from 01/04/16 with the intent to move to an approved provider framework during 2016/17.
- Ensure robust responses to actions and lessons learned from Care and Treatment Reviews which are embedded within processes and pathways of all providers and stakeholders
- Commence the move towards integration with the local authority for community learning disability services

Health Self-Assessment Framework and access to Mainstream Health Services

- Increase the number of people with learning disabilities that receive an annual health check in line with the Cardiff Health Check Tool
- Ensure all people with learning disabilities have a Health Action Plan which is reviewed frequently
- Development and Implementation of the Green Light Tool kit across Mental Health services for Adults with a Learning Disability and in addition, Adults with Autistic Spectrum Disorder(ASD). This intention impacts upon BCPFT, Dudley and Walsall MHT, Walsall Council and Walsall CCG

Confidential Inquiry into Premature Deaths

- Reduce health inequalities across primary and secondary health services for people with learning disabilities and ensure robust and prompt reporting and investigation across all agencies regarding sudden, premature and unexplained deaths
- Delivery of the findings from the Confidential Inquiry of Premature Deaths of people with Learning Disabilities and subsequent related reports.

Personalisation

- Increase the number of people with learning disabilities who have a personal health budget and direct payment
- Develop outcome focused support plans that maximise independence and access to social capital
- Empowering people and families through co-production of support plans, strategies and policies

Our plans	16/17		Investment £k +	Investment £k -
o Empowerment, Engagement and decision making	✓			
o Independent Advocacy (Care Act Compliance)	✓			
o Supporting and Developing the Voluntary and Charitable sectors	✓			
o Befriending Service for Autism	✓			
o Community breakthrough service for Autism	✓			
o Eye Clinic liaison and support and Sight Loss Register	✓			
o Befriending Service for Physical and Sensory Disabilities	✓			
o Supported Employment Service	✓			
o Disability Hub and Outreach	✓			775
o Summer Scheme	✓			
o Parents Project	✓			
o Housing Support	✓			
o SEND and Transition	✓			
o Older Peoples Transition	✓			
o Empowerment, Engagement and decision making	✓			
o Transforming Care – In Patient Beds Framework, Positive Behaviour and Community Intervention, Specialist health services review	✓			
o Carers Hub and Outreach				
o Carers and Care Act Compliance				

How we will measure success

- Performance against agreed measures as detailed in Appendix 2

What KPI's will we use to monitor progress?

- Operational plan, Local and contractual measures as detailed in Appendix 3

Risks and Mitigating Actions

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

4.6 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 2013/14	Best CCG's in England 2016/17	Opportunity for Saving / Outcome
£ per head of population – Primary Care			
Total Expenditure £ - Primary Care			
£ per head of population – Primary Prescribing			
Total Expenditure £ - Primary Prescribing			
£ per head of population – Community Care			
Total Expenditure £ - Community Care			
Complications associated with diabetes	106.30	100.37	-5.93
Diabetes and a foot examination and risk classification (DM012 / DM29)	90.63%	88.34%	-2.29%
Diabetes and Cholesterol 5.0 or less (DM004 / DM17)	80.49%	81.66%	1.17%
Diabetes and last blood pressure is 140/80 or less (DM003 / DM31)	80.68%	78.66%	-2.02%
Diabetes and last blood pressure is 150/90 or less (DM002 / DM30)	91.54%	91.75%	0.21%
Diabetes and last HbA1c is 59 mmol/mol (7.5%) or less (DM007 / DM26)	71.36%	70.01%	-1.36%
Diabetes and last HbA1c is 64 mmol/mol (8%) or less (DM008 / DM27)	78.27%	77.77%	-0.50%
Diabetes and last HbA1c is 75 mmol/mol (9%) or less (DM009 / DM28)	87.48%	87.16%	-0.32%
Diabetes and Proteinuria or Microalbuminuria on ACEi (DM006 / DM15)	95.57%	92.30%	-3.27%
Diabetes and record of retinal screening (DM011 / DM21)	91.12%	90.18%	-0.94%
Diabetes given Influenza Vaccine (DM010 / DM18)	94.75%	93.52%	-1.23%
Diabetes prevalence	8.89%	7.44%	-1.45%
Diabetes with albumin:creatine ratio (DM005)	87.68%	86.07%	-1.61%
Diabetes with dietary review (DM013)	91.01%	88.42%	-2.59%
Diabetes with structured education programme (DM014)	96.21%	95.22%	-0.99%
Hypothyroid Patients with TFT done (THYROID02)	94.73%	94.24%	-0.49%
All Patients on Hypothyroidism Register (THYROID01)	3.20%	3.29%	0.09%
Male diabetes asked about erectile dysfunction (DM015)	89.82%	86.93%	-2.89%
Male diabetes with erectile dysfunction and advice/assessment (DM016)	93.67%	93.97%	0.30%
Myocardial infarction, stroke and stage 5 chronic kidney disease in people with diabetes (ISR)	100.90	100.51	-39.47%

Description	WCCG 2013/14	Best CCG's in England 2016/17	Opportunity for Saving / Outcome
% acute stroke who receive thrombolysis	9.20%	12.19%	2.99%
% acute stroke who spend 90% or more of their stay on a stroke unit	76.70%	83.86%	7.16%
% AF with CHADS2 >1 and anti-coagulation drug therapy (AF004 / AF07)	83.30%	83.14%	-0.16%
% AF with CHADS2 1 and anti-coagulation drug therapy (AF003 / AF06)	99.45%	98.44%	-1.02%
% AF with stroke risk assessment (AF002 / AF05)	96.83%	97.61%	0.78%
% aged 40+ with BP in last 5 years (BP001)	98.66%	94.84%	-3.82%
% follow-up assessment 4 to 8 months after initial admission for stroke	40.40%	15.13%	-25.27%
% heart failure due to LVD with additional beta-blocker (HF004 / HF04)	91.12%	92.10%	0.98%
% hypertension diagnosed given lifestyle advice (CVD-PP002 / PP02)	85.36%	82.34%	-3.02%
% myocardial infarction treated variously (CHD006 / CHD14)	97.26%	96.99%	-0.27%
% new hypertension with cardiovascular risk assessment (CVD-PP001 / PP01)	96.39%	92.47%	-3.91%
% peripheral arterial disease on aspirin (PAD004 / PAD02)	93.79%	91.79%	-2.00%
% peripheral arterial disease with BP 150/90 or less (PAD002 / PAD03)	91.57%	90.50%	-1.07%
% peripheral arterial disease with cholesterol <5.0mmol/l (PAD003 / PAD04)	82.39%	81.98%	-0.41%
% stroke admitted to an acute stroke unit within 4 hours	57.80%	59.46%	1.66%
% stroke discharged from hospital with a joint health and social care plan	96.50%	72.98%	-23.52%
% stroke referred for further investigation (STIA002 / STK13)	88.60%	88.14%	-0.46%

% stroke with anti-platelet agent (STIA007 / STK12)	97.35%	96.43%	-0.92%
Cardiovascular disease prevalence	12.87%	11.60%	-1.26%
CHD and BP 150/90 or less (CHD002 / CHD06)	92.95%	92.31%	-0.64%
CHD and Cholesterol 5.0mmol/l or less (CHD003 / CHD08)	83.34%	83.60%	0.26%
CHD given flu jab in last season (CHD004 / CHD12)	96.57%	94.19%	-2.38%
CHD taking Aspirin or eqivalent (CHD005 / CHD09)	96.07%	95.62%	-0.45%
Coronary heart disease prevalence	7.43%	5.67%	-1.75%
DSR (PYLL) from Cerebrovascular diseases amenable to healthcare	303.30	237.78	-65.51
DSR (PYLL) from Ischaemic heart diseases amenable to healthcare	1013.60	694.08	-319.51
Heart failure taking ACEi (HF003 / HF03)	99.60%	99.06%	-0.54%
HF and echo or specialist confirmation (HF002 / HF02)	95.12%	95.42%	0.30%
Hypertension aged <79yr and BP 140/90 or less (HYP003)	78.09%	75.48%	-2.61%
Hypertension aged 16-74 and inactive and brief intervention (HYP005)	95.31%	91.54%	-3.78%
Hypertension aged 16-74 and physical activity assessment (HYP004)	86.70%	79.03%	-7.68%
Hypertension and BP 150/90 or less (HYP002 / BP05)	84.97%	83.16%	-1.81%
Hypertension prevalence	32.26%	30.27%	-1.99%
Under 75 mortality from cardiovascular disease (per 100,000 females)	45.40	43.19	-2.20
Under 75 mortality from cardiovascular disease (per 100,000 males)	122.60	90.57	-32.03
Under 75 mortality from cardiovascular disease (per 100,000 persons)	83.90	66.85	-17.04
Mortality within 30 days of hospital admission for stroke	0.90	1.17	0.27
Patients on CHD Register (CHD001 / CHD01)	4.05%	3.35%	-0.70%
Patients on heart failure Register (HF001 / HF01)	0.96%	0.73%	-0.24%
Patients on hypertension register (HYP001 / BP01)	15.68%	13.86%	-1.81%
Patients on Stroke / TIA Register (STIA001 / STK01)	1.78%	1.73%	-0.05%
Rate of potential years of life lost per 100,000 - Cerebrovascular Diseases	303.30	237.78	-65.51
Rate of potential years of life lost per 100,000 - Ischaemic Heart Disease	1013.60	694.08	-319.51
Register of patient with atrial fibrillation (AF001 / AF01)	1.58%	1.58%	0.00%
Register of peripheral arterial disease (PAD001 / PAD01)	0.66%	0.66%	-0.01%
Stroke / TIA and BP 150/90 or less (STIA003 / STK06)	91.05%	89.88%	-1.18%
Stroke / TIA and chol 5.0 or less (STIA005 / STK08)	79.11%	79.31%	0.19%
Stroke / TIA and chol check in 15 months (STIA004 / STK07)	90.64%	88.81%	-1.83%
Stroke / TIA given flu vaccine (STIA006 / STK10)	95.54%	93.05%	-2.49%
Stroke prevalence	3.10%	2.49%	-0.61%
Varicose Veins, EQ-5D, Health Gain	*	0.10	2.99%
% acute stroke who receive thrombolysis	9.20%	12.19%	7.16%
% acute stroke who spend 90% or more of their stay on a stroke unit	76.70%	83.86%	-0.16%
% AF with CHADS2 >1 and anti-coagulation drug therapy (AF004 / AF07)	83.30%	83.14%	-1.02%
% AF with CHADS2 1 and anti-coagulation drug therapy (AF003 / AF06)	99.45%	98.44%	0.78%
% AF with stroke risk assessment (AF002 / AF05)	96.83%	97.61%	-3.82%
% aged 40+ with BP in last 5 years (BP001)	98.66%	94.84%	-25.27%
% follow-up assessment 4 to 8 months after initial admission for stroke	40.40%	15.13%	0.98%
% heart failure due to LVD with additional beta-blocker (HF004 / HF04)	91.12%	92.10%	-3.02%
% hypertension diagnosed given lifestyle advice (CVD-PP002 / PP02)	85.36%	82.34%	-0.27%
% myocardial infarction treated variously (CHD006 / CHD14)	97.26%	96.99%	-3.91%
% new hypertension with cardiovascular risk assessment (CVD-PP001 / PP01)	96.39%	92.47%	-2.00%
% peripheral arterial disease on aspirin (PAD004 / PAD02)	93.79%	91.79%	-1.07%
% peripheral arterial disease with BP 150/90 or less (PAD002 / PAD03)	91.57%	90.50%	-0.41%
% peripheral arterial disease with cholesterol <5.0mmol/l (PAD003 / PAD04)	82.39%	81.98%	1.66%
% stroke admitted to an acute stroke unit within 4 hours	57.80%	59.46%	-23.52%
% stroke discharged from hospital with a joint health and social care plan	96.50%	72.98%	-0.46%
% stroke referred for further investigation (STIA002 / STK13)	88.60%	88.14%	-0.92%
% stroke with anti-platelet agent (STIA007 / STK12)	97.35%	96.43%	-1.26%
Cardiovascular disease prevalence	12.87%	11.60%	-0.64%
CHD and BP 150/90 or less (CHD002 / CHD06)	92.95%	92.31%	0.26%
CHD and Cholesterol 5.0mmol/l or less (CHD003 / CHD08)	83.34%	83.60%	-2.38%
CHD given flu jab in last season (CHD004 / CHD12)	96.57%	94.19%	-0.45%
CHD taking Aspirin or eqivalent (CHD005 / CHD09)	96.07%	95.62%	-1.75%
Coronary heart disease prevalence	7.43%	5.67%	-65.51
DSR (PYLL) from Cerebrovascular diseases amenable to healthcare	303.30	237.78	-319.51
DSR (PYLL) from Ischaemic heart diseases amenable to healthcare	1013.60	694.08	-0.54%
Heart failure taking ACEi (HF003 / HF03)	99.60%	99.06%	0.30%
HF and echo or specialist confirmation (HF002 / HF02)	95.12%	95.42%	-2.61%
Hypertension aged <79yr and BP 140/90 or less (HYP003)	78.09%	75.48%	-3.78%

Hypertension aged 16-74 and inactive and brief intervention (HYP005)	95.31%	91.54%	-7.68%
Hypertension aged 16-74 and physical activity assessment (HYP004)	86.70%	79.03%	-1.81%
Hypertension and BP 150/90 or less (HYP002 / BP05)	84.97%	83.16%	-1.99%
Hypertension prevalence	32.26%	30.27%	-2.20
Under 75 mortality from cardiovascular disease (per 100,000 females)	45.40	43.19	-32.031
Under 75 mortality from cardiovascular disease (per 100,000 males)	122.60	90.57	-17.04
Under 75 mortality from cardiovascular disease (per 100,000 persons)	83.90	66.85	0.272
Mortality within 30 days of hospital admission for stroke	0.90	1.17	-0.70%
Patients on CHD Register (CHD001 / CHD01)	4.05%	3.35%	-0.24%
Patients on heart failure Register (HF001 / HF01)	0.96%	0.73%	-1.81%
Patients on hypertension register (HYP001 / BP01)	15.68%	13.86%	-0.05%
Patients on Stroke / TIA Register (STIA001 / STK01)	1.78%	1.73%	-65.51
Rate of potential years of life lost per 100,000 - Cerebrovascular Diseases	303.30	237.78	-319.51
Rate of potential years of life lost per 100,000 - Ischaemic Heart Disease	1013.60	694.08	0.00%
Register of patient with atrial fibrillation (AF001 / AF01)	1.58%	1.58%	-0.01%
Register of peripheral arterial disease (PAD001 / PAD01)	0.66%	0.66%	-1.18%
Stroke / TIA and BP 150/90 or less (STIA003 / STK06)	91.05%	89.88%	0.19%
Stroke / TIA and chol 5.0 or less (STIA005 / STK08)	79.11%	79.31%	-1.83%
Stroke / TIA and chol check in 15 months (STIA004 / STK07)	90.64%	88.81%	-2.49%
Stroke / TIA given flu vaccine (STIA006 / STK10)	95.54%	93.05%	-0.61%
Stroke prevalence	3.10%	2.49%	2.99%
Varicose Veins, EQ-5D, Health Gain		0.10	

Description	WCCG 2013/14	Best CCG's in England 2016/17	Opportunity for Saving / Outcome
% asthma with assessment of asthma control (AST003 / ASTHMA09)	77.11%	75.72%	-1.39%
% asthma with measures of variability or reversibility (AST002 / ASTHMA08)	90.83%	88.24%	-2.60%
% COPD and dyspnoea with oxygen saturation (COPD005)	96.00%	94.41%	-1.59%
% COPD confirmed by post bronchodilator spirometry (COPD002 / COPD15)	92.14%	90.76%	-1.38%
% COPD who had flu vaccine (COPD006 / COPD08)	97.34%	96.19%	-1.15%
% COPD with FeV1 (COPD004 / COPD10)	88.39%	86.51%	-1.89%
% COPD with review, including dyspnoea score (COPD003 / COPD13)	91.96%	89.91%	-2.06%
% Maternal smoking at delivery	17.30%	12.09%	-5.21%
% teenage asthma with smoking status (AST004 / ASTHMA10)	89.26%	88.81%	-0.45%
COPD prevalence	5.07%	3.60%	-1.47%
DSR (PYLL) from Respiratory diseases amenable to healthcare	151.40	145.86	-5.53
Emergency admissions: lower respiratory tract infections. Girls	285.90	322.26	36.35
Emergency admissions: lower respiratory tract infections. Boy	488.50	441.74	-46.75
Emergency admissions: lower respiratory tract infections. Persons	389.70	383.47	-6.22
Under 75 mortality from respiratory disease (per 100,000 females)	21.90	25.35	3.45
Under 75 mortality from respiratory disease (per 100,000 males)	34.60	33.08	-1.52
Under 75 mortality from respiratory disease (per 100,000 persons)	28.30	29.21	0.910
Patients on Asthma register (AST001 / ASTHMA01)	6.39%	5.94%	-0.44%
Rate of potential years of life lost per 100,000 - Respiratory Diseases	151.40	145.86	-5.53
Register of patients with COPD (COPD001 / COPD14)	2.40%	1.83%	-0.57%

WCCG Outcome Indicator Set Trajectories	2013/14	2014/15	2015/16	2016/17	2017/18
Proportion of people feeling supported to manage their condition	63%	66%	66%	66%	66%
Health related quality of life for people with long term conditions	0.711	0.729	0.744	0.760	0.775
Under 75 mortality rate from cardiovascular disease	73	70	70	68.9	68.0
Under 75 mortality rate from respiratory disease	22	25	22	22.0	21.7

Strategic Objectives

- See Section 1.4

National Guidance

- See references at Appendix 4

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
- Better patient access to a 7-day GP service through a 'hub' model of provision
- Strengthen patient and public participation in primary care commissioning
- Ability to access patient records across primary care hubs to improve quality of care
- More flexible patient appointments available in general practice
- Extended range of services available in a primary care setting
- Increased use of systems in primary care to manage patient demand and ensure efficient use of available NHS resources
- Increased use of skill mix in general practice to ensure the patient sees the right clinician at the right time
- Support the sustainability of primary care and reduce unnecessary bureaucracy and pressure on general practice
- Support new ways of working and new models of care
- Primary care services delivered from modern, safe, accessible premises

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

o Extend access to and availability of GP services o Increase the uptake and use of technology in general practice o Increase the range of services available in primary care setting o Work with HEE and Walsall LMC to address workforce issues and increase clinical capacity in primary care o Support vulnerable GP practices o Utilise the Primary Care Transformation fund to transform general practice premises				

How we will measure success

- Performance against agreed measures as detailed in Appendix 2

What KPI's will we use to monitor progress?

- Operational plan, local and contractual measures as detailed in Appendix 3

Risks and Mitigating Actions

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

4.7 Provider Management and Development

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

4.7.1 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 2015-16 contracts, an example of some of the key findings are illustrated in **Figure 21 and Figure 22**. 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.

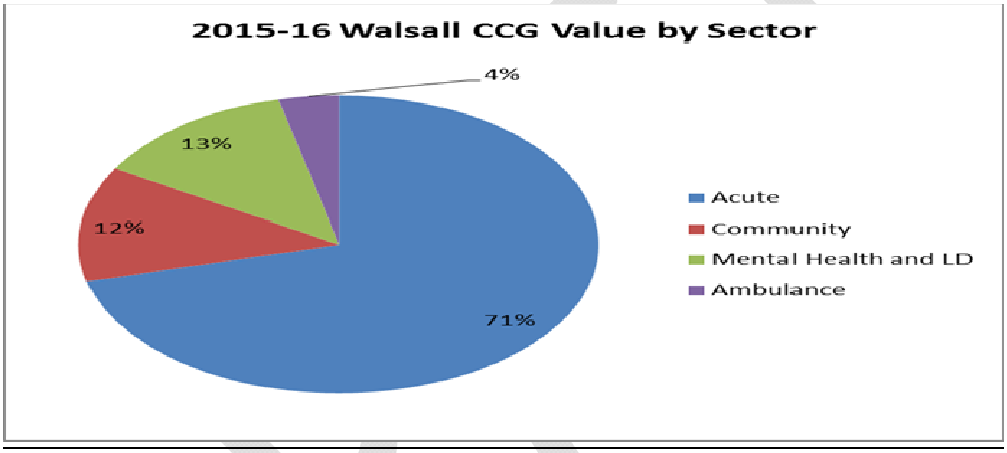


Figure 21 - 2015-16 NHS Contract Value by Sector

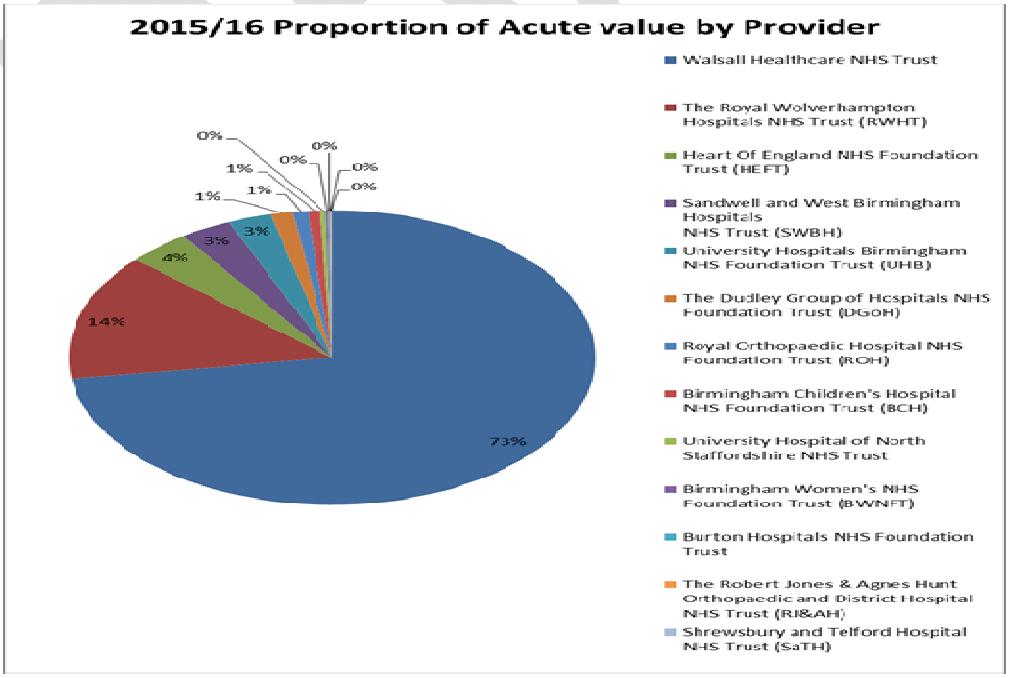


Figure 22 - NHS Acute Contract Value by Provider

4.7.2 Contract Management

As illustrated in **Figure 23**, 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.

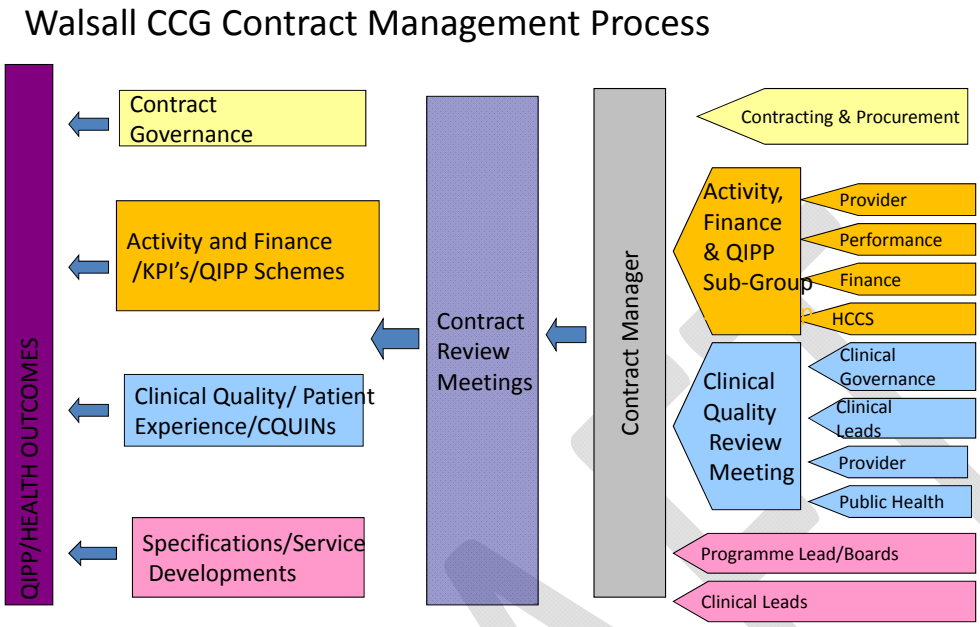


Figure 23- Walsall CCG – Contract Management Process

4.7.3 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 2016-17 in helping shape WCCG's approach to the market in areas that it recognises that there is a need for change.

4.7.4 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:

- 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 24**, 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.

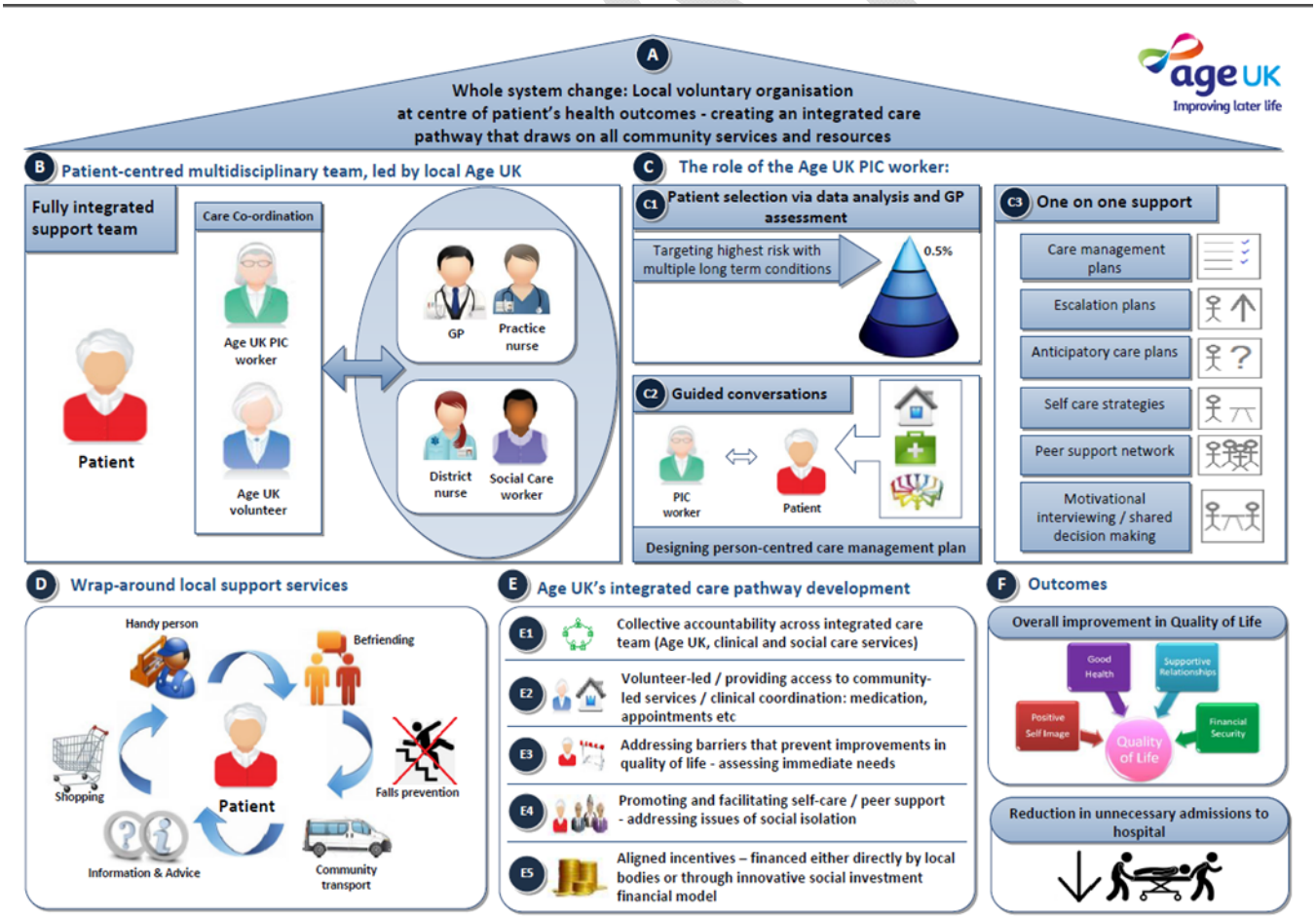


Figure 24 - Community Partners Project with Age UK

As illustrated in Section 2.4.1, WCCG remains committed to developing a strong primary care sector and is supporting GP Federations to develop. 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.

4.8 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.

Those services planned to be subject to formal procurement at this stage are:

- Pain Management
- Stroke / Neuro Rehabilitation
- ECG Interpreting – Telehealth
- Community ENT
- Home Oxygen Services (Regional Procurement)
- NHS111 (Regional Procurement)
- MSK
- Adult complex needs rehabilitation for mental health and LD.

The above is not a definitive list as other services may be identified as suitable for procurement as QIPP plans are developed. To support this, the CCG is currently conducting a review of procurements and QIPP programmes being planned or conducted by other CCG's across the country to identify any further areas which the CCG may wish to review and, where applicable, conduct procurement exercises in order to improve patient experiences and gain improved value for money.

Additionally, the CCG will be looking to use new models of contracting, such as Alliance and Lead Provider contracts, to support the integration and transformation agenda. The CCG is currently finalising an "Umbrella Agreement" to ensure that all of the providers within the urgent and emergency care pathway work in an integrated way and particularly support the integration of out of hours and 111 services. This approach is due to be fully operational in 2016-17 and, where applicable will be extended to other areas of service.

4.9 Personal Health Budgets (PHB)

As part of the personalized care Agenda the CCG is working to specify as part of its contracts with providers not only the priorities that follow but also the requirement that patients have access to a named accountable consultant.

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.

During 2016/17, 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.

4.10 Carers

During 2016/17, WCCG and WMBC will be delivering the 16 Commitments for Carers as agree regionally to ensure we are Care Act and Children and Families Act Compliant, we will create capacity utilising carers BCF funding to establish a baseline of Carers Awareness and involvement across the Health Economy in readiness for a new integrated National Carers Strategy later in 2016.

Section 5
Preparing for change

5.1 CCG Organizational Development

In recognition of the challenges within the Walsall healthcare system the CCG has responded by making some major changes and proactively developing the organisation: two additional Executive Directors have been employed; the clinical leadership has been revised; and a new selection process for the CCG Chair and Clinical Executives is successfully underway.

At the same time Walsall Council has employed a new Director of Health and Social Care and two new heads of commissioning. We have grasped this unique opportunity and together we have agreed to undertake a truly integrated development programme which will commence in early April.

These changes have increased our capability and capacity to maximise both the value that the patient derives from their own care and treatment and the value the whole population derives from the investment in their healthcare.

The CCG was successful in its submission to take full delegation for primary care medical services and this was reflected in the creation of a new primary care and integration directorate that includes the medicines management function that has always had a strong service delivery record.

A management of change process was carried out during 2015/16 and focused on strengthening both our commissioning function and clinical leadership. The introduction of the Clinical Executives supports the Executive Director posts in aligning accountability for each directorate, ensuring that dedicated clinical leadership is equally available to the whole of organisation.

5.2 Provider Workforce

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

Recent CQC report has rated WHT as an inadequate provider and the well led domain is also rated as inadequate. The report particularly highlights significant workforce related issues in the areas of maternity and Emergency department, although other workforce related issues are also evident within the report.

Immediate work has begun to address the apparent shortfall in maternity services, with birth: midwife ratios improving from 1:37 to 1:32 currently, CCG are leading a more strategic maternity services review to address the shortfall and mitigation is in place for immediate deficit.

Closer alignment with Deanery is now in place and the CQC oversight group with CCG representation will also be reviewing workforce capacity within the trust. WHCT workforce reports are a monthly feature of CQR, with significant challenge to performance being evidenced from CCG.

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.

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

To deliver the scale and quality of enhanced primary and community based care, increased numbers of relevant staff groups will be needed. A Primary Care Workforce Task and Finish Group has been established by WCCG to support the development of a sustainable workforce to enable the delivery of quality primary care.

Currently WCCG play an active part in the system wide Healthy Walsall Partnership Board which brings together commissioners and providers in a partnership approach to transformation. The Board has established 3 key work streams, Staying Well at Home, Rapid Assessment and Treatment and Getting Home Quickly and Safely. The impact on the workforce with regards roles and competencies will be addressed as this work develops.

WCCG are also seeking involvement in the Leading Integrated Care Workforce Solutions Programme which has been established to support system leaders in addressing the workforce issues that are present in their local health and social care economy. This programme is aligned with the approach to system workforce planning which is being developed by the Integrated Care Transformation Theme, as part of the work led by Health Education England.

5.3 Informatics

A priority is the development of an IT strategy.

The strategy will focus on a digital roadmap working with partner organisations in Walsall to identify opportunities leading to a health and care economy that is 'paper free at the point of care' by 2020. Stakeholders in the Walsall Digital Footprint include Dudley and Walsall Mental Health Partnership NHS Trust, Walsall Healthcare NHS Trust, the constituent General Practices and Walsall Council. Terms of reference have been developed for the steering group providing the required governance.

The information revolution harnessed as a key enabler with a strategic roadmap that by 2020 all electronic health records would be fully interoperable enabling patient records to be paperless.

Bids are developed to access the available national funding to deliver transformation initiatives, with the following schemes in development or delivery working towards a paperless NHS:

- Electronic Document Management Solution – Docman.
- Mobile working solution.
- Telehealth.
- GP2GP.
- Electronic Prescription Services release 2.
- Integrated Care Record.

In addition, ensuring the information captured within clinical care settings is appropriately and securely shared not only to enhance care but also provide management information to support secondary usage such as commissioning and public health activities.

Work will continue on gaining maximum value from the outsourced CCG IT and GPIT service level agreements, and continued alignment of the IT strategy and IT service to the organisational strategic objectives.

5.4 Estates

Walsall CCG has operated a Capital Review group for the last 18 months with representation from NHS England and NHS Property Services. The CCG has established a strategic estates forum alongside Wolverhampton CCG and involving representation from Walsall Healthcare NHS Trust, NHS Property Services and Community Health Partnerships. The work of the forum is informed by the associated service plans and housing development plans of Walsall Council. The CCG has also recognised the need to manage strategic estates issues and subsequently established in-house estates capacity in 2015. A senior officer is joining the Department of Health's strategic estates planning group.

This estates strategy will be underpinned by the CCG's Operational Plan 2015 - 2017 and NHS England's Five Year Forward View. It also considers population growth, estates development and maximising effective utilisation, with an aim to reduce void areas in funded buildings. As well as the potential rationalisation of underutilised, or unsuitable, premises. The strategy has been informed by a comprehensive utilisation survey of all Walsall general practice surgeries, which was undertaken during 2015.

The overarching objective of this strategy is to provide an evidence base and clear direction, which will deliver change. The supporting objectives of this strategy are to:

- Review the existing primary care estate, including condition;
- Articulate a vision for the future, based on the CCG's priorities;
- Identify priority estate projects, which require further analysis; and
- Have a clear understanding of the next steps and actions required.

In terms of finalising the strategy, the CCG will consider the key drivers and challenges in **Table 15** below:

Drivers for Change	Estates Impact
Population growth	Additional GP practices incorporated within community health facilities wherever possible. Integration of GP and community care at scale, provided through multi-specialty centres.
The financial challenge across the health economy: must be addressed, but the quality of service must also be maintained	Estate savings and efficiencies needed to assist reduction in spend on infrastructure. Modern, purpose-built premises with bookable spaces for use by many providers will ensure quality of provision.
Need to drive efficiencies via closer work with	Integrated, multi-specialty healthcare centres provide potential solution, including greater efficiencies in

Drivers for Change	Estates Impact
provider organisations	administrative services.
Pockets of multiple deprivation, with high levels of high-risk behaviours and multiple conditions	Use of the estate for preventative measures can be achieved through reconfiguration. Multi-speciality centres needed for frail elderly and those with Long Term Conditions/Complex needs.

Table 15 – Key Drivers and Challenges

5.5 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 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 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.

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.

5.6 Patient involvement and engagement

5.6.1 Engagement

As GPs, and as commissioners, it is important to us to design and commission services that meet the needs of our patients and provide the best health outcomes, but also to engage all our communities in preventative health services, to improve health overall and reduce health inequalities.

WCCG recognises that engagement and involvement is a key part of how services are planned, commissioned, delivered and reviewed. Throughout 2015/16 we have continued to develop robust methods of listening, engaging and involving patients and the public which have ensured that their insight and experiences have been acted upon at all stages of the commissioning cycle and have influenced our commissioning decisions. We have successfully engaged stakeholders, patients and the public in a range of activities to facilitate community involvement in how we design, deliver and improve local health services.

An illustrative example of this is the Urgent Care Review and public consultation which 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. Since then a new urgent care centre building has been commissioned in Walsall town centre. Patients and community groups played a key part in the planning of the new building, which includes layout, design, and access for people with disabilities, waiting rooms and signage. Members from Health watch Walsall, Youth of Walsall, Carer User Support Partnership Group (CUSP), Walsall Disability Forum and patient representatives were given an hour-long guided tour of the new facilities prior to its opening and specific actions have been carried out as a result of the feedback we received.

Walsall CCG is now engaging with staff and patient representatives on its Communications and Engagement Strategy for 2016 -2019. The draft strategy recognises the need to embed the six principles of engagement and involvement for patients, carers, and local communities when looking at new care models as follows.

- Care and support is person-centred: personalised, coordinating and empowering.
- Services are created in partnership with patients and diverse communities.
- There is a focus on reducing health inequalities.
- Carers are supported.
- Voluntary, community and social enterprise sectors are key enablers.
- Volunteering and social action are key enablers.

Service changes for new care models will be required at times to deliver the quality services that we want to commission for local people. Walsall CCG will continue to work in partnership with patients, local people and the community, to co-design local new care models. We will make sure consultations:

- Are carried out in line with relevant legislation and guidance, and engage with Walsall Health Overview and Scrutiny Committee to help determine the level of consultation required.
- Relate to proposals developed through clinical and public engagement.
- Are supported with clear, plain English communication materials.
- Seek the views of local people and stakeholders in a variety of appropriate ways, paying particular attention to any identified 'hard to reach' communities or groups.

WCCG will continue to reach out to and work with a wide range of citizens –which reflect the diversity of Walsall. We will engage with diverse groups, the hard to reach e.g. homeless people, gypsies and travellers, non-English speakers to have the necessary conversations about health, wellbeing, prevention and services.

We will do this by making it simple for people to be involved in the work of the CCG by providing support to clearly articulate the views of patients, public and carers in our commissioning plans, and by developing a range of communication and engagement materials that facilitate the participation of all parts of our community. This includes producing material in different languages and in 'easy read'.

WCCG will identify and involve different groups in order to improve their access to services, experience of services and health and wellbeing outcomes including carers, people with the worst health, health outcomes and experiences of care, including as a result of poverty, deprivation, unemployment, poor housing etc. We will do this by continuing to work with carers, voluntary organisations, community and social enterprise sector, that support these groups in Walsall

One of the ways Walsall CCG promotes community involvement is through Patient Participation Groups (PPGs). We ensure that the local intelligence gained from these groups' links into the commissioning process. Around forty GP surgery based Patient Participation Groups are so far established in Walsall,

many of which we have supported over the last twelve months and continue to do so. We also have a strong and proactive Patient and Participation Liaison (PPLG) that consists of representatives from PPGs across Walsall and provides a forum for networking and sharing best practice. The intention is that all active PPGs are represented on the group but more work needs to be done to ensure it is more representative of Walsall and the four localities.

Key deliverables for 2016 -2017 are:

- Improve and expand the use of our online platforms to assist communication, engagement and involvement with patients using our website, online surveys, social media and online PR from March 2016 onwards.
- Strengthen our current strands of public engagement and involvement and link them up to form a model of engagement by January 2017.
- Develop a role for patient representatives to be more involved on key CCG work streams by April 2016.
- Continue to support the development of our network of Patient Participation Groups (PPGs), enabling them to support improvements in their practices and in CCG campaigns including health and wellbeing, PPG awareness week and the winter campaigns by March 2016
- Deliver a programme of marketing campaigns including the 'self-care week' (November 2016) and winter campaigns (October 2016 and January 2017) to educate and help to encourage a cultural change around the use and access to local health services e.g. A&E and urgent care, and stimulate self-care and prevention of actions leading to poor health.
- Re-launch and grow our patient membership from March 2016, using segmentation to target patients based on their interest and priorities.
- Support communications between PPGs and the locality network from January 2016.
- Promote trust and transparency by ensuring that all outcomes of engagement and involvement are fed back to stakeholders, partners and the public using a range of communications e.g. online and off line.

5.6.2 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 is the development treatment plans with the patient and carers – see 2.3.2 of the plan
- Improving Access to psychological Therapies support – see 2.3.1 of the plan
- 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.

5.7 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 currently undertaken through the Birmingham, Solihull and Black Country Area Team for the West Midlands with the total value of specilaised commissioning services for Walsall totalling £61m.

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 and the CCG both in its own right and through the wider Black Country and West Birmingham footprint and STP will be seeking to have a more integrated approach to specialised commissioning so as to ensure that there is a joined up approach to locally commissioned services and a good understanding of the interdependencies between the two types of service. This will require improved communication between commissioners.

Where applicable, the CCG will consider the delegation of specialised commissioning where this is felt to be in the interests of Walsall Patients. The CCG is aware of previous discussions relating to the potential delegation of Renal, Bariatric Surgery, Specialised Wheelchairs and Neurology outpatients services and is willing to enter further discussions, either at a local or Black Country and West Birmingham level, regarding these or other services.

5.8 Commissioning Support Services

For over two years the CCG has worked in partnership with the other 6 CCGs in the Birmingham, Solihull and Black Country to manage and procure commissioning support services and has indeed project managed this activity. This has culminated in the award of new contracts for commissioning support services with Arden and GEM CSU (end to end services and IFR service) and Midlands and Lancashire (BI service).

This contract is now at mobilisation stage with the new contracts due to commence on 1st April 2016 and therefore during 2016-17 the CCG's focus will be on:

- Ensuring the smooth transition of end to end and the IFR service to the new provider.
- Developing a strong working relationship with the providers to ensure that there is a full understanding of the CCG's requirements.

- Establish robust contract monitoring arrangements including co-ordination with the other CCGs so that a consistent approach is applied.
- Exploring ways in which the providers can support the service transformation agenda in Walsall.

Section 6
Appendices

Programme Budgeting category	Saving £ '000									Responsible Programmes - Allocated by the greatest opportunity Less Current Worked Up QIPP								
	Transformational Schemes	Worked up Schemes			Transactional Schemes	Total Currently Identified QIPP	Areas of Concern Savings (AOC)	Option 2		Prescribing	Mental Health	Disabilities & Carers	Elective	Unscheduled	CHC	Primary / LTC & Community	Running Costs	Total
		Disinvest	Re-Invest	Net Saving				AOC - Pro rata QIPP Target	QIPP Req'd less Current									
01.Infectious diseases							£428	-£131	-£131					-£131				-£131
02.Cancers and tumours																		
03.Disorders of blood							£879	-£269	-£269				-£269					-£269
04.Endocrine, nutritional and metabolic problems							£940	-£288	-£288							-£288		-£288
05.Mental health disorders		-£1,010	£805	-£205	-£522	-£727	£8,437	-£3,313	-£2,586		-£2,586							-£2,586
06.Problems of learning disability					-£775	-£775		-£775										
07.Neurological							£7,529	-£2,308	-£2,308							-£2,308		-£2,308
08.Problems of vision							£2,069	-£634	-£634				-£634					-£634
09.Problems of hearing							£793	-£243	-£243				-£243					-£243
10.Problems of circulation							£971	-£298	-£298					-£298				-£298
11.Problems of the respiratory system		-£1,171	£857	-£314		-£314	£1,111	-£655	-£341							-£341		-£341
12.Dental problems																		
13.Problems of the gastro intestinal system								-£611	-£611					-£611				-£611
14.Problems of the skin							£146	-£45	-£45				-£45					-£45
15.Problems of the musculoskeletal system		-£146	£115	-£31	-£990	-£1,020	£4,499	-£2,399	-£1,379				-£1,378					-£1,378
16.Problems due to trauma and injuries																		
17.Problems of the genito urinary system							£3,132	-£960	-£960					-£560		-£400		-£960
18.Maternity and reproductive health																		
19.Conditions of neonates																		
20.Adverse effects and poisoning							£1,035	-£317	-£317					-£317				-£317
21.Healthy individuals																		
22.Social care needs																		
23.Other*		-£134	£70	-£64	-£4,981	-£5,045		-£5,045										
Prescribing					-£2,250	-£2,250	£6,752	-£4,319	-£2,069	-£2,069								-£2,069
Total Saving		-£2,462	£1,847	-£614	-£9,518	-£10,132	£38,722	-£22,611	-£12,479	-£2,069	-£2,586		-£2,570	-£1,917		-£3,336		-£12,479

Required						-£22,000			
Short Fall						-£11,868			

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

Operational Plan – National Guidance & reference documents

General

Five Year Forward View
The Forward View into Action: Planning for 2016/17
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

Operational Plan – National Guidance & reference documents

Think Autism 2014

National Commissioning for Quality Learning Disability Health Self-Assessment Framework (LD HSAF)

Equality Act 2010

Mental Capacity Act 2005

Transforming Care Programme

NHS Commitment to Carers 2014

Physical Disability and Sensory Impairment (PDSI) Strategy

Autism Strategy and Statutory guidance

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

CCG Outcome Indicators

Primary Care Web Tool