

**TELFORD AND WREKIN
CLINICAL COMMISSIONING GROUP**

OPERATIONAL PLAN 2012/13

(work in progress)



*Care of Telford and Wrekin
Every patient experience matters - Every clinician is involved*

"Telford and Wrekin Clinical Commissioners will deliver high quality, equitable, safe and locally driven care. Despite our finite resources, patients and clinicians together will strive for the best possible healthcare in Telford and Wrekin".

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Foreword

The Health and Social Care Bill proposes substantial change to the way the NHS is organised. Even before it has passed onto the Statute Book, there has been a transformation in the way the NHS is being run. Clinical Commissioning Groups (CCGs), led by clinicians are developing and will soon enter into a year shadowing the function of PCTs.

In setting up, CCGs are planning their structures and their needs for development. But they also have to keep up the day to day work of commissioning services. Further, there is the financial challenge summarised by the need to deliver £20Bn savings across the UK by 2015.

Annually, the Department of Health considers the priorities for activity and articulates these in the Operating Framework. There are similar plans presented by Strategic Health Authorities. Equally, as well as demonstrating competence for its future role, the CCG needs to articulate how it is going to operate in the coming year. This is set out in this document, our Operating Plan.

This year, pre-authorisation, the document is primarily aimed at bodies involved in the authorisation of the CCG. In future years, the Operating Plan will have a broader audience that includes all stakeholders in the CCG.

The nature of this plan means that it has a short term view, covering the coming year. Work also continues on long term 'System Planning' alongside this and it is the System Plan as well as the Joint Strategic Needs Assessment (JSNA) that will inform the annual revisions of the Operating Plan over the coming years.

The text describes how this plan sits at the head of a suite of plans that set out, collectively, how the CCG is going to deliver its statutory roles in 2012/13. In this sense, the document and the accompanying plans are operational in nature. However, we have tried to present them so as to demonstrate how the CCG will be transformational as well in this year of significant change to the healthcare economy in Telford and Wrekin.

Dr Mike Innes
Chair - Telford and Wrekin Clinical Commissioning Group

1. Introduction

This document is one of five documents collectively forming the Telford and Wrekin Clinical Commissioning Group’s (CCG) **Operational Plan** which details our priorities and activities in the coming year (2012/13) and how they are going to be addressed. This document clarifies the priorities of the CCG, to ensure that there is clear understanding of the challenges to be addressed here in Telford and Wrekin; the specific priorities the CCG has set and the deliverables under each target. The diagram below clarifies how these documents work together to deliver the Strategic Development Plan.



As there is significant cross-departmental impact on the delivery of the priorities, plans created by one part of the organisation inevitably have implications for other parts. The five documents above are written to integrate with each other and should be read in conjunction to provide an overall picture of the deliverables of the CCG. This document is the Operational Plan:



2. Telford and Wrekin CCG Priorities

The CCG has established 4 priorities and associated deliverables relating to each, these are:

1. Increasing Life Expectancy & Reducing Health Inequalities

Deliverables

- Reducing premature mortality from cardiovascular disease by further improving the management and treatment of CVD in primary care
- Reducing premature mortality from cancer
- Meeting the needs of the ageing population, specifically around mental health and dementia services
- Addressing long term conditions management and treatment, specifically around COPD and Diabetes
- Improving life chances for children and young people and addressing teenage pregnancy rates

2. Encouraging Healthier Lifestyles

Deliverables

- Addressing the Obesity rates in adults and children
- Reducing the number of alcohol-specific admissions (including in children)
- Improving access to information regarding lifestyle advice and ensuring services are delivered through front line staff e.g through every patient counts
- Reducing smoking-attributable hospital admissions and deaths by smoking intervention programmes
- Reducing the high levels of smoking in pregnancy
- Increasing the breastfeeding rates

3. Supporting Vulnerable People

Deliverables

- Ensuring Carers have appropriate access to health and prevention services
- Ensuring patients recovering from episodes of ill health or following injury have access to rehabilitation and re-enablement
- Treating and caring for people in a safe environment and protecting them from avoidable harm, severe harm or death ensuring that all patient safety incidents reported and investigated

4. Improving Quality & Service Transformation

Deliverables

- Continuing to improve the quality of medicines management
- Ensuring that people have positive experience of Primary Care Services by continuing to improve the quality and safety in Primary Care - by assessing GP and Out of Hours Services
- Ensuring that people have a positive experience of hospital care through improved dialogue with secondary care in terms of patient experience
- Maintaining and improving the partnership between NHS and Local Government through joint working through the Health and Wellbeing Board
- Too many people are spending their final days in hospital, when they would rather be at home

3. Underpinning Values

The CCG will strive to continually improve the quality of patient care ensuring that the priorities identified above have taken this into account. This, together with the improved involvement of patients in the commissioning process across the health economy, will keep quality and equality of service delivery at the forefront of all developments. The communications and engagement lead will ensure that the voice of the patient will be important in our decision making. Our vision for engagement however is shown on the right.



Safeguarding, and keeping a sustained focus on robust safeguarding arrangements, will be in partnership through local safeguarding boards (Child and Adult). Designated professionals will work closely with the CCG to ensure robust local arrangements. Safeguarding work sits in the Quality and Safety team within the PCT currently.

There are seven steps to patient safety as outlined by the National Patient Safety Agency and CCG will adopt these to ensure that when commissioning services, patient safety and clinical governance is assured:

1. Build a safety culture which is open and fair
2. Lead and support staff by establishing a clear and strong focus on patient safety throughout the organisation
3. Integrate risk management into daily routines
4. Promote reporting to ensure incidents can be reported quickly and efficiently
5. Involve and communicate with patients and public which involved listening as well as informing
6. Learn and Share safety lessons
7. Implement solutions to prevent harm through change in practice, process and systems

4. Derivation

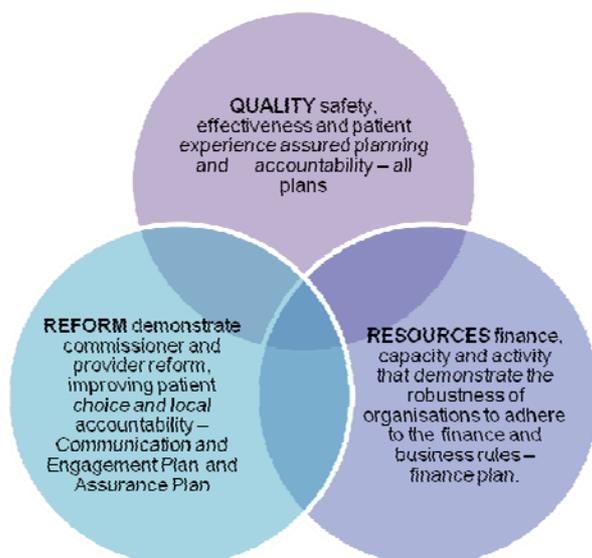
4.1 National / Local Context

In order to ensure that the CCG takes into account the national and regional priorities, consideration has been given to the following documents in formulating our plans:

- The National Operating Framework 2012/13
- The NHS Outcomes Framework 2012/13
- The NHS Midlands and East Regional Commissioning Framework 2012/13
- The NHS West Mercia Cluster Integrated system

There are some key messages running through the above documentation, including:

- The need to improve patient services (especially for the vulnerable) and the CCG intends to include stakeholder engagement when addressing these key messages.
- Current PCT performance levels are to be maintained and improved, especially with regards to the challenge of quality, innovation, productivity and prevention (QIPP). The CCG has been taking a lead role in terms of progressing the QIPP challenge and financial balance forward with the PCT and will continue to keep this as a key deliverable in the future.



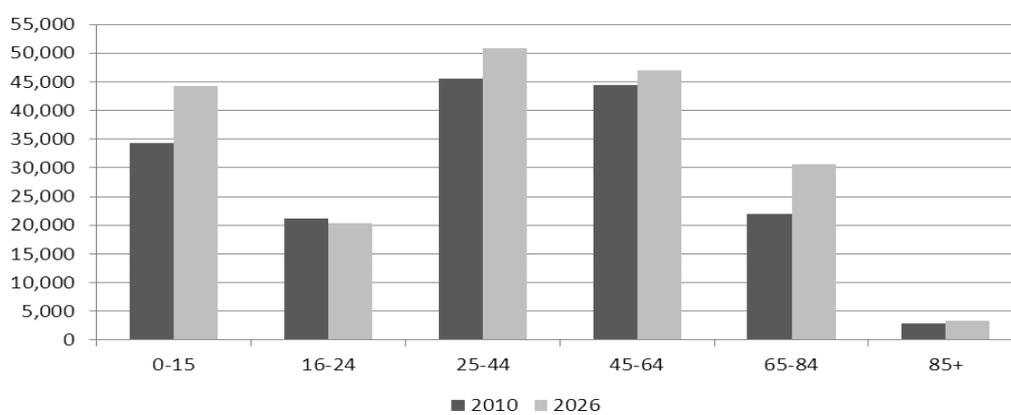
In addition to the local CCG priorities, there are National and Regional priorities which the CCG will need to meet. The performance indicators for these areas are not yet confirmed and when further detail is known quarterly targets will be set. However, these are detailed below as they exist currently.

National Health Outcomes	Enhancing quality of life for people with long-term conditions Helping people recover from episodes of ill health or following injury Ensuring that people have positive experience of care Treating and caring for people in a safe environment and protecting them from avoidable harm Safety incidents involving severe harm or death	NHS Midlands and East Regional priorities	Eliminating avoidable grade two, three and four pressure ulcers Making every patient count through systematic healthy lifestyle advice delivered through front line staff Significantly improving the quality and safety in Primary Care Ensuring radically strengthened partnership between NHS and Local Government Create a revolution in patient and customer experience
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4.2 Joint Strategic Needs Assessment

The above health outcomes have been prioritised using the intelligence in the JSNA. CCG recognises the current reconfiguration of Public Health and Local Government and the development of the local Health and Wellbeing Strategy by the Health and Wellbeing Board and that this will clearly have an effect on the CCG. The local priorities for the CCG have been taken after due consultation of the local Joint Strategic Needs Assessment (JSNA). The local Health and Wellbeing Strategy for Telford and Wrekin is currently in development and cross reference will be made to the priorities of the CCG and the Health and Wellbeing Board when available, however by basing the CCG priorities on the local JSNA and national priorities, the significant risk of major change being required is mitigated.

The supporting evidence has been taken from the JSNA and is in connection with the associated health needs associated with deprivation and the predicted increase in the population of the Telford and Wrekin over the coming years. The overall population is expected to rise to 196,300 by 2026, which is an increase of 15%. The two age groups which are expected to increase the most are 0-15 year olds and 65 – 84 years.



Source of data for chart – Telford and Wrekin Council – Telford and Wrekin Population Profile 2011/12:

In addition to the population increase Telford and Wrekin is in the top 30% most deprived local authorities in the West Midlands, and in the top 40% most deprived nationally according to the Index of Multiple Deprivation 2010 (IMD 2010).

The CCG has utilised the above statistics and taken into consideration the ongoing effect of the population increase and the levels of deprivation and together with other the statistical data on current health outcomes from benchmarking data has agreed the priorities in section 1 as being key to address the health related issues in Telford and Wrekin.

5. Quality, Improvement, Productivity and Prevention Work Programme

The main purpose of CCG is to improve the quality of healthcare commissioned and provided for the population of Telford and Wrekin. There is a Quality, Improvement, Productivity and Prevention (QiPP) programme running in Telford and Wrekin PCT, which CCG have led over recent months and this has led to “3 Big Bets” which are the significant areas of service transformation:

- Unscheduled care QIPP scheme
- Improving the quality and management of referrals into secondary care
- Improving access to appropriate Mental Health services

The details of these schemes are provided in detail in the CCG QiPP plan. The PCT supported by the CCG are on target to meet the QIPP targets for 2011/12, however some of the projects made more of an impact than others which resulted in the overall target being met but some individual projects missing their targets. To mitigate this in 2012/13, the finance plan will outline how the QiPP plans are to be monitored therefore ensuring that any projects which are not delivering can be highlighted in year to address slippages and changes prior to year end.

CCG are responsible for the improvement of care provided in GP practices and support will be provided to practices in order to ensure that they meet the agreed standards in the provision of their services. Further clarification on how this will progress will be provided when the NHS Commissioning Board define their processes in terms of performance management of GP Practices.

6. Implementation, Delivery, Reporting and monitoring structures

It is recognised that at present much of the delivery of the priorities will be fulfilled in partnership with the Commissioning Support Service (CSS) and Local Authority however the responsibility to ensure that targets are met will remain with the CCG. Whilst CCG acknowledges it is their responsibility to ensure that national and regional targets must be delivered, there is ongoing dialogue on what these specific measurable targets will be and how they will be monitored. Discussions on the current structure of CCG, Commissioning Support Service (CSS) and the reconfiguration of Public Health arrangements are underway. Discussions are also underway regarding possible Joint Commissioning arrangements with the Local Authority and neighbouring CCGs. Negotiations on the activities to be undertaken by the different organisations will determine the delivery arrangements for all targets. CCG will at present concentrate on the immediate health needs of the local population. The CCG will ensure clear arrangements are in place to enable all other clinical colleagues providing health services locally to inform the work of the CCG through provision of advice via the clinical senate and other agreed mechanisms.

There are processes in place via the CCG Board to enable clinical perspectives to lead the work of the CCG and Appendix 1 provides details of how CCG will deliver its main priorities.

6.1 Baseline Data and Targets

Up to date data for the final 3 columns, in Appendix 1: how success will be measured; the baseline for the existing performance; and the targets to be reached in year is not currently available as these will be set on the year end position as at 2011/12. Examples have been given in this columns top demonstrate the types of data which the CCG will use. The actual data sources will be agreed by the CCG Board and adjusted based on publication of the latest performance outcomes in 2011/12.

Upon formal agreement of the operational plans and the structure of CSS/CCG, a formal update will be provided to the CCG Board on a monthly basis, giving assurance of the delivery of the agreed priority areas.

6.2 West Mercia PCT Cluster

CCG will continue to work with the West Mercia PCT Cluster to ensure that the implementation arrangements for delivery, reporting and monitoring structures with the CSS and Local Authority are robust.

7. Key challenges, Risks and Mitigation

There are many challenges and risks within Clinical Commissioning, however ensuring that the governing focus is outward facing as well as identifying internal strategic risks should assist in the mitigation of risk. The Governance Plan addresses how the overarching risks and challenges will be managed and the processes in place to mitigate these risks. The key risks and current mitigation around non-delivery of the Operational plan are:

Challenge	Risk	Mitigation
Capacity	For projects to be delivered effectively, input from local GPs is required.	<p>The Commissioning Group has five committed GPs on the Board and their time is currently restricted to working on a part time basis. However, CCG has the additional support of the 22 Practices in Telford and Wrekin and GPs from all of these practices are currently involved in some form of service transformation which does lessen this capacity risk. Many of these projects are delivered by way of the Quality and Productivity indicators contained in the Quality and Outcomes Framework and the Clinical Commissioning Incentive Scheme.</p> <p>A formal strategy is currently being developed regarding how GPs and Practices engage and contribute to the CCG.</p>
	Should either of the above funding streams cease, GPs may not be able to be released from their surgeries to continue with the service transformation projects.	Ensure that the funding streams remain open
	In addition to the GP involvement, the risk of loss of continuity and knowledge by PCT staff currently leading changes, who may leave the PCT to take up roles outside CCG is a significant risk to the delivery of the Operational plan.	Allocation of staff members to new formal structures will reduce this risk. Agreement via service level agreements between commissioning support services and joint commissioners should mitigate this risk
Demand management	Some of the projects require demand management to ensure delivery of the outcomes. Demand management concerns controlling the flow of patients to hospitals, such that the predicted contract activity and thresholds are not exceeded. This is specifically relevant for QiPP related schemes	The financial plan which should be read in conjunction with the operational plan outlines plans for demand management which should reduce the effect of this risk.
Accountability	There is a risk of accountability from any change implemented	<p>Working within the agreed Governance Framework and in conjunction with the Health and Wellbeing Board will help to mitigate this risk.</p> <p>A newly formatted template for all CCG Board papers clearly requests the author of any Board papers to demonstrate that they have considered risks from</p>

Challenge	Risk	Mitigation
		individual projects. Any significant risk will be added to the CCG Risk Register and therefore result in formal tracking and management
	Speed of decision making could also be a factor to the success of some of the projects.	The accountability arrangements contained in the Governance Assurance Framework should assist in mitigating this factor.
Strategic change	Legislation detailing the final details of Clinical Commissioning has not yet been passed. Therefore all planning has been done on predicting the responsibilities of Clinical Commissioning groups and may be subject to change.	The priorities contained within the Operational Plan should not be subject to significant change in terms of health outcomes, as these have been designed to meet to health needs of the population and address health inequalities. Nevertheless there is still a risk in terms of external factors which could impact on the overarching CCG strategy, reputation or long-term viability needs to remain as a risk.
Finance	The finance plan will outline all the key financial risks; however should the anticipated budgetary position change or QiPP schemes not deliver a financial risk will arise.	The finance plan will address mitigation of financial risks

8. Benefits and Corporate objectives realisation

The CCG Strategic Development Plan outlined the key indicators behind priorities and decisions being:

- Reductions in health inequalities
- Access to health services
- Improvements in patient experience
- Less or more appropriate use of secondary care
- Self management of conditions
- Care closer to home
- Access to information
- Improving quality of primary care
- Improving quality of health outcomes within the agreed resource

The priorities in the Operational Plan have begun to address these key indicators. The Strategic Development Plan outlines a timeline for defining the 2012/13 key objectives and outcomes and this operational plan for 2012/13 will ensure that this timeline is on target.

The components for setting the CCG's priorities are set in the Organisational Development Plan. Specifically, the components that the operational plan has met are:

- **Substantially strengthen collaboration with the Local Authority** – including shared working an co-location as appropriate
- **Getting the basics right every time**, maintaining a grip on performance, meeting quality and productivity challenge and building the new delivery system.
- **National performance measures**
- **The 5 Cluster ambitions** – Eliminating avoidable pressure ulcers, making every contract count, significantly improving quality and safety in Primary Care, Ensuring radically strengthened partnership between NHS and local governance and creating a revolution in patient and customer experience

In terms of the specific priorities the expectation is that the health of the population will be improved as follows:

- **Increasing Life Expectancy & reducing Health Inequalities** – Improvement in the management and treatment of CVD and Long Term Conditions, reduction in the premature mortality rates from cancer, the mental health and dementia outcomes for our ageing population and life chances for children and young people will be improved
- **Encouraging healthier lifestyles** – By the improvement in lifestyle management and access to information, obesity rates in adults and children, smoking attributable hospital admissions and the number of alcohol-specific admissions (including in children) will be reduced. Improvements to the high levels of smoking in pregnancy and breastfeeding rates will also be seen
- **Supporting Vulnerable people** – Through improved access to quality services and improvements to rehabilitation and re-enablement, CCG will provide additional support to vulnerable people living in Telford and Wrekin
- **Improving quality and service transformation** – Continued improvement to the quality of medicines management and robust monitoring GP and Out of Hours Services together with improved patient experience of hospital care and joint working with the Health and Wellbeing Board will continue to improve and address health concerns of the population of Telford and Wrekin.

Appendix 1 - Priority areas for Telford and Wrekin Clinical Commissioning Group (CCG)

Up to date data for the final 3 columns, in Appendix 1: how success will be measured; the baseline for the existing performance; and the targets to be reached in year is not currently available as these will be set on the year end position as at 2011/12. Examples have been given in this columns top demonstrate the types of data which the CCG will use. The actual data sources will be agreed by the CCG Board and adjusted based on publication of the latest performance outcomes in 2011/12. Upon formal agreement of the operational plans and the structure of CSS/CCG, a formal update will be provided to the CCG Board on a monthly basis, giving assurance of the delivery of the agreed priority areas.

a) Increasing Life expectancy and reducing health inequalities

Reducing premature mortality from cardiovascular disease (CVD) by improving the management and treatment of CVD in primary care				
Clinical Rationale / Current Commissioning Overview	Associated Work-streams / Key Actions	How will we measure success? (awaiting further guidance)	Baseline* Examples provided however further detail awaited	Target Examples provided however further detail awaited
<p>Despite the continued decrease in rates of premature mortality from CVD outcomes remain significantly worse than the national average. There are comparatively low levels of expenditure on CVD (evidenced through benchmarking) and management and treatment of CVD in primary care is relatively poor.</p> <p>It is estimated that 2.5% of people aged 16+ years (approximately 4,418 adults) have suffered a stroke or TIA. However, at the end of March 2011 only 1.5% of the general practice population (2,656 adults) were recorded as having a diagnosis of hypertension in primary care</p> <p>It is estimated that 30.9% of people aged 16+ years (approximately 39,798 adults) have hypertension. However, at the end of March 2011 only 13.5% of the general practice</p>	<p>Stroke Strategy CVD LES (to be reviewed) NHS Health Check Obesity Action Plan The Abdominal Aortic Aneurysm (AAA) screening programme Delivery of the Single Point of Access (SPOA)</p>	<p>NHS Outcomes Framework indicator 1.1. Under 75 mortality rate from cardiovascular disease.</p> <p>Public Health Outcome Framework indicator 4.4 – Mortality from cardiovascular diseases</p> <p>Stroke performance measures and National performance measure PHQ31: Coverage of NHS Health Checks, PHQ30 – Smoking quitters</p> <p>Public Health Indicators Domain 2 – 2.11 – Diet, 2.12 – Excess weight in adults, 2.13 – proportion of physically active and inactive adults</p> <p>Review of Strategies</p>	<p>(HP04 - Practice) % of patients: Last (9months) blood pressure >=150/90 76.42%</p> <p>(CHD02 - Practice) CHD prevalence ratio: observed/predicted 76.77</p> <p>(IH05 – Acute) Emergency readmissions - % within 30-days following discharge – Stroke 6.7%</p> <p>(IH10 – Acute) Emergency readmission - % within 30 days following discharge – CHF 16.8%</p>	<p>Q1 Q2 .33333 Q3 Q4 - HP04 – 78.9% CHD02 – 74.55 IH05 – 9.5% IH10 – 18.4%</p>

Reducing premature mortality from cardiovascular disease (CVD) by improving the management and treatment of CVD in primary care				
Clinical Rationale / Current Commissioning Overview	Associated Work-streams / Key Actions	How will we measure success? (awaiting further guidance)	Baseline* Examples provided however further detail awaited	Target Examples provided however further detail awaited
<p>population (23,059 adults) were recorded as having a diagnosis of hypertension in primary care</p> <p>It is estimated¹ that 5.6% of people aged 16+ years (approximately 7,849 adults) have coronary heart disease. However, at the end of March 2011 only 3.2% of the general practice population (5,472 adults) were recorded as having a diagnosis of CHD in primary care</p>				

Reducing premature mortality from cancer				
Clinical Rationale / Current Commissioning Overview	Associated Work-streams / Key Actions	How will we measure success?	Baseline* Examples provided however further detail awaited	Target Examples provided however further detail awaited
<p>Male premature mortality from all cancers is significantly worse than the national average as is the male mortality rate for lung cancer. Lung cancer is a key local contributor to reduced life expectancy.</p> <p>There are comparatively low levels of expenditure on cancer (evidenced through benchmarking) and lower than average coverage for cervical and bowel cancer screening.</p>	<p>Shropshire, Telford and Wrekin Cancer Services Action Plan</p> <p>National Awareness & Early Diagnosis Initiative (NAEDI) early intervention lung cancer project is currently being evaluated.</p> <p>GP Incentive scheme</p> <p>Action plans to improve uptake of screening</p> <p>Public awareness to increase early presentation to general practice</p>	<p>NHS Outcomes Framework 1.4 (i-Vii) – Reducing premature mortality from cancer.</p> <p>Public Health Indicators – Domain 4 – 4.5 - Mortality from cancer</p> <p>Performance Measures – Domain 1 - PHQ03 – PHQ09 – cancer waits</p> <p>Greater Midlands Cancer Network indicators</p>	<p>(PE02 – Acute) Diagnostic waits - % of patients waiting over 5 weeks 8.2%</p> <p>(PE05 – Acute) Cancer waits - % waiting less than 62 days from GP referral to first treatment 77.6%</p>	<p>Q1</p> <p>Q2</p> <p>Q3</p> <p>Q4 – PE02 – 5.3% PE05 – 86.5%</p>

¹ Modelled Association of Public Health Observatories Prevalence Estimate <http://www.apho.org.uk/resource/view.aspx?QN=DPMLDP>

*Data source for baseline information – Practice Quality Profile – Winter 2011 & Acute Trust Quality Dashboard – Summer 2011

Meeting the needs of the ageing population - improving dementia services				
Clinical Rationale / Current Commissioning Overview	Associated Work-streams / Key Actions	How will we measure success?	Baseline Examples provided however further detail awaited	Target Examples provided however further detail awaited
<p>Over the next 15 years the population is forecast to increase by 23%, the 65+ population rising by 48%, those aged 85+ will double</p> <p>It is estimated that 1,580 people were suffering from dementia in 2010 in Telford and Wrekin. The numbers of people expected to be suffering from dementia by 2015 is set to increase by 17% to 1,851. At the end of March 2011 only 644 adults were recorded as having dementia in primary care</p> <p>Long term conditions prevalence is increasing</p>	<p>Dementia Strategy Health Through Warmth Falls Prevention Strategy Rehabilitation and Re-ablement Strategy Long Term Conditions model Rapid response and multi-disciplinary team Third Sector partnerships required to deliver low level preventative work. GP Projects – reducing unnecessary Ophthalmology referrals to secondary care, clinical support to care homes, community based lower urinary tract service Quality and Outcomes Framework RAID – Rapid Assessment Interface Discharge</p>	<p>NHS Outcomes Framework – 2.6 – Enhancing quality of life for people with Dementia, 3.6 – Helping older people to recover their independence after illness or injury.</p> <p>Public Health Indicators – Domain 1 – 1.19 – Older people's perception of community safety, Domain 2 – 2.24 – Falls and fall injuries in the over 65s. Domain 4 – 4.13 – Health-related quality of life for older people, 4.14 – hip fractures in over 65s, 4.15 – Excess winter deaths, 4.16 – Dementia and its impacts.</p> <p>Formal review of GP projects, Strategies, QiPP scheme</p> <p>Quality and Outcomes Framework</p>	<p>(DM04 – Practice) Dementia hospital admission rate (as % of practice list size) 0.28%</p> <p>(EQ02 – Length of stay (days) for patients >65 years old admitted in an emergency with Dementia) 6.1%</p>	<p>Q1 Q2 Q3 Q4 – DM04 – 0.45% EQ02 – 5.5%</p>

*Data source for baseline information – Practice Quality Profile – Winter 2011 & Acute Trust Quality Dashboard – Summer 2011

Addressing long term conditions management and treatment, specifically around COPD and Diabetes				
Clinical Rationale / Current Commissioning Overview	Associated Work-streams / Key Actions	How will we measure success?	Baseline Examples provided however further detail awaited	Target Examples provided however further detail awaited
<p>Smoking related deaths and smoking-attributable hospital admissions remain significantly worse than the national average</p> <p>It is estimated that 3.4% of people aged 16+ years (approximately 4,418 adults) suffer from COPD. However, at the end of March 2011 only 1.8% of the general practice population (3,136 adults) were recorded as having a diagnosis of COPD in primary care</p>	<p>Quality and Outcomes Framework GP incentive scheme Smoking commissioning plan Long Term conditions plan GP extended services Self care management GP Project – Diabetes care and COPD Service Improvement Plan to be developed</p>	<p>Quality and Outcomes Framework</p> <p>Review of GP Incentive scheme</p> <p>Review of strategies and plans</p>	<p>(R07 – Practice) % of patients with COPD: record of FeV1 in last 15 months 87.73%</p> <p>(R10 – Practice) COPD hospital admissions rate (as % of practice list size) 0.29%</p> <p>(IH06 – Acute) Emergency readmission - % within 30 days following discharge – COPD 15.6%</p> <p>(Db05 – Practice) % of patients with diabetes: last (15 months) HbA1c is <=10 87.05%</p> <p>(Db20 – Practice) Diabetes hospital admission rate (as % of practice list size) 0.11%</p> <p>(R13 – Practice) % of patients with asthma: had an asthma review in the last 15 months 76.88%</p> <p>(Ep01 – Practice) % of patients age 18 and over on drug treatment for epilepsy who have a medication review 95.17%</p>	<p>Q1</p> <p>Q2</p> <p>Q3</p> <p>Q4 – R07 – 88.84% R10 – 0.34% IH06 – 23.3% Db05 – 88.19% Db20 – 0.11% R13 – 78.46% Ep01 – 95.17%</p>

*Data source for baseline information – Practice Quality Profile – Winter 2011 & Acute Trust Quality Dashboard – Summer 2011

Improving life chances for children and young people, addressing teenage pregnancy rates				
Clinical Rationale / Current Commissioning Overview	Associated Work-streams / Key Actions	How will we measure success?	Baseline Examples provided however further detail awaited	Target Examples provided however further detail awaited
<p>The income deprivation affecting children index shows that 10,200 children aged under 15 (almost a third - 31%) live in areas ranked in the 20% most deprived in England</p> <p>Levels of child poverty remain high.</p> <p>Teenage pregnancy rates remain significantly worse than average.</p> <p>Levels of young people not in education, employment or training are lower than average.</p> <p>Levels of breastfeeding (initiation and duration) and smoking in pregnancy remain significantly worse than the national average, with clear inequalities across the Borough.</p>	<p>Health Inequalities action plan Teenage pregnancy strategy re-fresh Health Visitor implementation plan Breastfeeding strategy and action plan Smoking commissioning plan Communication and Engagement plan Family Nurse Partnership and Family Intervention Project</p>	<p>NHS Outcomes Framework indicator 1.6i and 1.6ii infant and perinatal mortality</p> <p>Public Health Outcomes Framework indicator 2.2i and 2.2ii breastfeeding initiation and duration at 6-8 weeks and 2.3. smoking at time of delivery</p> <p>Public Health Indicators Domain 2, 2.1 – Low birth rate of term babies, 2.3 – smoking status at time of delivery, 2.4 – Under 18 conceptions, 2.5 – Child development at 2-2.5 years, 2.6 – Excess weight in 4-5 and 10-11 year olds, 2.7 – Hospital admissions caused by unintentional and deliberate injuries in under 18s, 2.8 – Emotional wellbeing of looked after children, 4.1 – Infant mortality</p> <p>Review of Strategies</p>	<p>TBA</p>	<p>Q1 Q2 Q3 Q4 TBA</p>

*Data source for baseline information – Practice Quality Profile – Winter 2011 & Acute Trust Quality Dashboard – Summer 2011

b) Encouraging healthier lifestyles

Addressing the Obesity rates in adults and children				
Clinical Rationale / Current Commissioning Overview	Associated Work-streams / Key Actions	How will we measure success?	Baseline Examples provided however further detail awaited	Target Examples provided however further detail awaited
<p>About 20.1% of year 6 children are classified as obese.</p> <p>Estimates levels of adult healthy eating and obesity are worse than the England average</p>	<p>Long term conditions self care management</p> <p>Looking After Me expert patient programme course</p> <p>Making Every Contact Count (MECC)</p> <p>Service delivery of the single point of access (SPOA),</p> <p>Obesity Strategy and action plan</p> <p>NHS Health Check</p> <p>Smoking Commissioning Plan</p> <p>Existing QIPP scheme: Health population</p> <p>GP Project – Diabetes care and COPD</p>	<p>Public Health indicators – Domain 2 – 2.11 – Diet, 2.12 – Excess weight in adults, 2.13 - Proportion of active and inactive adults, 2.14 – smoking prevalence, 2.23 self- reported wellbeing.</p> <p>Domain 4 – 4.4 Mortality from all cardiovascular disease</p> <p>Review of Strategies</p>	TBA	<p>Q1</p> <p>Q2</p> <p>Q3</p> <p>Q4</p> <p>TBA</p>

Reducing the number of alcohol-specific admissions (including in children)				
Clinical Rationale / Current Commissioning Overview	Associated Work-streams / Key Actions	How will we measure success?	Baseline Examples provided however further detail awaited	Target Examples provided however further detail awaited
<p>Hospital admission rates for alcohol-related harm are improving. Alcohol-related harm was the only issue I considered in my 2006/7 report; the report went on to provide the basis for a comprehensive joint strategy agreed between partner agencies, including Telford and Wrekin Council and the PCT</p>		<p>Public Health indicator – 2.18 – alcohol admissions to hospital</p>	TBA	<p>Q1</p> <p>Q2</p> <p>Q3</p> <p>Q4</p> <p>TBA</p>

*Data source for baseline information – Practice Quality Profile – Winter 2011 & Acute Trust Quality Dashboard – Summer 2011

Improving access to information regarding lifestyle advice and ensuring services are delivered through front line staff				
Clinical Rationale / Current Commissioning Overview	Associated Work-streams / Key Actions	How will we measure success?	Baseline Examples provided however further detail awaited	Target Examples provided however further detail awaited
Information is provided to patients regarding lifestyle advice	Engagement and Communication Plan Quality and Outcomes Framework Making Every Contact Count (MECC) Service delivery of single point of access (SPOA), NHS Health Check Smoking Commissioning Plan Obesity Strategy and action plan GP Project – Diabetes care, COPD	MECC performance framework Public Health indicators – Domain 2 – 2.11 – Diet, 2.12 – Excess weight in adults, 2.13 - Proportion of active and inactive adults, 2.14 – smoking prevalence, 2.23 self- reported wellbeing. Domain 4 – 4.4 Mortality from all cardiovascular disease Quality and Outcomes Framework Review of GP projects Review of Strategies	TBA	Q1 Q2 Q3 Q4 TBA

*Data source for baseline information – Practice Quality Profile – Winter 2011 & Acute Trust Quality Dashboard – Summer 2011

Reducing smoking-attributable hospital admissions and deaths by smoking intervention programmes				
Clinical Rationale / Current Commissioning Overview	Associated Work-streams / Key Actions	How will we measure success?	Baseline Examples provided however further detail awaited	Target Examples provided however further detail awaited
<p>The smoking quitter rate is the best in the West Midlands, with in excess of 100% of the target number of smokers remaining quit at four weeks.</p> <p>However, smoking related deaths and smoking-attributable hospital admissions remain significantly worse than the national average</p> <p>Further, the male premature mortality rate from for lung cancer is significantly worse than the national average and lung cancer is a key local contributor to reduced life expectancy</p> <p>The importance of primary care continuing and improving smoking cessation through brief interventions and linked to the NHS Health Check programme is well recognised. The additional public health investment in 2011/12 has been channelled into both these two top national public health priorities.</p>	<p>Smoking Strategy Smoking scheme aimed at reducing hospital admissions PbR tariff pilot for smoking cessation Quality and Outcomes Framework</p>	<p>NHS Performance Measure PHQ30 – Smoking quitters</p> <p>Public Health Outcomes indicators 2.9 – Smoking prevalence 15 year olds, 2.14 – Smoking prevalence adults (over 18s), 2.1 smoking in pregnancy]</p> <p>Quality and Outcomes Framework</p>	<p>TBA</p>	<p>Q1</p> <p>Q2</p> <p>Q3</p> <p>Q4</p> <p>TBA</p>

*Data source for baseline information – Practice Quality Profile – Winter 2011 & Acute Trust Quality Dashboard – Summer 2011

Reducing the high levels of smoking in pregnancy				
Clinical Rationale / Current Commissioning Overview	Associated Work-streams / Key Actions	How will we measure success?	Baseline Examples provided however further detail awaited	Target Examples provided however further detail awaited
Levels of smoking in pregnancy remain significantly worse than the national average, with clear inequalities across the Borough	Smoking Strategy Review of evidence base for smoking in pregnancy and review plan Commissioning Incentive Scheme to reduce the number of smokers during pregnancy and at delivery.	Public Health Indicator Domain 2 - 2.1 Low birth weight of term babies, 2.3. smoking at time of delivery Performance Measure – PHQ30 – smoking quitters	TBA	Q1 Q2 Q3 Q4 TBA

Increasing the breastfeeding rates				
Clinical Rationale / Current Commissioning Overview	Associated Work-streams / Key Actions	How will we measure success?	Baseline Examples provided however further detail awaited	Target Examples provided however further detail awaited
Despite year-on-year improvements in initiation and duration, breastfeeding rates remain significantly worse than national average Clear inequalities exist with worse than average levels of breastfeeding amongst younger mothers (particularly teenagers) and mothers from the most disadvantage communities NICE recommends the implementation of UNICEF Baby Friendly Initiative requirements as a minimum standard in at least three of its guidance documents	Breastfeeding Strategy UNICEF Baby Friendly Initiative Social marketing insight work and re-branding of campaign and promotional work GP Commissioning Incentive scheme to improve uptake of breastfeeding	Public Health Outcomes Framework indicator 2.2i and 2.2ii breastfeeding initiation and duration at 6-8 weeks– Target trajectories for breastfeeding and smoking in pregnancy in all relevant in service specifications with providers Review incentive scheme	TBA	Q1 Q2 Q3 Q4 TBA

*Data source for baseline information – Practice Quality Profile – Winter 2011 & Acute Trust Quality Dashboard – Summer 2011

c) Supporting Vulnerable people

Ensuring Carers have appropriate access to health and prevention services				
Clinical Rationale / Current Commissioning Overview	Associated Work-streams / Key Actions	How will we measure success?	Baseline Examples provided however further detail awaited	Target Examples provided however further detail awaited
Healthy life expectancy is significantly lower than average Emerging social care priorities: Prevention, Enablement, Personalisation & Choice, Dignity & Safety, Carers	Review of Adult Social Care Emergency Response Carer Service GP Project – clinical support to care homes Quality and Outcomes Framework Carers – support self care management of carers via the Looking After Me expert patient programme course	Quality and Outcomes Framework Review of GP project	TBA	Q1 Q2 Q3 Q4 TBA

Ensuring patients recovering from episodes of ill health or following injury have access to rehabilitation and re-enablement				
Clinical Rationale / Current Commissioning Overview	Associated Work-streams / Key Actions	How will we measure success?	Baseline Examples provided however further detail awaited	Target Examples provided however further detail awaited
Emergency readmissions need to continue to reduce as patients receive better planned care and are supported to self-care more effectively. The savings made need to be invested in clinically driven initiatives to support outcomes through Re-ablement and post-discharge support.	Engagement and Communications Strategy 18 Weeks Referral to treatment GP Project – Musculo skeletal project Increased use of community services promotion in general practice QIPP big bet – Planned Care Implementation of a post discharge review pathway for patients with COPD Rehabilitation and Re-ablement Strategy Service reconfiguration Develop Third Sector Partnerships to deliver Low Level Preventative work Rapid response and multi-disciplinary team Carers Strategy Dementia plans Continuing Healthcare and personal health budgets	Performance measure PHQ17 Public Health indicator – Domain 4 – 4.11 Review of GP projects Review of QiPP scheme 18 weeks RTT monitoring Review of Strategies	TBA	less than 1% of patients to wait more than 6 weeks for a diagnostic test. Q1 Q2 Q3 Q4 TBA

*Data source for baseline information – Practice Quality Profile – Winter 2011 & Acute Trust Quality Dashboard – Summer 2011

Treating and caring for people in a safe environment and protecting them from avoidable harm, severe harm or death ensuring that all patient safety incidents reported and investigated e.g. eliminating avoidable grade two, three and four pressure ulcers and ensuring the use of specially designed mattresses and cushions to protect vulnerable parts of the body				
Clinical Rationale / Current Commissioning Overview	Associated Work-streams / Key Actions	How will we measure success?	Baseline* Examples provided however further detail awaited	Target Examples provided however further detail awaited
Emerging social care priorities: Prevention, Enablement, Personalisation and Choice, Dignity and Safety, Carers	Quality and Outcomes Framework Infection Prevention and Control Team Audit Programme Primary Care Quality Team - Patient quality and safety Monitoring of GP, antibiotic prescribing by Medicines Management Team	Achievement of Commissioner MRSA <i>and C. diff</i> targets by end of financial year.	(SC05 – Acute) HCAI – MRSA bacteria rate per 1,000,000 occupied beds 28.4 (SC06 – Acute) HCAI – C Diff bacteria rate per 100,000 bed days 9.6	Q1 Q2 Q3 Q4 - SC05 – 17.2 SC06 – 8.4

*Data source for baseline information – Practice Quality Profile – Winter 2011 & Acute Trust Quality Dashboard – Summer 2011

d) Improving quality

Continuing to Improve the quality of medicines management e.g. reducing the use of antibiotics, NICE guidelines – QIPP scheme				
Clinical Rationale / Current Commissioning Overview	Associated Work-streams / Key Actions	How will we measure success?	Baseline Examples provided however further detail awaited	Target Examples provided however further detail awaited
The Medicines Management team works consistently with Practice in order to continually improve the quality of medicines management.	<p>Develop emerging clinical commissioning groups to undertake quality assessments of practices and support quality improvement</p> <p>Significantly reducing prescribing of quinolones and cephalosporins, broad spectrum antibiotics associated with C.difficile - Work on-going with Medicines management on reducing prescribing of antibiotics in Primary Care</p> <p>Improve management of patients taking the anticoagulant Warfarin</p> <p>Ensure patients receive the best quality in care for managing their diabetes</p> <p>Quality and Outcomes Framework</p> <p>Prescribing Incentive Scheme</p>		TBA	<p>Q1</p> <p>Q2</p> <p>Q3</p> <p>Q4</p> <p>TBA</p>

*Data source for baseline information – Practice Quality Profile – Winter 2011 & Acute Trust Quality Dashboard – Summer 2011

Ensuring that people have positive experience of Primary Care Services by continuing to improve the quality and safety in Primary Care by assessing GP and Out of Hours Services and introducing quality standards and targets				
Clinical Rationale / Current Commissioning Overview	Associated Work-streams / Key Actions	How will we measure success?	Baseline* Examples provided however further detail awaited	Target Examples provided however further detail awaited
<p>The quality of Primary Care Services in GP Practices in Telford and Wrekin is currently benchmarked by using nationally available data; however there is no formal balanced scorecard approach and no formal mechanism for follow up.</p> <p>The OOH contract is currently led by the Lead Commissioner for Primary Care, who has the responsibility for regular contract meetings with the provider.</p>	<p>Engagement and Communications Strategy</p> <p>Quality of primary care services review.</p> <p>Commissioning Incentive scheme to improve urgent access in Primary Care</p> <p>Quality and Outcomes Framework 111 project group</p> <p>New Telford Referral and Quality Service initiative (QIPP Big Bet – Planned Care).</p> <p>PBC provider services for Dermatology, Diabetes, Paediatrics and Endoscopy</p> <p>Choice of GP practice</p>	<p>Performance measure PHQ18 – patient experience survey</p> <p>PBC service reviews</p> <p>Quality and Outcomes Framework</p> <p>Review of Incentive Scheme</p> <p>Review of strategies</p>	TBA	<p>Q1</p> <p>Q2</p> <p>Q3</p> <p>Q4</p> <p>TBA</p>

Ensuring that people have a positive experience of hospital care through improved dialogue with secondary care in terms of patient experience				
Clinical Rationale / Current Commissioning Overview	Associated Work-streams / Key Actions	How will we measure success?	Baseline* Examples provided however further detail awaited	Target Examples provided however further detail awaited
<p>Patient experience is an integral part of the national contracts we have for Acute and Community services.</p> <p>Within any significant redesign programme we will engage with service user groups to inform these reviews.</p> <p>We regularly monitor compliance for mixed sex accommodation. Performance is monitored at the monthly quality meeting.</p>	<p>Engagement and Communications Strategy</p> <p>Choice of provider and clinical assessment services),</p> <p>National contracts</p> <p>Monthly performance and quality meetings that include standing items on incident report monitoring, complaints and compliments, SUIs and performance monitoring of national targets.</p> <p>Within the contracts there are patient experience schedules as well as the outcomes of the annual patient survey. These are reported at the quality meeting.</p>	<p>Performance measure - PHQ26 – MSA breaches</p>	<p>(PE17 - Acute) Overall inpatient experience measure 76.2%</p> <p>(PE18 - Acute) Overall outpatient experience measure 79.0%</p> <p>(PE19 - Acute) Overall A&E experience measure 75.9%</p> <p>(PE20 - Acute) Mother satisfaction measure 88.9%</p>	<p>Q1</p> <p>Q2</p> <p>Q3</p> <p>Q4 – PE17 – 74.4% PE18 – 78.4% PE19 – 74.7% PE20 – 83.8%</p>

*Data source for baseline information – Practice Quality Profile – Winter 2011 & Acute Trust Quality Dashboard – Summer 2011

Maintaining and improving the partnership between NHS and Local Government through joint working through the Health and Wellbeing Board				
Clinical Rationale / Current Commissioning Overview	Associated Work-streams / Key Actions	How will we measure success?	Baseline Examples provided however further detail awaited	Target Examples provided however further detail awaited
Telford and Wrekin have been working with joint commissioning arrangements for some time and this is anticipated to continue in clinical commissioning.	Engagement and Communication Strategy GP Board representation member of Health and Wellbeing Board. Current PCT collaborative work through joint commissioners. Personal health budgets Joint LA telecare/telehealth lead - Collaborative working with LA and CCGs		TBA	Q1 Q2 Q3 Q4 TBA

End of Life Care – most people are spending their final days in hospital, when they would rather be at home				
Clinical Rationale / Current Commissioning Overview	Associated Work-streams / Key Actions	How will we measure success?	Baseline Examples provided however further detail awaited	Target Examples provided however further detail awaited
Changing knowledge, attitude and behaviours towards dying, death and bereavement and through this making “living and dying well” the norm	<p>Unscheduled care End of Life working group (led by Dr Jeremy Johnson, Medical Director of the Severn Hospice) leading health economy wide planning and implementation</p> <p>Review of community services for palliative and end of life care to develop best available options of care</p> <p>Identify Quality standards for care in End of Life</p> <p>Suite of training for End of Life related skills and competencies for relevant staff</p>	<p>End of Life pathway easy to navigate, care coordinated centrally, shared database of EOL patients</p> <p>Relatives ‘PROM’ to measure quality of services</p>	TBA	Q1 Q2 Q3 Q4 TBA