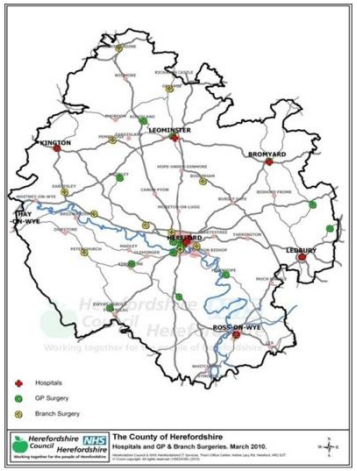
Transforming Health and Care in Herefordshire

Herefordshire CCG's Five-Year Strategic Plan for a high quality, sustainable, integrated Health and Care System

June 2014

Contents

Foreword – Herefordshire Clinical Commissioning Group is committed to transformation and change



Herefordshire health care system faces many challenges relating to sustainably of services in a rural county with a geographically dispersed population. Major transformation is required to deliver an improved and more efficient model of care. The CCG is collaborating closely with partners who all recognise that this needs to happen at pace and are committed to overcoming any organisational-form or estate constraints preventing the development of capable integrated public services.

There has been significant progress over the last three months as system leaders across health and social care commissioning have linked with our main providers to agree a new approach to reshaping health and social care in the county. At the same time the CCG is ensuring that it is true to its principles of putting patients and the public at the heart of everything we do and supporting clinical leadership to guide changes that will deliver maximum benefits to patients.

The CCG is committed to developing integrated teams of multi-disciplinary health and social care professionals around GP practice populations. We have signalled our intention to work closely with the NHS England Area Team to ensure that Primary Care transformation is an essential component of the agenda. There have been previous attempts to create integrated community teams in Herefordshire and the CCG is well placed to gain from this experience to ensure that the lessons learnt are appropriately applied.

The CCG is on track to radically redesign the urgent care system through an outcomes based approach that will result in improved alignment of services from GP out of hours and ambulance services through to A&E and the Clinical Assessment Unit. Public engagement and clinical involvement have been key features of this work to date. In addition the CCG is working alongside Wye Valley Trust leadership to review and redesign secondary care services ensuring patients have access to clinically safe and effective services.

Our priority is to ensure that patients receive the best care possible from public services and we believe this is best achieved by having a relentless focus on delivery of programmes and projects through to completion. This plan represents an extension of the delivery of HCCG's own Two-Year plan, recognising that the challenges and solutions sit across a number of neighbouring organisations. The CCG is committed to upholding and promoting the NHS Constitution as well as the NHS Mandate, and we embrace the description of the NHS it presents. Our GP members are key to the functioning of the CCG, and we will continue to engage widely with them during the transformation. Last but not least we will also continue to strengthen our engagement and involvement of voluntary sector organisations and individuals who support communities or care for others.

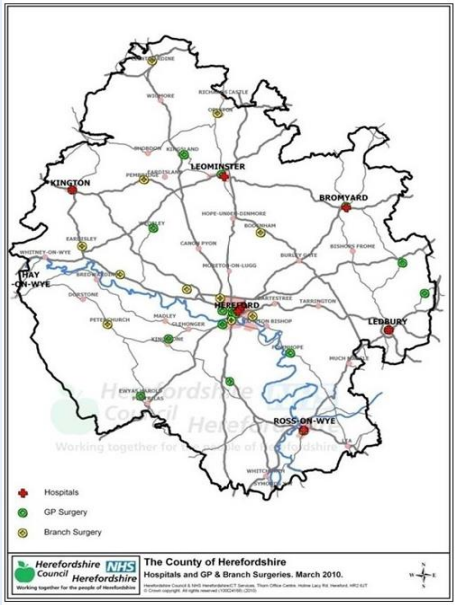
Dr Andrew Watts
Chair

Jo Whitehead
Accountable Officer

Introduction

This section covers:

- **Vision**
- **Current system challenges**



Our vision for Herefordshire Health and Care system is focused on seamless integrated services

By 2020 Herefordshire system partners will provide seamless integrated care and support designed around the needs of individuals, their carers and their families.

We want to be at the leading edge of seamless integration of care and support around individuals and their families. For patients, service users and their families this will mean that services “wrap around them”, to provide co-ordinated consistent and high quality services across organisational boundaries.

Primary care and practice populations will act as the focal point around which we will organise community health and wellbeing, social care and voluntary sector services. In this way we will :

- Support patients, service users and their families to maximise their independence
- Promote proactive anticipatory care planning (Providing appropriate alternatives to hospital admission)
- Support self-management
- Deliver effective reablement and integration back into people’s usual place of residence and their communities
- Provide improved information, advice and care planning

This will ensure that the people of Herefordshire (adults, children and families) are at the heart of decision making about their health and wellbeing. We will enable community led planning to reflect local need and aspiration. We will in transforming our current service delivery ensure that we have a range of interventions that can respond to individuals, families and communities in a joined up way, with a specific focus on the most vulnerable children and adults building on nationally recognised programmes we are already involved in such as the Troubled Families.

We will deliver this transformational change through a focus on four key transformational change workstreams:

- Supportive Communities
- Community Collaborative
- Planned Care
- Urgent Care

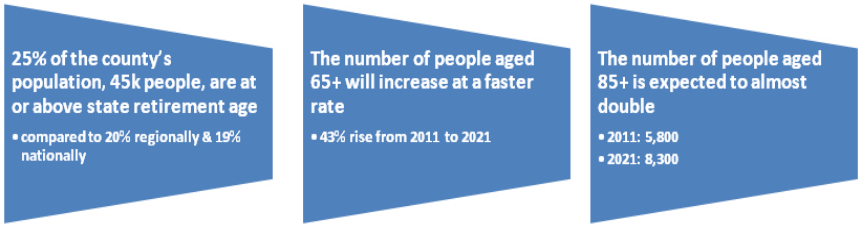
To ensure delivery of our vision we are establishing a transformation programme that will drive key aspects of our work forward.

The Herefordshire health and care system face several complex challenges and joint-working risks which need to be mitigated

Our current health and care system challenges have been discussed in several workshops between the partners, and can be summarised as follows:

- Population that is scattered across a large geographic area, with some areas of high deprivation which are nationally evidenced as having recognised additional health inequalities, making equitable access to services a very real issue
- Large and growing proportion of elderly people (greater than the national average), with increasing demand on care services to ensure their health, well-being and independence needs are met; increasing numbers with dementia, who will need enhanced care

Herefordshire age profile



- High and rising prevalence of long term conditions
- Increasing health effects from lifestyle behaviours such as smoking, alcohol and obesity
- Demands on our Urgent Care system, including achieving quality standards relating to access to services
- Challenged and relatively underdeveloped provider market

Although health in the county is relatively good, the JSNA has identified a disproportionate difference in health outcomes for people in less affluent areas we must transform the Herefordshire local health and care system to meet the service, quality, demographic and financial challenges we face.

To develop a sustainable health and care system for local residents, our priority is to work in partnership to ensure we are making best use of public funds whilst improving health outcomes for people, providing high quality patient and user-centred services, and co-designing this with the citizens.

Our priorities have been informed by both local health needs analysis provided by the Joint Strategic Needs Assessment and national, regional and local priorities.

In response we have shared and discussed existing and proposed plans, and the CCG have used several benchmarking tools, including Anytown Rural, Commissioning for Value and the QIPP Opportunities for 14/15 to inform the discussions and planning.

For example, we have examined and cross-referenced all of the these inputs, and looked at targets for CHD and CVD as this was the area where we had inequalities.

As another example of benchmarking, we have also used the 'Croydon List' to help identify low value treatments to add to our own list. However, we found these opportunities to be a little unrealistic, although are renewing focus on implementation this year. The Herefordshire Low Priority Treatment Policy (LPTP) itself was seen as an example of best practice, and used across the West Midlands.

A key risk for Herefordshire would arise if health and care commissioners and providers were not aligned on delivering the radical changes and transformation needed across the whole system.

We intend to mitigate this risk through strong system leadership and joined-up thinking at systems level to ensure we remain focused on outcomes and the delivery programmes. This is further outlined in our section on governance, and additional risks summarised in our section on risks.

The Herefordshire health and care system is facing financial challenges; we need to find a sustainable solution

There is a large financial challenge across the Health and Social Care system that we recognise we need to tackle collectively through the health and social care transformation programme. As system partners we have taken time to understand our individual and collective financial situations, and the scale of the challenge we are facing together.

Together, HCCG, NHSE, other Commissioners and the Local Authority have combined expenditure of about £413m within Herefordshire. The CCG and Social Care estimated required savings is circa £63m between our joint health and care budget and actual expenditure requirements over the coming five years. In addition our providers have an additional efficiency saving requirement of circa £52m over the same period.

There is need for further clarification of any overlap between the commissioner and provider savings targets. Thus although the overall system shows a significant savings target requirement over the five years, this could potentially be reduced/increased by any overlap/ double counting of assumptions, and work to jointly understand the totality of the financial plans better is planned so that the extent of the funding shortfall can be further tested fully.

During our Leader's workshops we also identified that there may be duplication of overhead costs across the area, and our Finance Directors committed to work in a spirit of openness to challenge assumptions around fixed costs and all expenditure areas with the aim of reducing the deficit wherever possible. Whilst at the same being cognisant of the need to avoid wherever possible movements of costs between organisations.

It has been agreed by the System Leader's that an integrated care approach, based around the Shropshire Integrated Community Services model, will be adopted and adapted for Herefordshire as part of its joint Five-Year Plan, and this will be one of the mechanisms for the improved delivery of health and care services.

A roadmap will now be developed by the joint programme team to ensure our system is transformed over the next five years, building on the current CCG plans in place, but also recognising that radical change is required and that some of the initiatives on our current Two-Year plan may need to stop if they do not align to the wider system plans for integrated care.

Our main acute service provider Wye Valley Trust has challenges of its own, which we aim to help address jointly through the system partnership*

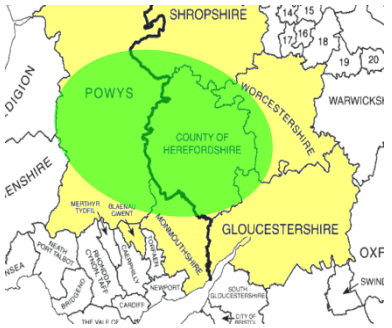
Wye Valley NHS Trust (WVT) recognises it has a structural financial deficit of around £9 million per year, and has in previous years, been supported through external funding to ensure achievement of financial balance in year.

The Trust is applying for TDA distress capital for the current year which helps buy time whilst changes are made, and has committed to delivering 18 week targets and to achieve financial balance for 14/15 (with external financial support).

WVT is currently working internally on improving its acute services as part of the Two Year Business Plan (see appendix), examples include:

- Improving quality and safety, through better service delivery and recruiting an additional 36 nursing staff as part of workforce planning and to ensure quality care within the hospital
- Improving engagement with the public and patients, as well as to create networks for clinical services with suitable partners to ensure that all required services are accessible to patients in a timely manner
- Improving the Urgent Care pathway, and creating capacity for income-generating elective activity
- Sustaining the recent roll out of the Clinical Assessment Unit which has resulted in ambulatory patients being assessed and then usually going home, reducing the demand for hospital beds
- Improved financial planning internally and with its commissioners
- Improving their Information Technology systems, bidding for NHS England funding for an Electronic Patient Record system and linking to wider community and social care systems

WVT provides acute services from the County Hospital in Hereford covering circa 220k population in Herefordshire and Mid Wales, catchment as shown in green on the figure alongside; also provides community services from three community hospitals



WVT, in partnership with HCCG, is also reviewing the future of Herefordshire's community health services, including Children's Services, neighbourhood teams and community hospitals. Recent work has shown that community health services cannot be reviewed in isolation - they are connected to the rest of the health and social care system and thus require a system-wide approach for integration, which recognises equity and equality issues across the patch.

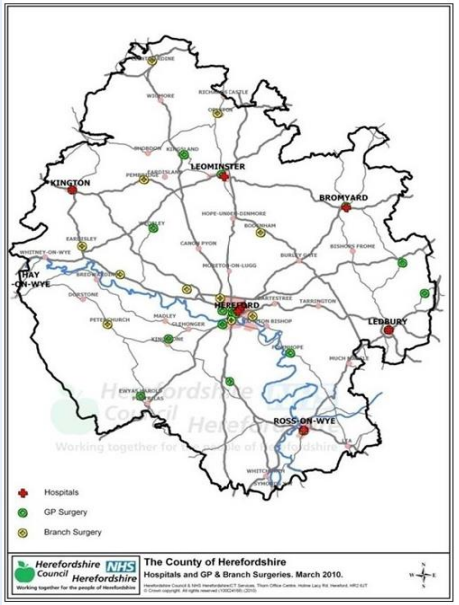
It has been agreed by the System Leaders that an integrated care approach including early supported discharge through in-reach multi-professional teams , as well as acute admissions avoidance through risk stratification and management (based around the Shropshire model) will be adopted and adapted for Herefordshire as part of its joint Five-Year Plan, and this will provide the mechanism for the improved delivery of acute and community services, and move them more towards financial viability.

*referenced from Wye Valley NHS Trust's Five Year Plan

Our Plans

This section covers

- **Introduction**
- **Our Two Year plan s**
- **Five Year Roadmap**



We are linking existing operational plans with the Herefordshire system Five Year Plan

The CCG has a necessarily ambitious improvement programme that is currently being delivered within the CCG programme management governance structure. Now that a combined vision and approach has been agreed by system leaders, respective organisations are working together to ensure continuous alignment of programmes to avoid duplication and gaps. Programme plans are described in the following pages and the CCG will determine which of these should be channelled though existing governance system or into the joint transformation programme board, reporting directly into the CCG Governing Body.

A full analysis of which projects/schemes of work will be aligned to the four workstreams, with immediate priorities identified. These programmes of work are: Integrated Prevention and Discharge processes (based on the Shropshire Model), Community Services Redesign and Urgent Care Plans.

All of the CCG's strategic themes are aligned to the Five-Year Plan, and there is clear overlap between the these and the proposed joint working in the future.

To illustrate this we have highlighted in red the schemes of work which we believe will be aligned below.

Our intention is to-expand the scope of these initiatives once agreed through organisational and system wide governance procedures Efficient delivery will be achieved through a system wide joint planning and support virtual team which will include programme management, performance reporting and communication.

Herefordshire CCG's Two Year plan is focused on 8 key strategic work areas aimed at delivering our priorities

Herefordshire CCG - Two Year Plan on a Page 2014-16

Our Vision

A high quality, sustainable, and integrated health and care economy, with the patient and the public at the heart of everything we do

Our Priorities

- *Greater integration of care*
- *Long term conditions – care closer to home*
- *Modernising mental health services*
- *Delivering high quality primary and secondary care*
- *Improving urgent care system*

We will achieve our vision through local system leadership by ensuring:

- *Strong patient and public engagement*
- *Quality care is seamlessly provided*
- *Access to services is improved*
- *Meaningful Clinical engagement*
- *The CCG manages the system*

Delivering System Change

Preventing Ill Health & Improving Health
CCG Lead: Alison Talbot-Smith
Clinical Lead: Andy Watts

- Improved CVD and CHD outcomes and reducing associated inequalities
- Greater proactive anticipatory care and supported self management
- Greater focus on preventative care pathways and reductions in admissions due to alcohol, smoking and obesity related conditions
- Enhanced use of technology to support healthcare (Telecare/ telehealth)
- Make Every Contact Count MECC

Improving and Enhancing Planned Care
CCG Lead: Adrian Griffiths
Clinical Lead: Richard Kippax

- Local agreed care pathways for key conditions to ensure consistent practice
- Electronic referral systems that improve quality of referrals and enable virtual consultations, improving access to specialist opinion
- Education programme to embed pathways across primary care (GP and Practice Nurses)
- More cost-effective use of high cost drugs to maximise outcomes

Improving Urgent Care
CCG Lead: David Farnsworth
Clinical Lead: Ritesh Dua

- Improve the delivery of urgent care services by moving to an outcomes based commissioning approach
- Ensure the urgent care system provides high quality services and good access
- Reducing the number of avoidable admissions, readmissions, repeat visits and length of stay
- Enhanced end of life care

Greater Integration of Care
CCG Lead: Alison Talbot-Smith
Clinical lead: Ian Tait

- Seamless working across all care settings
- Improved signposting for patients and public for health and social care services
- Putting in place a model for 7 day working
- Enhanced reablement & intermediate care
- Modernising community services including reablement and intermediate care services
- To integrate voluntary sector and community support into all care services and pathways
- Information sharing between health and social care (including NHS Number)

Improving Health Outcomes for Children
CCG Lead: Alison Talbot-Smith
Clinical Lead: Position advertised - TBC

- Improved outcomes and access to health services for vulnerable children
- Better respite and short term care for vulnerable children
- Better outcomes for children with disabilities and long-term conditions
- CAMHS
- Special Educational Needs
- Improved educational attainment for children

High Quality Clinical Services
CCG Lead: David Farnsworth
Clinical Lead: Ian Tait

- Enhanced Quality Assurance process
- Modernising Health and Care - establish future options for Herefordshire health and social care system which are clinically appropriate, high quality, patient centred and value for money
- Specific work on medicines optimisation, stroke and cancer services
- Robust safeguarding practice (adults and children)

Developing Primary Care
CCG Lead: David Farnsworth
Clinical Lead: Crispin Fisher

- Ensuring equitable access and provision of quality primary care
- Reducing variation in quality of care and improving standards
- Putting in place a model for 7 day working
- Delivering prevention and early intervention
- Establish future options for Primary Care services in Herefordshire
- Developing community teams based around practice populations

Modernising Mental Health Services
CCG Lead: Alison Talbot-Smith
Clinical Lead: Simon Lenanne

- Delivering Parity of Esteem through all work programmes
- Patient-centred care pathways for mental health services
- Improved community-focused memory service for people with dementia
- Mental Health and wellbeing needs assessment to inform re-procurement
- Psychiatric liaison in acute services (RAID)
- Increase in access to psychological therapies for all groups and services

Preventing ill-health and improving health

Goals and ambitions

- Improving CVD and CHD outcomes and reducing associated inequalities
- Greater proactive anticipatory care and supported self management
- Greater focus on preventative care pathways reductions in admissions due to alcohol, smoking and obesity related conditions
- Improved health related quality of life with people with long terms conditions

Risk Stratification (Virtual Wards)

Proactive anticipatory care and supported self management for long-term conditions programme

CVD & CHD programme

Access to Primary Care services programme (including 7 day working)

Preventative Pathways programme

Smoking	Alcohol	Obesity

Patient and Public engagement throughout service redesign programmes

Key measures of success

- Increase Dementia diagnosis rates to 67% by March 2015
- Reduction in referrals for dermatology, gastroenterology and cardiology by 5% in 2013/14; reducing premature mortality due to cardiovascular disease - under 75 mortality rate
- Reductions in admissions, re-admissions and length of stay for people with a LTC (12/13 baseline to be determined)
- Avoidable emergency admissions reduced
- Reduction of proportion of older people not at home 91 days after hospital discharge
- Permanent admissions of older people to residential and nursing homes reduced
- Increase in number of people who feel supported to manage their long term condition
- Reduced emergency admission for alcohol related liver disease; enhance quality of life for those with long-term conditions
- Reduced time spent in hospital for people with long term conditions, including under 18s
- Positive experience of GP services
- Reduced number of patients falling into crisis and needing admission to hospital or care home
- Reduction in admissions due to smoking, alcohol and obesity related conditions

Improving and enhancing planned care

Goals and ambitions ***Key measures of success***

- Locally agreed care pathways for key conditions to ensure equitable access and consistent practice and to improve access to specialist opinion
- Electronic referral systems to replace paper-based system to reduce variability of referrals
- Greater proactive anticipatory care and supported self management
- Improved stroke pathways and outcomes
- Improve access to and quality of Cancer services
- Enhanced end of life care

E-referral

Integrated Clinically-led pathways through Map of Medicine

Enhance End of Life Pathways

Proactive anticipatory care and supported self management for long-term conditions programme

Single front door for health & social care

Patient and Public engagement throughout service redesign programmes

- Increase Dementia diagnosis rates to 67% by March 2015
- Increase in proportion of people with Mental Health disorders receiving psychological therapies to 15% by March 2015
- Growth of Elective FFCEs limited in 14/15
- Maximum 18 week wait RTT (maintained above 95 %);
- Improved Patient Experience (including Friends and Family test)
- Improving outcomes from planned treatments
- Avoidable emergency admissions reduced
- Improve bereaved carers' views of quality of care in last 3 months of life
- Reduction in number of people with Length of stay >30 days
- Improved choice in end of life care

Improving Urgent Care

Goals and ambitions ***Key measures of success***

- Improve the delivery of Urgent Care services by moving to an outcomes based approach
- Ensure the Urgent Care system provides high quality services and good access
- Reducing the number of avoidable admissions, readmissions, and repeat visits
- Reduced length of stay for non-elective admissions

Urgent Care - Outcome Based Commissioning

Urgent Care Improvement Plan

Community Team Development

Clinical Assessment Unit

Hospital at Home

Patient and Public engagement throughout service redesign programmes

- Reduction in non-elective admissions in 2014/15
- Reduction in non-elective FFCE in 2014/15
- A&E Waiting times (max 4 hrs.) (performance maintained at >95%)
- Maintain A&E attendances at 2012/13 levels
- Category A ambulance calls resulting in an emergency response arriving within 8 minutes – 75% (standard to be met for both Red 1 and Red2 calls separately
- Delivery of all Cancer targets including max 2 wk prior to 1st outpatient appointment for suspected cancer (93%)
- Improved Patient Experience (including Friends and Family test)
- Reduction in number of people with Length of stay >30 days
- Reduction in delayed discharges/performance maintained

Greater integration of care

Goals and ambitions

- Seamless working across all care settings
- Improved signposting for patients and public for health and social care services
- Putting in place a model for seven day working
- Enhanced re-ablement and intermediate care
- Modernising community services
- Enhanced end of life care
- Integrate voluntary sector services and community support into all services and pathways of care
- Information sharing between health and social care (including NHS Number)

Clinical Service Review

Seven day working across Health and Social Care

Single front door for health and social care

Re-ablement and Intermediate care programme

Patient and Public engagement throughout service redesign programmes

Key measures of success

- Improved Patient/service user experience (including Friends and Family test)
- Access to services seven days a week
- Reduce avoidable hospital admissions
- Reduced admissions to residential and care homes
- Reduced delays in transfer of care
- Patients feel supported with self management and independence
- Improved choice in end of life care
- Increased number of people with a health and social care personal budget
- Increased number of older people at home 91 days after discharge from hospital care into re-ablement
- Reduced number of patients falling into crisis and needing admission to hospital or care home
- Patient and service users are involved in service planning/redesign

Improving Health Outcomes for Children

Goals and ambitions

- Improved outcomes and access to health services for vulnerable children
- Better respite and short term care for vulnerable children
- Better outcomes for children with disabilities and long-term conditions
- Improved urgent care pathways for Children
- Improved Maternity Services
- Improved educational attainment as a result of better familial support

Children's Integration (Health, Social Care, Education)

Disabilities and LTC service transformation

Improvement of Maternity Services (midwifery-led)

Single front door for health and social care

Develop the market for children's services provision

Patient and Public engagement throughout service redesign programmes

Key measures of success

- Delivering safe care to children in acute settings
- Improving children's and young people's experience of healthcare
- Reduction of alcohol related admissions – children's
- Reduction in emergency admissions of children with self harm
- Improved patient experience – adult/child/parent/carer
- Reduction in readmissions to inpatient units for children with mental health needs
- Reduction in specialist children's placements (out of county)
- Increase the number of organisations providing help for children and families that are funded by sources other than council/health
- Reduction in Caesarean-Sections

High Quality Clinical Services

Goals and ambitions

- Establish future options for Herefordshire health and social system
- Strategy for clinically safe, high quality and financially viable services
- Improving local access to secondary care
- Enhanced Quality Assurance process
- Medicines Optimisation

Clinical Services Review

Access to secondary care services

Medicines optimisation

Enhanced Quality Assurance Framework

Herefordshire Health and Social Care Transformation

Stroke Pathways

Cancer Forum Programme

Patient and Public engagement throughout service redesign programmes

Key measures of success

- Improved Patient/service user experience (including Friends and Family test)
- Access to services seven days a week
- Patients feel supported with self management and independence
- Improved choice in end of life care
- Patient and service users are involved in service planning/redesign
- Future options for Herefordshire's health system identified inc options for transforming community services
- QIPP targets delivered
- Quality metrics delivered e.g. mortality rates reduced, fewer Sis and Never events, continued improvement in pressure ulcer rates, MRSA/CdiFF
- Delivery of all Cancer targets inc - Max 2 wk prior to 1st outpatient appointment for suspected cancer (93%)

Developing Primary Care

Goals and ambitions ***Key measures of success***

- Ensuring equitable access and provision of quality primary care
- Reducing variation in quality of care and improving standards
- Putting in place a model for seven day working
- Delivering prevention and early intervention
- Establish future options for Primary Care services in Herefordshire

Prevention and early intervention

Value Based service commissioning

Business continuity through PCS transition

Improving Access to services (7 day working)

Medicines Optimisation

Improved Quality/ Variation reduction

Primary Care Strategy (Medical, Dental, Ophthalmic, Pharmaceutical)

Patient and Public engagement throughout service redesign programmes

- Friends and Family test in General Practice
- Improving patient experience of primary care
- increased access to Primary Care (seven day working)
- Patients feel supported with self management and independence
- Increase Dementia diagnosis rates to 67% by March 2015
- Increased in number of people who feel supported to manage their long term condition

Modernising Mental Health

Goals and ambitions ***Key measures of success***

Delivering Parity of Esteem through:

- Patient -centred care pathways for mental health services
- Improved community focused memory service for people with dementia
- Complete Mental Health Needs Assessment
- Psychiatric liaison in acute services (RAID)
- Increase in psychological therapy in Herefordshire

Service Redesign of Mental Health services

Memory service for dementia

Mental Health Procurement (Adult and Children's)

Mental Health Needs Assessment

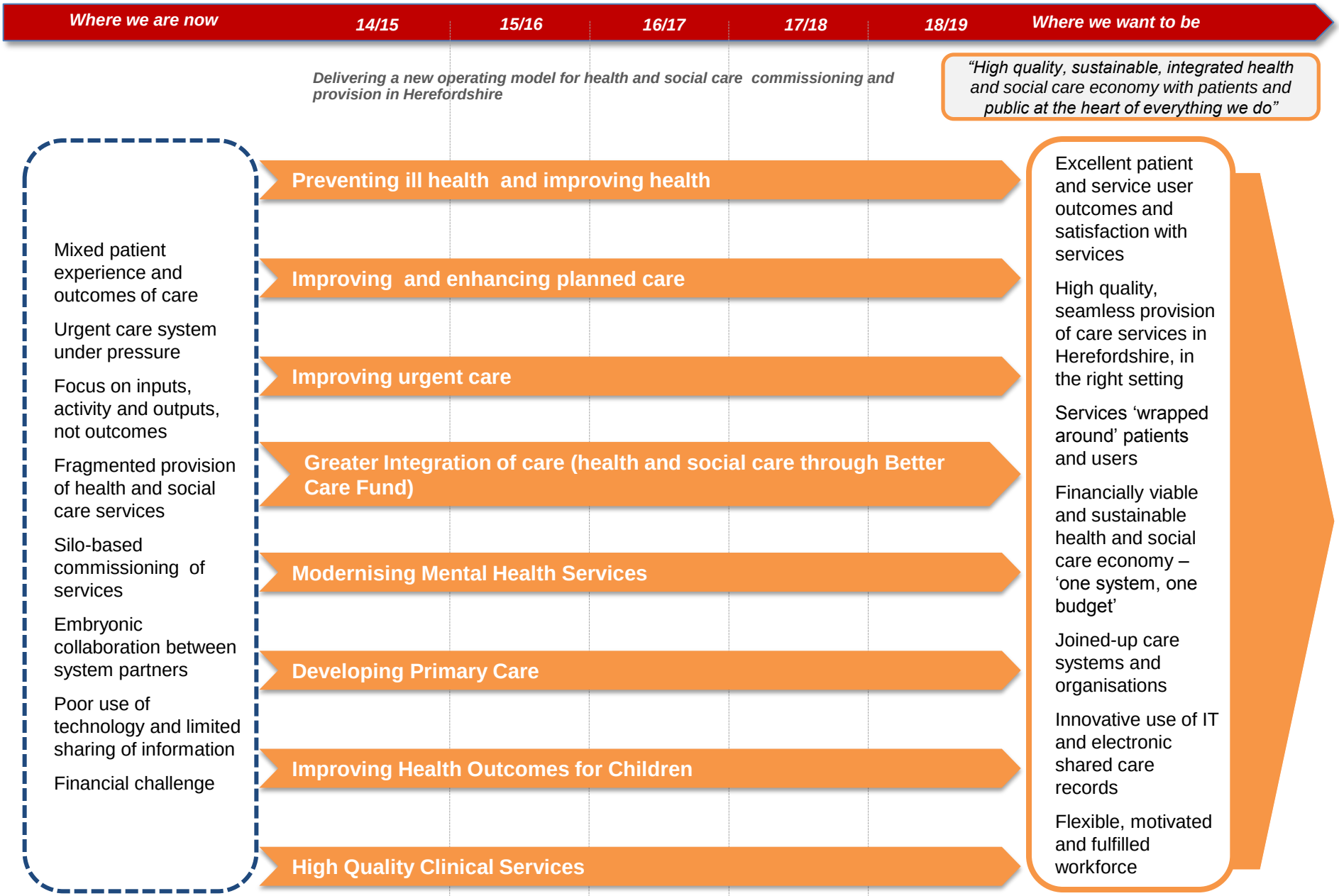
Psychiatric Liaison in acute

RAID

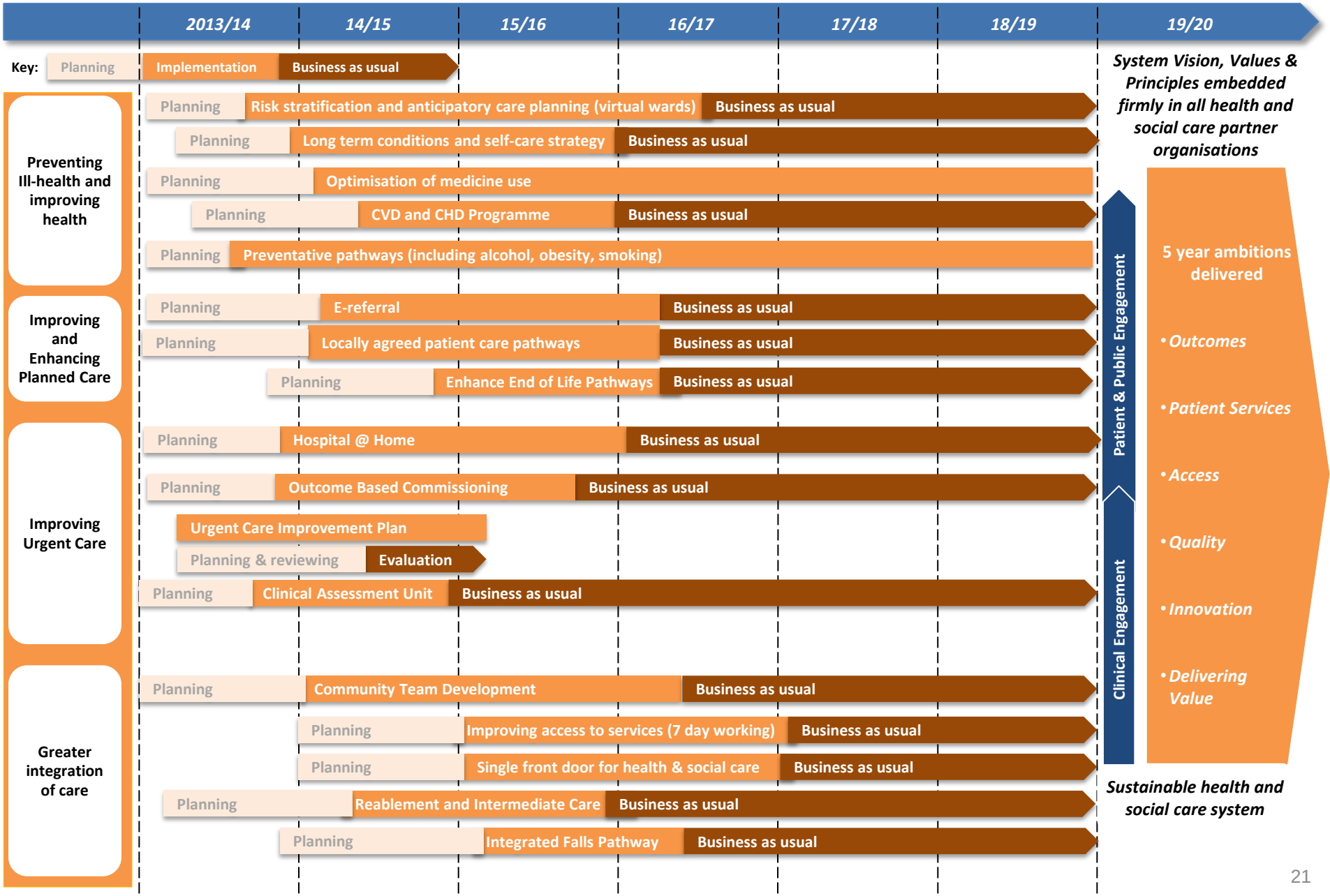
Patient and Public engagement throughout service redesign programmes

- Increase IAPT rates to 15 % by end of 14/15
- Increase Dementia diagnosis rates to 67% by March 2015
- Increased in number of people who feel supported to manage their long term condition
- Enhancing the quality of life for people with dementia
- Enhancing quality of life of people with mental illness

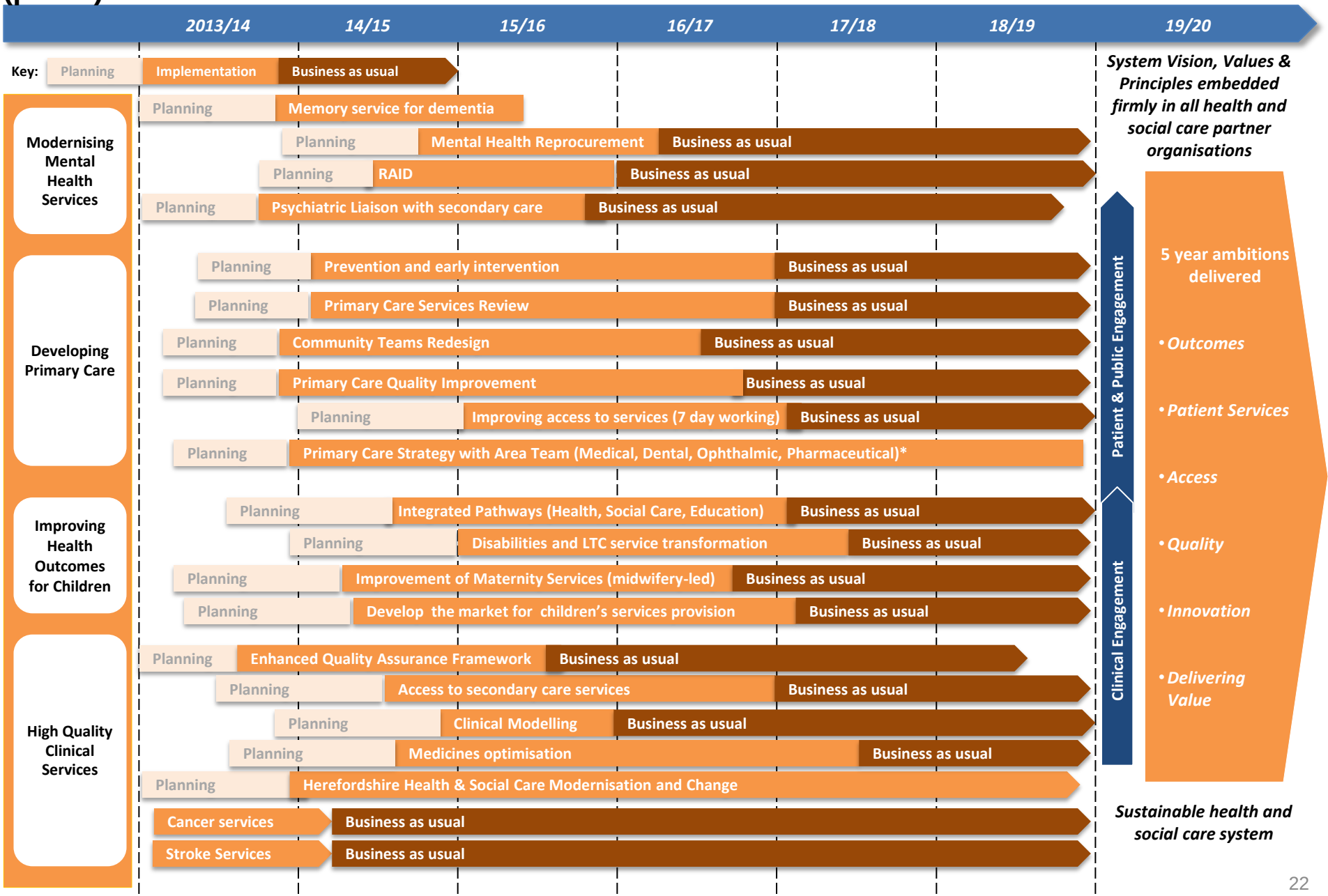
Our Two Year plan will lead into the Five Year planning process – indicators of success are shown below



The CCG is working with system partners to develop a clear roadmap for change as part of the Five Year planning & implementation process (part 1)



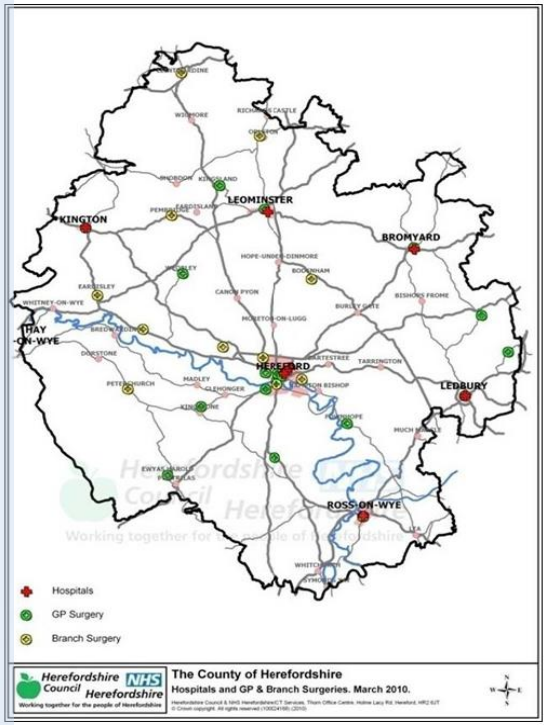
The CCG is working with system partners to develop a clear roadmap for change as part of the Five Year planning & implementation process (part 2)



Developing the Initiatives

This section covers:

- **Developing the Herefordshire Transformation Programme**
- **Five-year Plan on a Page**
- **Five year key projects**
- **Overview of workstreams**
- **Success criteria and measures**
- **Alignment to the Six Characteristics**
- **System Principles**
- **Alignment to the 5 National Themes**
- **Linkage between our Two- and Five-year plans**



Developing the Herefordshire system-wide transformation programme plans

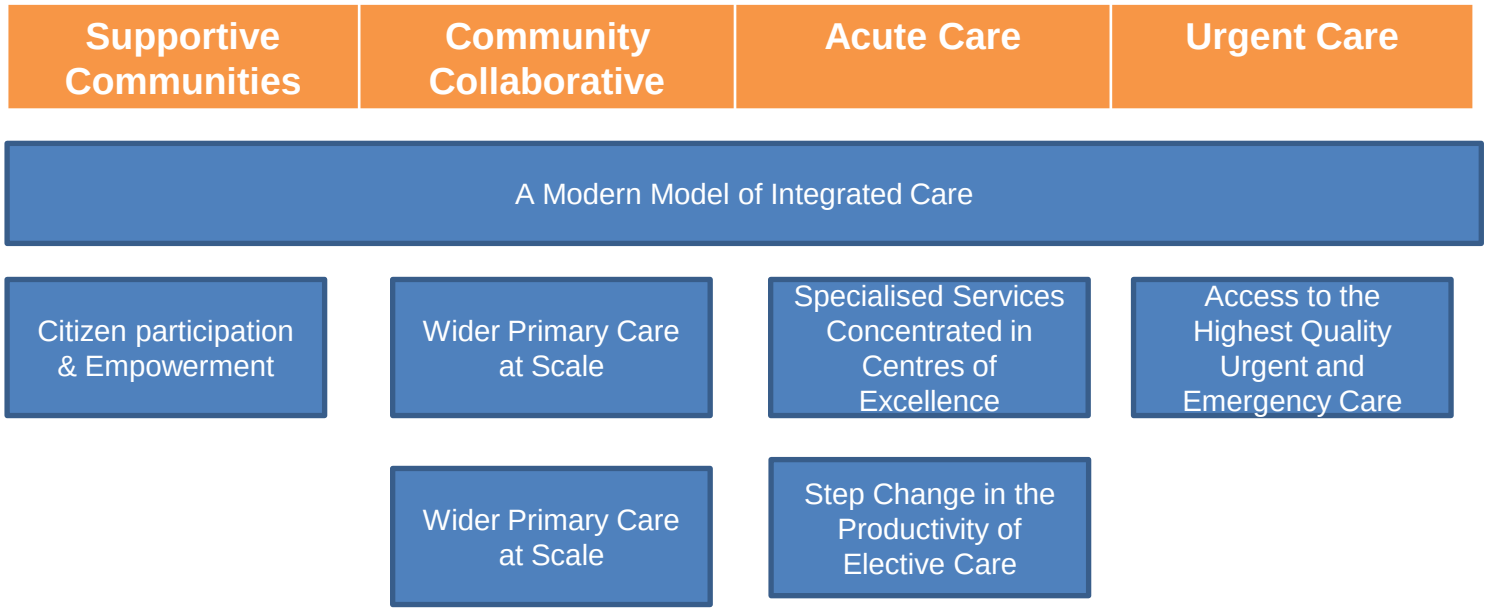
Herefordshire has created a 'virtual' programme team, with representatives from across the health and social care system. The team has been tasked with designing the programme approach and framework to carry out the whole system transformational change required.

The projects in our programme, jointly agreed at both programme and leadership level, have originated from the six characteristics of a …" high quality, sustainable health and care system in England…." (Everyone Counts – Planning for Patients 2014/15 – 2018/19).

The team followed an iterative process to ensure that the projects were inclusive to all partners (both health and local authority) and that they were locally relevant.

The diagram below shows the four key workstreams agreed locally and how the six characteristics are mapped to those workstreams.

It is recognised within Herefordshire that Specialised Services will be delivered through a network solution.



Herefordshire's system programme plan is being developed to outline our key interventions and objectives designed to deliver change

By 2020 Herefordshire system partners will provide seamless integrated care and support designed around the needs of individuals and their families.

System Objectives	Our projects	Our delivery schemes
Securing additional years of life	Community Collaborative	*Reablement (and short term breaks)*
Improving health-related quality of life		*Mental Health Redesign*
Reducing hospital admissions		*Single Front Door / Point of Access*
Increased people at home 91 days after discharge*		*Integration of Children's Services*
Increasing positive experience of hospital, primary, community care	Acute Care	*Virtual Wards / Hospital at Home*
Avoidable hospital deaths reduction		*7-day Working*
Improve the health, wellbeing and educational outcomes for Children	Urgent Care	*Outcome based Urgent Care System*
Improving health		*Clinical Assessment Unit*
Reducing health inequalities		*Rapid Access to Assessment and Care RAAC*
Parity of esteem	Supportive Communities	*Prevention and Early Intervention*
		Long Term Conditions / Self Care Management

Governance

Transformation Programme Board to drive forward the care transformation programme. It Includes all senior Health and Care leaders in the system. Initial programme delivery will remain within partner organisations, however overall accountability for measurement and monitoring of success will lie with the Board.

Detail is outlined on page 37.

Our success will be based on the improvement in quality outcomes as defined by the ambitions, and outlined further on page 16.

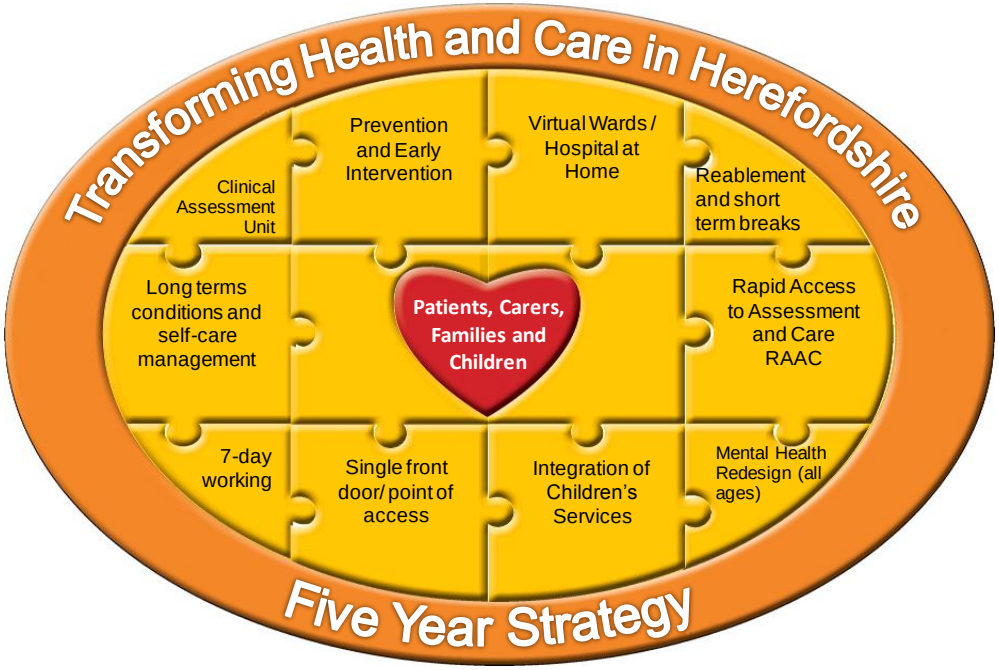
It will also be based on improved joint working and creation of a financially stable system.

The values and principles we will work to include:

- Strong patient and public engagement
- Quality care provided seamlessly
- Improved access to services
- Meaningful partner engagement
- Managing the system as a whole and in the best interest of the public and patients in Herefordshire

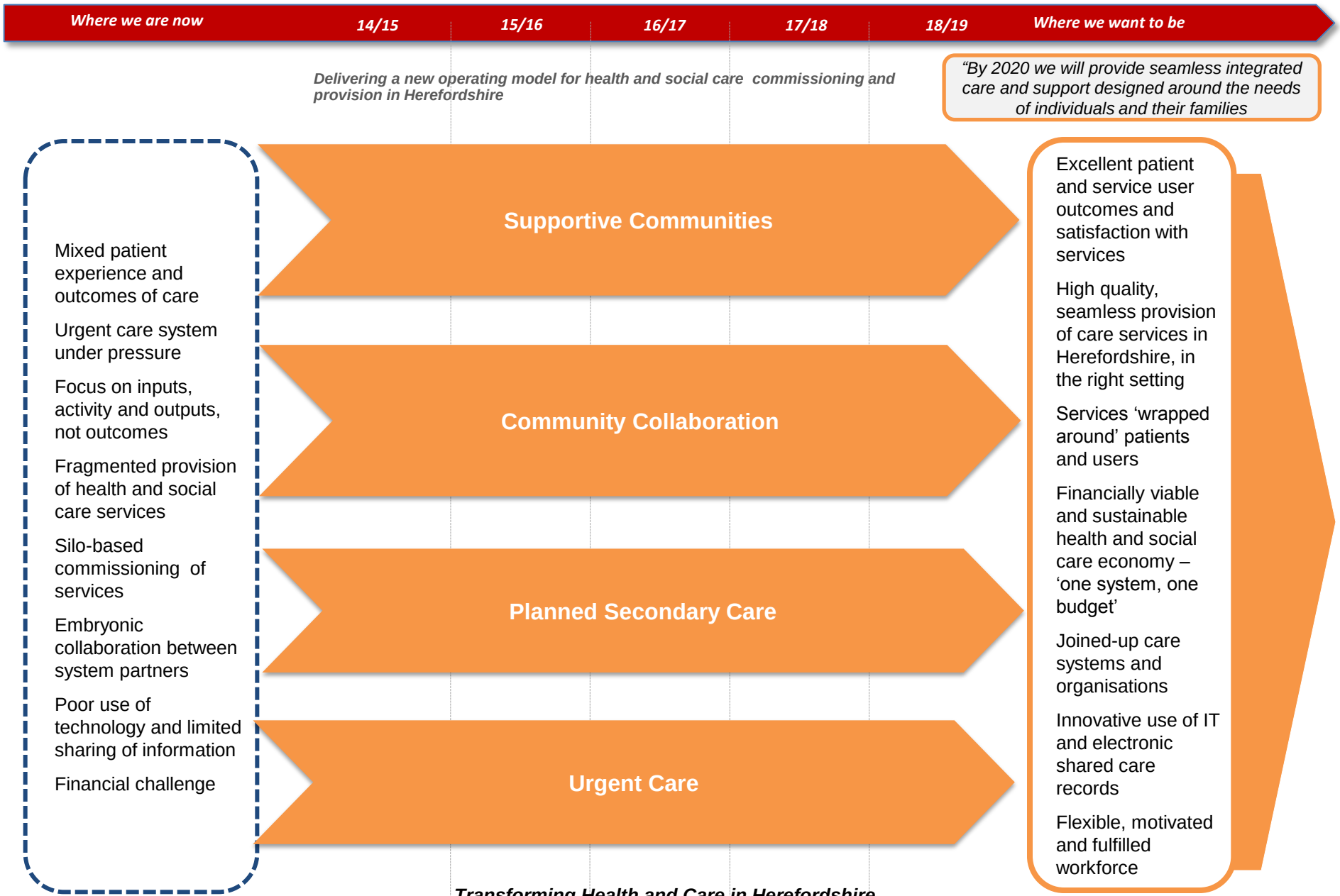
The system partner's Five Year Plan - Key projects

The Leaders' Group has ~~have~~ grouped our planned improvement interventions over the next five years into four key projects under the Herefordshire transformation programme.

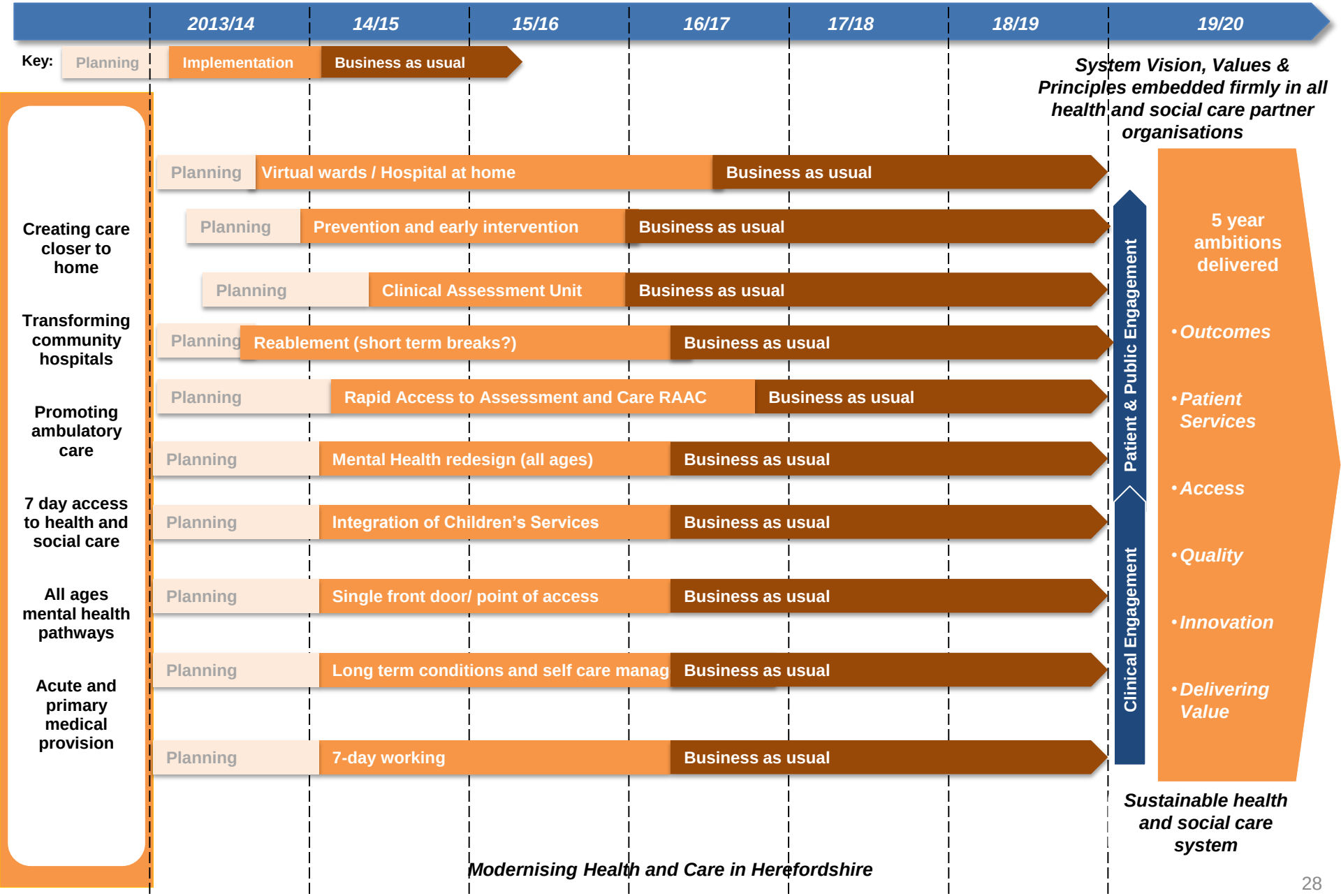


We have also identified joint programmes of work, centred around the needs of patients, carers, families and children, building largely on work already underway within the CCG's two-year plan.

Overview of workstreams



Our ten joint initiatives to deliver change by 2020



Modernising Health and Care in Herefordshire

We are developing a clear set of top line success criteria and measures that we will use to evaluate success against the seven ambitions

Ambition area	Metric	Proposed attainment in 18/19
1 Securing additional years of life for people with treatable mental and physical health conditions	Potential Years Life Lost from conditions amenable to healthcare - PYLL rate per 100,000 population	2069.8 to 1789.0 (3.2% min improvement)
2 Improving health-related quality of life for people with one or more long term conditions, including mental health conditions** - also BCF measure	Health-related quality of life for people with long term conditions, measured using EQ5D score (from GP survey) for people reporting having one or more long-term condition Proportion of people aged 18 and over suffering from a long-term condition feeling supported to manage their condition	74.90 to 78.92 0.72 by 2014/15
3 Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital (reduced A&E attendances/ emergency admissions)*	A&E attendances Avoidable emergency admissions – average per month (BCF) Emergency admissions composite indicator	57195 to 56452 by end 14/15 1720.9 to 1581.5
4 Increased the proportion of older people living independently at home following discharge from hospital*	Proportion of older people (65+) who were still living at home 91 days after discharge from hospital into reablement/rehabilitation services – BCF measure	87.1% to 92.9%
5 Increasing the number of people having a positive experience of hospital care **	Patient experience of inpatient care - proportion of people reporting poor patient experience of inpatient care	139.8 to 132.6
6 Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community (link to ASCOF measure)	The proportion of people reporting poor experience of General Practice and Out-of-Hours Services Reduce long term admissions of older people to nursing and residential homes, per 100,000 population – also BCF measure Reduced delayed transfer of care from hospital per 100,000 population – also BCF*	4.20 to 4.06 593 to 503 1701 to 864
7 Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	Hospital mortality *Clostridium difficile* infection cases reduction Improved reporting of medication errors MRSA – zero tolerance	 Max 46 in 14/15

We are developing a clear set of top line success criteria and measures that we will use to evaluate success

Ambition area	Metric	Proposed attainment in 18/19
9 Reducing health inequalities (Public Health outcomes)	Reduction in absolute inequalities in CVD mortality under 75 years Reduction in absolute inequalities in cancer mortality under 75 years Reduction in inequalities in infant mortality across social groups EDS2 implementation	To be agreed
10 Parity of esteem	IAPT roll out – proportion of people entering treatment against level of need in general population IAPT recover rate Dementia diagnosis rate Reduced rates of self-harm Improved identification of vulnerable patients through recognition of parity of esteem Identification and support for young people with severe mental health illness Reduce 20 year gap in life expectancy for people with severe mental illness	15.2% by 15/16 50% by 14/15 maintain 15/16 67% by March 2015 (52% by March 14)
11 Children & Young People	*Priority areas with metrics to be agreed* Early Years – Facility Approach (0-2yrs) Children with Disabilities Strategy Mental Health – including HIPPS and Parental Mental Health Youth Offending Families First	To be agreed

The Herefordshire Health and Care system will encompass the six characteristics of a high quality and sustainable system

The Herefordshire Health and Care system will be designed to maintain high quality services to its citizens, while ensuring it remains financially sustainable. As part of our approach to realising this vision we will:

- Ensure that we involve **Herefordshire citizens** in the design and development of our health and care services; we are dedicated to involving the right citizens at the right level to ensure meaningful engagement. This has and continues to be a fundamental part of the strategic and individual programme plans.
- **Involve patients and carers, children, young people and families** in the planning and delivery of their care, ensuring they have access to all the services, information, expertise and support they need to feel reassured and cared for; delivery of our electronic and hand-held care plans aim to provide the patient /carer's with long-term conditions access to their data.
- Aim to encourage people to take far more **responsibility for their health and wellbeing**, which will support the H&WB system ambitions around prevention of ill-health and reducing health inequalities.
- Develop our **Primary Care services** to look after patients with long-term physical and mental health conditions, so that they can access services 7 days a week, within a local setting, and feel supported in their care.
- Use the GP Practice population catchment to form a local base for health and social care staff to work across system boundaries to provide seamless care
- Work with NHSE on Primary Care transformation including workforce development, running costs, shared patient records, and named senior practitioner owners of multi-long term conditions cases.
- Transform our primary, acute and community services to offer tailored services to vulnerable and older people in our population; we will be commissioning and planning our services jointly between health commissioners, providers and social care under the 'Transforming Health and Care in Herefordshire' umbrella , to ensure health and social care is seamlessly provided to our citizens and patients at point of delivery.
- This **integrated model of care** delivery will build on our past experience and ensure we learn from it. The Better Care Fund will be a key vehicle for this. We plan to expand the scope of our work to include wider health and wellbeing
- Draw on the work by and the governance structure of the Urgent Care Working Group to lead the Urgent Care workstream to further improve the quality of **emergency care provision,** and ensure our providers work together in and out of hours to better manage crises and ensure patients and users flow through the care system safely and efficiently
- Review our primary and secondary care **elective care provision** to ensure it is safe, high quality and productive, and hence sustainable.
- Build solid relationships with centres of excellence providing **networked services and/or specialised** services as appropriate to our population, as they emerge.

Principles underpinning the development of our system

The system partners are leading a process to articulate and engage widely on a vision, plan and desired outcomes. The initial stages of this have been achieved through a number of collaborative workshops between commissioners and providers to:

- Agree a common understanding of the **key challenges** and possible solutions
- Agree the **joint programmes of initiatives** to deliver agreed outcomes;
- Agree a **governance framework** with defined roles and responsibilities for all partners, with clear accountability into existing organisational structures
- Ensuring strong **Patient and Public Engagement**
- Securing **collaborative working between partners** (Wye Valley Trust, 2gether FT, Herefordshire Council, Voluntary sector, NHS England, CSU, Public Health England, partner CCGs, and General Practice)

The next stage is to detail supportive **effective transition plans** that outlines the key risks and how these can be mitigated, as well as high-level costing and potential savings

Key framing principles around system-level change

- Resources need to shift from treatment and hospital admission to education, health promotion, and preventative strategies
- Herefordshire residents need access to high quality services which are "wrapped around them", so that they are enabled to stay in their own homes and localities and retain control of and responsibility for their own care for as long as possible
- Patients, carers and the public should expect to receive integrated services, irrespective of organisational boundaries
- We need to address the "enablers" of change, by agreeing targets and metrics for common objectives and moving away from Payment-by-results (PbR) activity-funding mechanisms (as demonstrated in our outcome-based commissioning of urgent care)

In developing solutions for Herefordshire we have developed the following working principles between partners:

- Radical change is needed at both strategic and local levels, and will be supported by strong governance frameworks (through the H&WB Board and organisational governance arrangements).
- Participants must give time and space to developing options which are in the best interest of the local system and the people that receive services.

Aligning the system to the five national themes of Quality, Access, Innovation, Value and Patient and Public Involvement

Quality

- The transformation programme will be designed to incorporate a Quality Assurance Framework which builds on existing arrangements within partner organisations, including conducting quality and equality impact assessments
- We will include patient and service user experience in our monitoring of quality, and enhance current complaints processes to ensure we act promptly and learn from issues
- We will develop our combined workforce to ensure we have:
    - The establishment required to meet the needs of the integrated services, leveraging the strengths and opportunities afforded by system working, and also develop a future pipeline for training of staff at all levels
    - The right skills, competencies and behaviours in place across the system, responding to the needs of our population and to the 6C's in Compassion in Practice

Access

- The system-wide services will be designed to provide seven-day access for users
- We will aim to address inequalities in our population, for example delivering against the NHS Constitution
- Consideration will be given to greater use of telecare and telehealth care across the county to improve access
- Spreading the 'Making Every Contact Count' initiative to ensure all social and health care contacts improve lifestyle advice and service signposting for people, and help address inequalities further

Innovation

- The system partners will link in to the work of the Academic Health Science Network AHSN to leverage innovative technologies and working practices to improve delivery of services and outcomes for people in Herefordshire
- For example, this may include changes to services which encourage patients, users and carers to be actively involved in their care planning through personalised care plans, or developing roles in primary care including physicians assistants and nurse practitioners

Value

- We will review our system revenues and costs, and act on streamlining our overheads to protect and enhance frontline services in the best interest of the people of Herefordshire

Patient and public involvement

- The Herefordshire health and care system will ~~be~~ define a communications and engagement strategy to support the system working plans
- We will build in greater engagement of vulnerable groups in service redesign work, to ensure we address inequalities and inequities in the system
- We have already started to engage widely across Herefordshire, and will be providing mechanisms for patient, carers and the population of Hereford to inform and influence plans
- We will build on our innovative Experience Lead Engagement process for specific schemes of work (e.g. integrated pathway development), and continue ~~to~~ openly to publish feedback on services (e.g. "You said, We did" and Healthwatch feedback)

We are linking existing operational plans with the Herefordshire system Five Year Plan

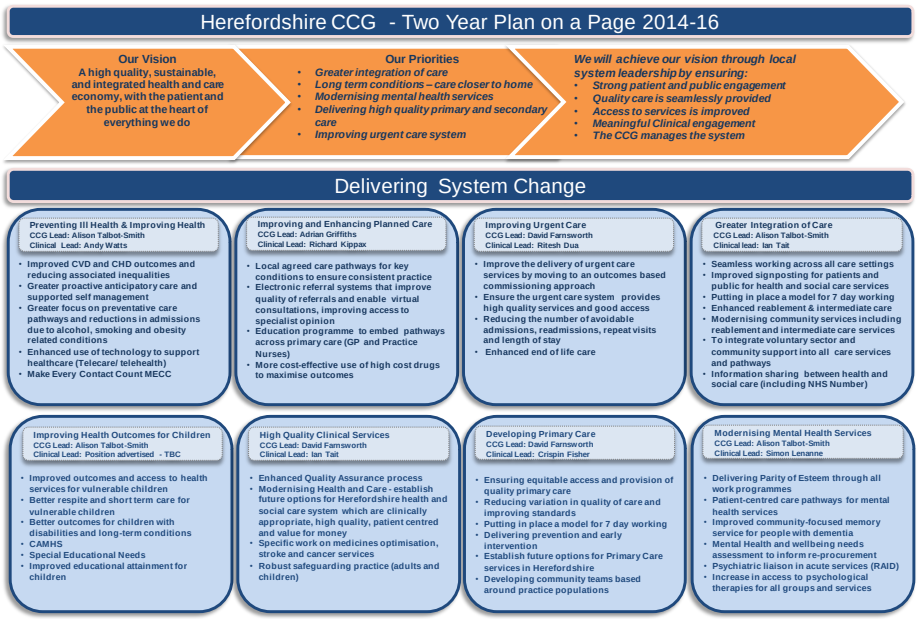
At this point in the process, the system partners have agreed an outline vision and joint programme of work (six priority areas and ten supporting initiatives) to deliver a modernised health and care system in Herefordshire.

We will now develop the details behind each initiative,. As a starting point the system planning team is using the CCG's two-year plan (shown alongside and copied in appendix 2).

All of the eight strategic themes in this are aligned to the Five-Year Plan, and there is clear overlap between the eight CCG themes and the proposed ten joint programmes of work in the future.

To illustrate this we have outlined the CCG's eight themes in more detail in the following pages:

- Preventing Ill Health and improving health
- Improving and enhancing planned care
- Improving urgent care
- Greater integration of care
- Improving health outcomes for children
- High quality clinical services
- Developing primary care
- Modernising mental health



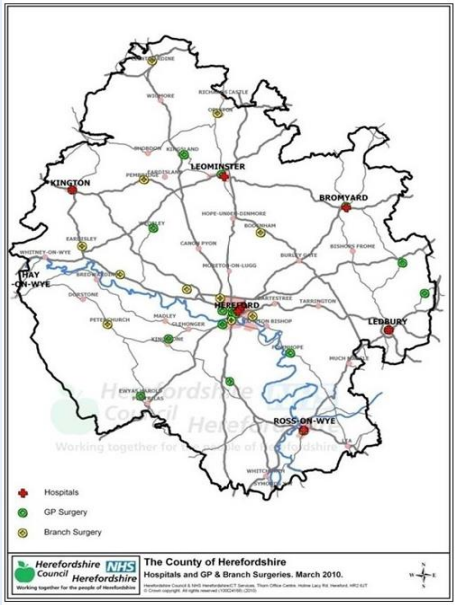
Our intention is to expand the scope of these initiatives with our partners, and then complete them as a 'system planning team'.

Our governance arrangements are being discussed to agree how these initiatives will then be jointly delivered and monitored.

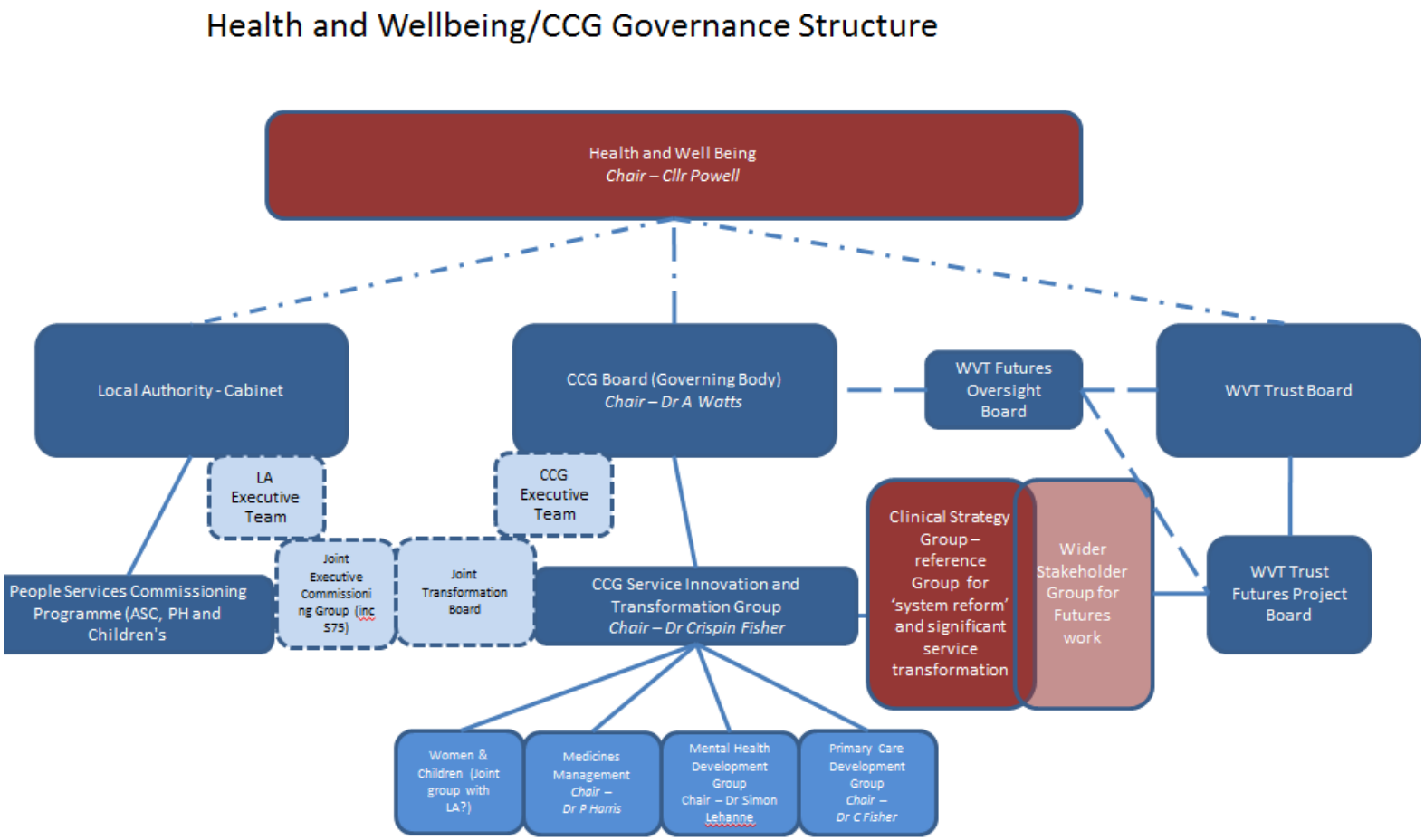
Enablers to deliver the Plan

This section covers:

- **Governance and programme management**
- **Better Care Fund**
- **Patient Engagement & Public Involvement**
- **Key enablers**
  - **Workforce**
  - **Organisational Development**
  - **Estates and Facilities**
  - **Informatics**



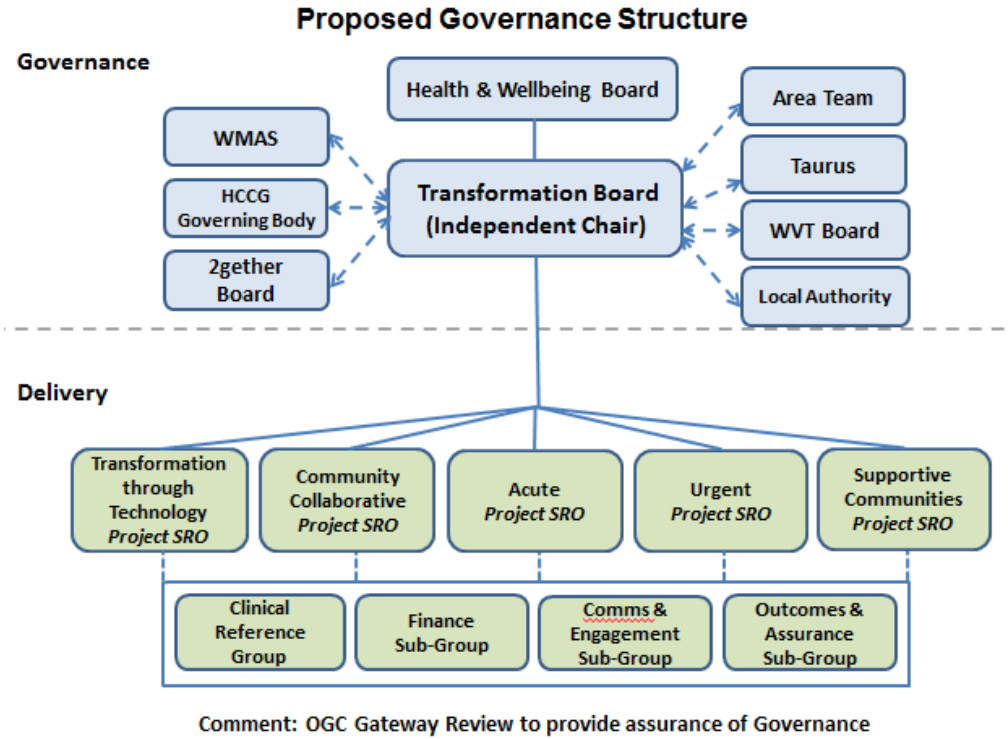
The transformation programme will be delivered within the current CCG governance framework



It is important that the system transformation programme has a robust governance framework to monitor and deliver the programme at pace

As system partners, we have agreed a governance structure to ensure we collaborate closely on developing, monitoring and reviewing our Five Year Strategic Plan.

We have decided that the Transformation Board will lead change on behalf of the Health & Wellbeing Board, and will be accountable to each partner's governing body , which will retain decision making authority. The programme management structure will coordinate engagement of respective partners throughout the process to ensure alignment of thinking.



Comment: OGC Gateway Review to provide assurance of Governance

- **Programme Governance -** The **Transformation Board** will have an independent chair, and will be responsible for delivering the radical change required to deliver the Five Year Strategic Plans, including the Better Care Fund. It will review progress against delivery, and lead the planning review on an annual basis going forward. The Board membership has been agreed and terms of reference will be drafted shortly, with the first meeting due by the first week of July 2014. The Transformation Board is accountable to the partner governing bodies as shown in the diagram alongside and not a decision making body.

Programme Delivery – the delivery will be led by a dedicated Programme Director who is being recruited. This role will report into the Transformation Board,. and will have overall responsibility for the delivery of all four main projects in the programme. Each project will have an appointed Senior Responsible Officer (SRO) who will be accountable for delivery of the projects. They will work closely with a designated Critical Friend as well as the appointed project manager and project management team. This group will also link closely to Clinical, Professional, Finance, Communications & Engagement, and Outcomes & Assurance sub-groups for subject matter expertise and reference.

The Better Care Fund will be deployed to fund the transformation programme projects which are aligned to its objectives, and monitoring and reporting against the fund will be the responsibility of the Finance sub-group.

Prioritised Herefordshire project delivery will initially be based on prototypes of new models of care to allow rapid progress, subject to Plan-Do-Study-Act (PDSA) cycles. Once testing is complete, a clear rationale and resource requirement will need to be outlined in a business case which will be approved by the Transformation Board.

The Better Care Fund plans are aligned to proposed future joint commissioning and delivery plans, and will contribute to moving towards integrated models of care over the next five years

Our Better Care Fund plans also align to the **six priorities** we have defined:

- Creating Care Closer to Home
- Transforming Community Hospitals
- Promoting Ambulatory Care (Providing appropriate alternatives to hospital admission)
- Delivering seven day access to health and social care interventions
- Implementing 'all ages' mental health pathways that include enablement and crisis resolution
- Primary and acute care medical provision

A key enabler around information sharing between health and social care has also been identified, using the NHS number as an identifier.

The Better Care Fund has also identified some **key objectives** for delivery, which again align to the Five Year plan objectives proposed:

1. To provide proactive anticipatory care that promotes supported self-management and prevents crisis presentations
2. To embed reablement across all health and social care settings as a fundamental building block of preventative care
3. To integrate voluntary sector services and community support into all services and pathways of care
4. To align services (statutory and voluntary) around primary care, making it the heart of community services that provide real alternatives to emergency hospital admission and facilitate earlier discharge home
5. To enable effective liaison and integration of processes across organisational boundaries to ensure seamless pathways of care – in particular between primary, secondary, mental health and social care services
6. To embed patient and public views into commissioning plans, service developments and monitoring and evaluation of delivery

Several **health and social care outcomes** will be impacted by the Better Care Fund, and these include:

- Reduce avoidable hospital admissions
- Reduce admissions to residential and care homes
- Reduce delays in transfer of care
- Patients feel supported with self management and independence
- Improve choice in end of life care
- Engage patient and service users in service planning
- Increase the number of people with a health and social care personal budget
- Maintain the numbers of older people at home 91 days after discharge from hospital care into reablement
- Reduce the number of patients falling into crisis and needing admission to hospital or care home

Patients and Public will be at the heart of everything the system partners do; we will ensure they are engaged in our service redesign and changes

Our model of patient and public engagement is being designed using the “Transforming Participation” model to ensure wide-spread and meaningful patient and public involvement in future planning.

As partners we will continue to work together, build on and strengthen the patient and public engagement already undertaken; we will embed patient and public involvement in everything we do from service redesign to contracting processes.

Herefordshire people have said that public organisations should use existing groups, forums and meetings to gain feedback rather than setting up new mechanisms.

We will thus continue to go out to existing patient and community groups to discuss the emerging proposals and feedback the information gained into the working groups, where possible using local people to share their experience first-hand with the working groups.

Examples of this expanded engagement with our partners in the county and nationally include:

- Working with HealthWatch Herefordshire and NHSIQ to identify and recruit Patients, Public and Carers to working groups, and develop their skills in supporting future planning and commissioning activities we undertake.
- Engaging in national pilots such as NHS Citizen, Patients in Control and Involve programmes, as well as Patient Participation Groups (PPG) and other local public and voluntary sector arrangements to inform service redesign and planning work, expanding our ‘your voice’ engagements from May 2014 onwards.

Good practice to date

- ***Urgent Care experience led event including workshops and surveys across county (Health watch actively involved)***
- ***Events with schools to hear voice of children***
- ***Strengthened “you said, we did” feedback process and patient stories at Governing Bodies***
- ***Involvement of patients in design of diabetes patient held records and development of dementia pathways***
- ***E-referral design groups with patients***
- ***There are over 200 members in the CCG Membership Scheme***
- ***Members are engaged via newsletters with information and invitations to attend various events –such as our forthcoming Call to Action***
- ***Established database of 255 third-sector and other organisations where the membership scheme is promoted***
- ***Awareness and distribution of PALS/Complaints leaflets including to voluntary and community sector***

Our Urgent Care engagement event defined a vision for the future

We have undertaken widespread engagement to inform current initiatives and the emerging transformation programme

Since submission of our draft, there has been significant engagement activity to support the Five-year Strategic Plan, the Better Care Fund and the wider Health and Wellbeing transformation work; this has been linked together to avoid duplication and confusion amongst our target audience. We have used social media extensively, and are carrying out an e-survey to support the transformation process.

HCCG is developing a central repository for Public, Patient and Carer feedback, which will enable the feedback to be used in the development of any programmes of work or projects without the need to repeat questions already asked. This repository will also be used to develop future strategic plans. Specific Five-Year Strategic Plan engagement we have undertaken is detailed in appendix xx and includes:

- Urgent Care OBC Project Coproduction Workshops
- E-consultation/e-referal Project Workshops
- 5 year plan engagement sessions with Herefordshire Disability United, Herefordshire Services for Independent Living, Deaf Direct and the Diabetes Network.

Summary of key themes emerging from engagement so far:

- *Patients want be treated holistically – especially those with long term health conditions*
- *Community hospitals are valued, patients would like to see their services being extended, including volunteer-led support services*
- *Better and easier to access information is important*
- *Improve communication and information sharing between services*
- *Allow the patient to be involved at all stages - greater involvement in decision about care and treatment plans*
- *Patients welcome better use of technology in treatment but also value the benefit of face to face contact*
- *Patients want their opinion to be valued by health staff and for staff to take into consideration that people are distressed when acutely unwell*
- *Better information for patients and their families about their illness would help in preventing further illness*
- *Waiting times need to be reduced*
- *Patients want to be seen by people they know and trust*

Examples of patient and user feedback

You said:

"We want to receive care closer to home"

"Autism services in Herefordshire for adult service users do not always meet local needs"

"Diabetes patient hand held record could be improved"

We did:

- Set up 'Virtual Wards' delivered in the patients' own home based on hospital care and treatment
- Met with service users to understand their experiences. Joint working with local authority to develop a clear strategy and plan to address feedback
- Sought feedback on how improvements could be made, and improved records. Ongoing evaluation in progress to ensure records are effective for service users

Patient response

"I haven't felt like this many people have cared about me before, thank you"

"This is marvellous service and all the staff I have met so far are fantastic"

"When you say you're going to do something you do it"

"I've have had a full night's sleep after your initial visit which is the first time in three months, because I feel someone is there for me and to help me feel better"

Other key enablers to consider as we move towards a joined-up Health and Care system across Herefordshire

Workforce – system wide

We recognise that developing and implementing our modernisation plans will require significant change to the workforce skills and configuration across the system. We will be working as partners with the Local Education & Training Board LETBs to develop this over the coming months.

The main elements of the workforce plans are:

- Enable reconfiguration of the workforce through improved modelling and planning, widening the skills base
- Ensure that service redesign and workforce development are aligned
- Identify, recruit and develop for the various roles in the care system (e.g. clinicians, professionals, support staff etc)
- Improve carer registration and support to streamline the carers assessment process

Our modernisation programme is likely to focus on:

- Further development of community teams, primary care and care pathways will have substantial workforce implications across the health and social care economy
- Training and education of clinicians across Herefordshire in the use and implementation of Map of Medicines Pathways
- Community health and social care teams having an increased focus on prevention of admissions through partnership working with GPs, carers, and the wider community workforce through integrated care models

Organisational Development

The system partners have agreed to develop the core services and functions first, and then work out how best to develop the organisational forms to deliver this. The organisational form does not mean integration of organisations, but could involve innovative ways of working across organisational boundaries to deliver the best care to the people of Herefordshire. The CCG recognises that the CSU will be instrumental in providing expertise and resource to support the delivery of change in Herefordshire.

Estates and Facilities

The estate and facilities available across the health and care system in Herefordshire will also require consideration; again initial focus will be on providing the services from existing estates, and rationalisation can then take place over the coming years to maximise use of the estate across health and social care partners to further reduce the system's overhead costs and maintain frontline services.

Informatics

Information requirements are growing; there is a clear commitment to enable sharing of patient and service user data across partner organisations, and the NHS identifier is the start of this process. Provision of seamless care across health and social care will require access to records and information, and the supporting infrastructure and mobile devices to support improved access to this.

Appendices

This section covers:

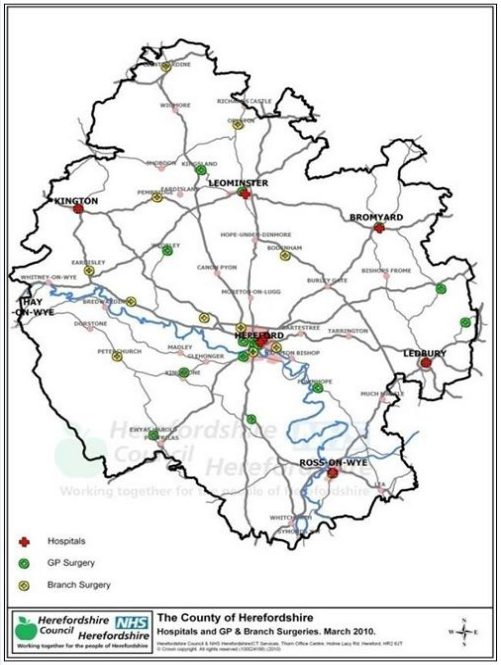
A: Risks and mitigation actions

B: WVT 2 Year plan on a page

C: Methodology for developing our system plan

D: Patient engagement results

E: Key Lines of Enquiry references



A. Risk Management

- We have identified a number of financial, clinical and organisational system risks with the Unit of Planning exercise
- Our plan sets out an ambitious transformational and improvement programme that requires clinical leadership and working across the Health and Social Care system in the County
- Our Governing Body and sub committees will monitor and review risks and their associated mitigation plans to ensure appropriate management action is being delivered and having the intended impact
- The Governing Body and sub committees also monitor and review Quality and Performance reports and are responsible for the Quality Assurance Framework, which is used to provide additional assurance and minimise risk

Appendix A: In planning our transformation, several key risks, their impact and mitigating actions have been identified

	Risk	Risk before mitigation	Impact	Mitigation	Risk after mitigation
1	Deliverability of financial and efficiency challenge in Herefordshire – without consequential adverse quality effects	High	System becomes unaffordable and services cannot be sustained, resulting in shortages of essential quality care provision in Herefordshire	Partners are exploring the potential for further pooling of budgets, in line with the BCF submission. It is recognised that each organisation needs to be cogniscant of its statutory financial requirements and reporting governance arrangements. Clear benefits and outcomes, and clear accountability for delivery and monitoring via the Transformation Board/ Finance sub-group.	Medium
2	Maintaining quality and access within the cost envelope over the five years of the plan	High	Cost pressures lead to resources being cut from service delivery, which in turn leads to waiting time increases and poor quality and clinical outcomes	Clinical and professional buy-in and oversight needs to be sought and maintained throughout the transformation planning and delivery via the clinical and professional sub-groups, all schemes and programmes of work need clear Quality Impact Assessments	Medium
3	Capability and capacity to deliver changes within the system (commissioner and provider)	High	Programmes of change are not delivered and benefits and outcomes not achieved	Alignment of joint resource plans to ensure the programme and projects adequately prioritised and resourced in all system partner organisations	Medium
4	The scale, challenge and pace of the transformation required may result in some partner organisations being overwhelmed	High	Transformation actions are loaded on top of business as usual, which leads to over-worked staff	Upfront sign-up to the transformation plans by all partners; agreement of the pace and acknowledgement of the workload; appropriate partner representation at a senior level at Programme Board	Medium
5	Future financial sustainability will depend on partner organisations being willing to repurpose budgets and funding to allow changes to be made, beyond any non-recurrent money for test phases	High	Reluctance by partners to allow funding arrangements to be made around the new models of care results in resources not being made available for the test and roll out phase	Commitment from CEOs and FDs to enable this to happen; and necessary redistribution of resources needs to be reflected in contract negotiations for the coming year; need to agree a transitional funding arrangements and risk share	Medium
6	Ability to recruit a programme director and project managers for the transition programme in a short period of time available	High	Lack of coherent management of the programme and projects, resulting in over-work of current staff trying to deliver the transition plans and their day jobs	Needs to be highlighted as a key priority for the transition board to resolve, and fast-track any initial roles required for the test phase	Medium

Appendix A: In planning our transformation, several key risks, their impact and mitigating actions have been identified (cont.)

	Risk	Risk before mitigation	Impact	Mitigation	Risk after mitigation
7	Citizens and other key stakeholders feel uninvolved and not consulted on key health and care service changes and service redesign projects	High	HCCG and its partners are seen as ineffectual organisations and service changes are not owned or focused on patient and public needs	HCCGs revamped patient and public involvement plan will ensure greater focus on patient engagement and involvement and use of HVOSS and voluntary sector; a system-wide transformation engagement plan will be developed	Medium
8	NHS Constitutional commitments are not delivered for Herefordshire residents	High	Services and outcomes for patients expected are not delivered, and safety of patients is put at risk	Clear programmes of improvement are in place, robust performance frameworks will ensure tight grip on delivery and keeping an eye on business as usual through the transformation	Medium
9	Implementation delays caused by the need to change contractual and commissioning arrangements	High	Changes can not take place due to arguments over contractual arrangements, delaying implementation	Partner agreement to waive or flex any contractual changes required during the testing phase; deliberate efforts to focus on function rather than organisational form; any formalised contractual changes post-testing and pre-roll out to be planned	Medium
10	Health and Care Commissioners and Providers are not aligned on delivering key improvement and financial challenges	High	Inability to agree financial budgets, savings and investments, delaying progress towards integration of services	Joint system transformation programme planning and governance to ensure common agreement of programme plans/ budgets at senior levels; accountability at senior level to the partner's	Medium
11	Implementation issues and delays caused by HR issues or a lack of change management planning	Medium	Changes in structures of reporting lines is blocked by Union or staff representatives, delaying the test phase or roll out	Early involvement of HR and OD representatives from all partner organisations; development of a change management blueprint	Low
12	Limited opportunity for staff/ wider stakeholder engagement due to the pace of delivery required and short lead time between prototyping and roll-out to all sites	Medium	Staff and other stakeholders feel excluded from the planned changes and disengage, hence resisting change	Agreed format for communicating prototype learning and outcomes with affected stakeholders, and an engagement plan to start early during the testing phase	Low

Appendix A: In planning our transformation, several key risks, their impact and mitigating actions have been identified (cont.)

	Risk	Risk before mitigation	Impact	Mitigation	Risk after mitigation
13	Capacity and resource constraints to implement change during winter pressures in 14/15	**Medium**	Staff and resources are diverted to deal with winter pressures at a critical roll out time, resulting in a lack of resource to deliver the new models of care	Deliberate planning and implementation at pace to embed key changes ahead of the winter period; phased approach to implementation and dedicated delivery teams	**Low**
14	No linkage and inter-dependency with current priority initiatives such as the Urgent Care Working Group focused on improving RTT performance at Wye Valley Trust	**Medium**	Changes and objectives proposed with the new models are misaligned or not run in sequence with other system-wide changes, causing confusion and disrupting services to patients and service users	Project inter-dependencies to be mapped and review management and reporting arrangements to ensure total alignment and lack of duplication between key project teams	**Low**

Appendix B: Herefordshire CCG's Two Year plan is focused on 8 key strategic work areas aimed at delivering our priorities

Herefordshire CCG - Two Year Plan on a Page 2014-16

Our Vision

A high quality, sustainable, and integrated health and care economy, with the patient and the public at the heart of everything we do

Our Priorities

- *Greater integration of care*
- *Long term conditions – care closer to home*
- *Modernising mental health services*
- *Delivering high quality primary and secondary care*
- *Improving urgent care system*

We will achieve our vision through local system leadership by ensuring:

- *Strong patient and public engagement*
- *Quality care is seamlessly provided*
- *Access to services is improved*
- *Meaningful Clinical engagement*
- *The CCG manages the system*

Delivering System Change

Preventing Ill Health & Improving Health
CCG Lead: Alison Talbot-Smith
Clinical Lead: Andy Watts

- Improved CVD and CHD outcomes and reducing associated inequalities
- Greater proactive anticipatory care and supported self management
- Greater focus on preventative care pathways and reductions in admissions due to alcohol, smoking and obesity related conditions
- Enhanced use of technology to support healthcare (Telecare/ telehealth)
- Make Every Contact Count MECC

Improving and Enhancing Planned Care
CCG Lead: Adrian Griffiths
Clinical Lead: Richard Kippax

- Local agreed care pathways for key conditions to ensure consistent practice
- Electronic referral systems that improve quality of referrals and enable virtual consultations, improving access to specialist opinion
- Education programme to embed pathways across primary care (GP and Practice Nurses)
- More cost-effective use of high cost drugs to maximise outcomes

Improving Urgent Care
CCG Lead: David Farnsworth
Clinical Lead: Ritesh Dua

- Improve the delivery of urgent care services by moving to an outcomes based commissioning approach
- Ensure the urgent care system provides high quality services and good access
- Reducing the number of avoidable admissions, readmissions, repeat visits and length of stay
- Enhanced end of life care

Greater Integration of Care
CCG Lead: Alison Talbot-Smith
Clinical lead: Ian Tait

- Seamless working across all care settings
- Improved signposting for patients and public for health and social care services
- Putting in place a model for 7 day working
- Enhanced reablement & intermediate care
- Modernising community services including reablement and intermediate care services
- To integrate voluntary sector and community support into all care services and pathways
- Information sharing between health and social care (including NHS Number)

Improving Health Outcomes for Children
CCG Lead: Alison Talbot-Smith
Clinical Lead: Position advertised - TBC

- Improved outcomes and access to health services for vulnerable children
- Better respite and short term care for vulnerable children
- Better outcomes for children with disabilities and long-term conditions
- CAMHS
- Special Educational Needs
- Improved educational attainment for children

High Quality Clinical Services
CCG Lead: David Farnsworth
Clinical Lead: Ian Tait

- Enhanced Quality Assurance process
- Modernising Health and Care - establish future options for Herefordshire health and social care system which are clinically appropriate, high quality, patient centred and value for money
- Specific work on medicines optimisation, stroke and cancer services
- Robust safeguarding practice (adults and children)

Developing Primary Care
CCG Lead: David Farnsworth
Clinical Lead: Crispin Fisher

- Ensuring equitable access and provision of quality primary care
- Reducing variation in quality of care and improving standards
- Putting in place a model for 7 day working
- Delivering prevention and early intervention
- Establish future options for Primary Care services in Herefordshire
- Developing community teams based around practice populations

Modernising Mental Health Services
CCG Lead: Alison Talbot-Smith
Clinical Lead: Simon Lenanne

- Delivering Parity of Esteem through all work programmes
- Patient-centred care pathways for mental health services
- Improved community-focused memory service for people with dementia
- Mental Health and wellbeing needs assessment to inform re-procurement
- Psychiatric liaison in acute services (RAID)
- Increase in access to psychological therapies for all groups and services

Appendix C: Wye Valley NHS Trust Two Year is aligned to the system plans

Two Year Business Plan Summary 2014-16

Wye Valley NHS
NHS Trust

We will sustain and improve our service quality	We will ensure that patients receive prompt, effective care	We will improve the productivity of our elective services	Our staff will be engaged in the plans and direction of the Trust	We will achieve our financial plans, laying the basis for future years	We will develop a clear strategy that will build confidence in the future
Quality & Safety	**Urgent Care**	**Planned Care**	**Workforce**	**Finance**	**The Future**
Protecting people from avoidable harm	Deliver the Urgent Care Improvement Programme	Improve theatre scheduling	Develop a pay and reward strategy	Deliver the savings programme	Continue to work with the TDA to clarify the future shape of the organisation
Ensuring a safe and skilled workforce	Redesign the A&E Dept.	Reduce additional session costs	Integrate workforce plans with business plans	Improve performance on budgetary management	Work with commissioners to transform local services
Reduce mortality rates	Improve acute assessment and ambulatory care	Reduce the volume of work done in the private sector	Improve staff productivity	Seek appropriate income levels from commissioners	Develop a five-year integrated business plan as a blueprint for the future
Treating patients with privacy, dignity, respect & compassion	Strengthen short stay care	Increase the number of seven day services	Improve recruitment practices	Seek better financial arrangements for the PFI contract	
Delivering patient centred care	Improve patient flow and reduce length of stay		Enhance leadership and management development	Review the long term financial plan	
Improve access times for services	Improve discharge arrangements		Improve staff commitment and engagement	Develop a performance culture	
Ensure people's care and treatment achieves good outcomes	Increase the number of seven day services		Develop clear HR policies		
Ensure the Trust has clear and transparent governance processes					

Supporting Strategies:	Information Technology	Estates
	Procuring an e-Patient Record Improved infrastructure	Reducing the number of sites Making the best use of buildings

Appendix D: Our methodology for developing and jointly agreeing a system plan across all key partners in Herefordshire

The strategic partners of Herefordshire, including members of the Health & wellbeing Board, have over the last four months, been meeting regularly in the form of interactive workshops to identify the framework needed to deliver system wide radical change. Commissioners and Providers have been give the opportunity to share individual organisational pressures and challenges. The information shared continues to shape the overall system challenge which will enable a commissioner/provider jointly agreed transformation programme.

We recognise that these plans are only at a very early stage, and will continue to be developed over the coming months, before delivery starts. However, we also acknowledge that many of the projects will be an extension or adaption of current work already underway across the CCG and its partners.

To support the transformation programme a 'virtual' programme team has been established with representation from all key partners to ensure that the design of the delivery framework is jointly created and owned. Decisions will always be deferred back to each partner's governing body, and we have outlined how this will work in our governance section.

Participants in the developmental workshops included:

Herefordshire Council including:

Chief Executive
Director of Adult's Wellbeing
Director of Children's Wellbeing
Lead Councillor for Adult Wellbeing (and Chair of the Health and Wellbeing Board)
Lead Council for Children
Chief Finance Officer

Herefordshire CCG

Clinical Lead
Chief Officer
Chief Finance Officer
Head of Clinical Outcomes and Service Transformation
Board GP

Taurus

Chair

Wye Valley NHS Trust

Chief Executive
Director of Nursing
Director of Finance
Director of Operations
Head of Programme Delivery

2gether Mental Health Trust

Chief Executive
Director of Organisational Development
Interim Director of finance

Area Team

Director
Director of Commissioning
Director - Clinical Strategy.

Appendix E – Results of Herefordshire CCG's Engagement Programme

Herefordshire CCG has undertaken a significant amount of Public, Patient and Carer Engagement in its e-consultation/ referral pilot, dementia strategy and urgent care pathway work including over 500 hours co-production.

The outputs of this work have informed the priorities in the 5 year plan. The urgent care workshop was the first of a number of patient/public events, and having a patient/public reference group to validate/review/critique submitted bids for the procurement.

Specific 5 year Plan Engagement:

- Herefordshire CCG has developed a stakeholder database of over 200 stakeholder groups across the county. This database is being used to arrange discussions about the 5 year plan through existing forums.
- Herefordshire CCG has already presented and discussed the 5 year plan with a range of key patient and community groups including:
    1. Healthwatch Herefordshire
    2. Herefordshire Voluntary Organisations Support Service (HVOSS) – Childrens' Interest Group and Older Persons Interest Group
    3. Herefordshire Disability United
    4. Diabetes UK
    5. Herefordshire Services for Independent Living
    6. Deaf Direct

- Herefordshire CCG has developed a public slide set outlining the 'Case for Change' and a public questionnaire to support the development of the 5yr Plan. These have been:
    1. Made available on-line with associated social media awareness campaign
    2. Sent to all 200 CCG Members and Practice Participation Groups
    3. Disseminated to over 50 key stakeholder groups on the CCG Stakeholder Database

There have been 76 responses to date – the interim report follows as appendix D(i).

- The CCG is currently undertaking 'visioning workshops' with key strategic partners (LA, WVT, 2Gether, Taurus) to gain agreement on the Health and Wellbeing Modernisation Programme priorities and Better Care Fund which will feed the 5yr plan.
- Following the above workshops the CCG will engage local stakeholder groups (identified through its database) in developing the key areas of work required to deliver each of the identified priorities via workshops aligned to the specific priorities.
- As each of the work streams and projects associated with the 5 year plan priority areas are developed the CCG is engaging the public, patients and carers, and is planning to use coproduction workshops to develop the solutions. The plans for this stage of engagement are in development and will continue to be refined as the priority areas and related projects are finalised.
- The engagement activity to support the 5 year plan, the Better Care Fund and the wider Health and Wellbeing Modernisation work is being linked together to avoid duplication and confusion.
- Regular updates about system/ service developments and engagement opportunities are being made available:
    1. On the CCG Website
    2. Via Twitter and Facebook
    3. Via CCG membership newsletter
    4. Via Stakeholder newsletter

Appendix E – Results of Herefordshire CCG's Engagement Programme (cont)

- The CCG is developing a central repository for Public, Patient and Carer feedback, which will enable the feedback to be used in the development of any programmes of work or projects without the need to repeat questions already asked. This repository will also be used to develop future strategic (2 and 5year plans)
- **Specific 5 year Plan Engagement:**
    - Public and patient engagement has been carried out with the following groups:
    - Urgent Care OBC Project Coproduction Workshops
    - E-consultation/e-referal Project Workshops
    - 5 year plan engagement sessions with:
        1. Herefordshire Disability United
        2. Herefordshire Services for Independent Living
        3. Deaf Direct
        4. Diabetes Network
- For the report we have used a word cloud below to help identify common themes and display them in a visual way. The most frequently spoken words are shown larger in the cloud. We have also listed the common themes too.

What did people say?

- *Patients want be treated holistically – especially those with long term health conditions.*
- *Community hospitals are valued and patients would like to see their services being extended (perhaps by volunteer led support services etc.)*
- *Better and easier to access information is important.*
- *Improve communication and information sharing between services.*
- *Allow the patient to be involved at all stages - greater involvement in decision about care and treatment plans.*
- *Patients welcome better use of technology in treatment but also value the benefit of face to face contact.*
- *Patients want their opinion to be valued by health staff and for staff to take into consideration that people are distressed when acutely unwell.*
- *Better information for patients and their families about their illness would help in preventing further illness.*
- *Waiting times need to be reduced.*
- *Patients want to be seen by people they know and trust.*

Appendix E(i) – Results of Herefordshire CCG's Engagement Survey

Herefordshire Healthcare - Fit for the Future
The need for change – Shaping our 5 Year Plan

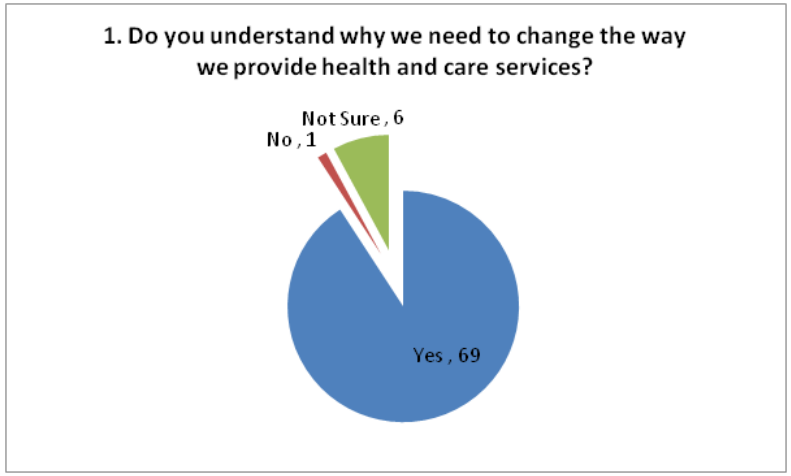
Herefordshire Public Services are facing significant challenges as a result of the increasing needs of the population, financial constraints and a national requirement to increase access to services. We are in the process of setting out our priorities and vision for the next five years and produced a survey to hear the views of the public.

Background information and suggested plans were available to read first before completing the survey.

The survey was open up to the 6th of June 2014 and a total of 76 responses were completed.

Where free text answers were given, this report shows the main themes of those answers.

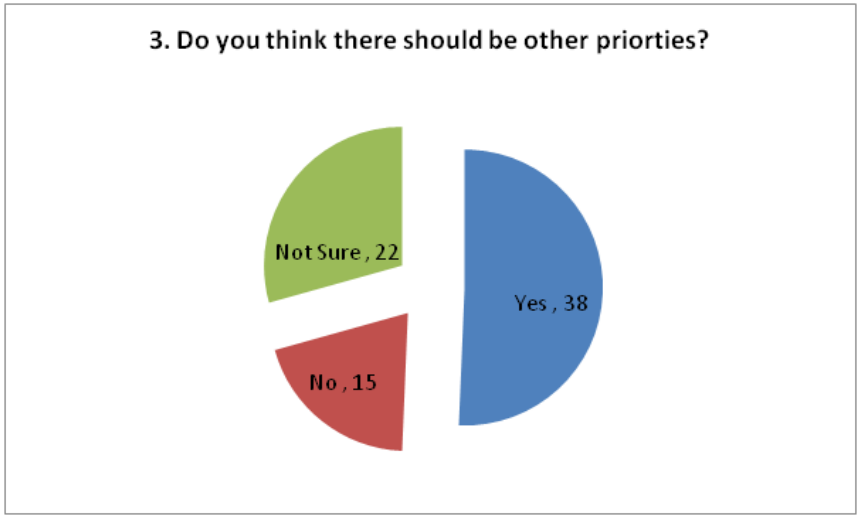
General questions



2. Please rank the priority areas we have identified in order of importance to you:

The priority areas were ranked in the following order:

1. ***7 Day Access to Health and Social Care***
2. ***Primary and Acute Medical Provision***
3. ***Transforming Community Services***
4. ***All Ages Mental Health Pathway***
5. ***Care Closer to Home***
6. ***Promoting Ambulatory Care***



Appendix E(i) – Results of Herefordshire CCG's Engagement Survey (cont.)

3a. Themes from what you identified as being a priority are:

- Improved communication between healthcare staff.
- Continuity of care.
- Assistance in managing long term health conditions.
- Integration of services and more care at home.

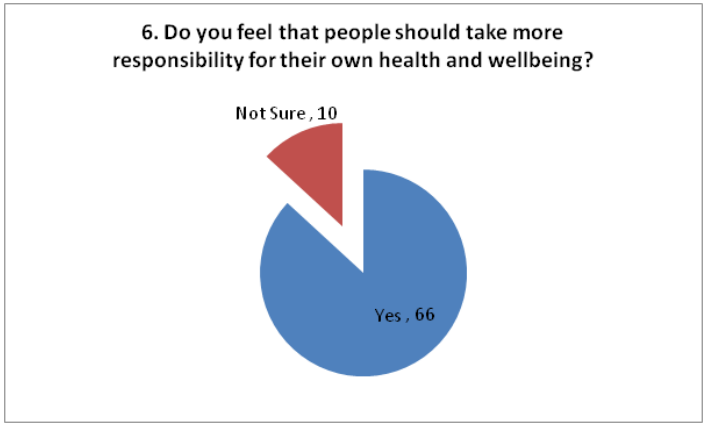
4. How or where do you think we could save money?

- Increased use of technology and information systems.
- Appropriate use of A&E services and community hospitals.
- Focusing on preventative care.
- Work more with community groups and the voluntary sector

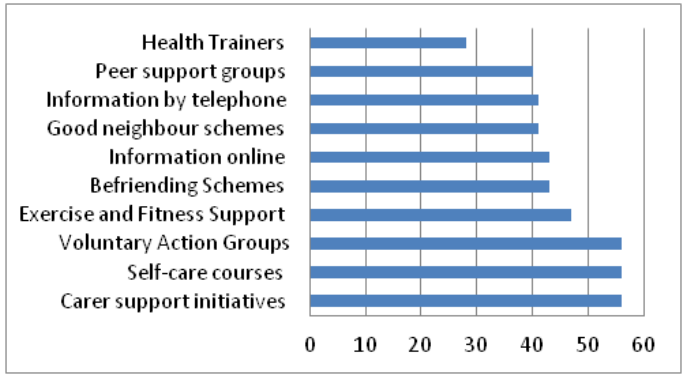
5. If we get things right, what in 5 years' time would have changed for you, your family and friends?

- Effective health care available at reasonable times in accessible places.
- Lower waiting times.
- Appropriate use of services.
- More information about conditions and services.

SELF-CARE



7. Which of the following groups/initiatives do you think could help people to look after themselves better and continue to live independently at home?



Appendix E(i) – Results of Herefordshire CCG's Engagement Survey (cont.)

8. What other support should be available to help people care for themselves?

- Easily accessible information.
- Signposting to other agencies, community groups and voluntary sector.
- Education programmes and health courses on keeping healthy
- Information about services, health initiatives and equipment (home adaptions etc).

MENTAL WELLBEING

9. What does Mental Wellbeing mean to you and your family?

- Security - both at home and socially.
- Being confident and informed to be able to make decisions about my care and my life.
- Knowledge of warning signs and how to manage them

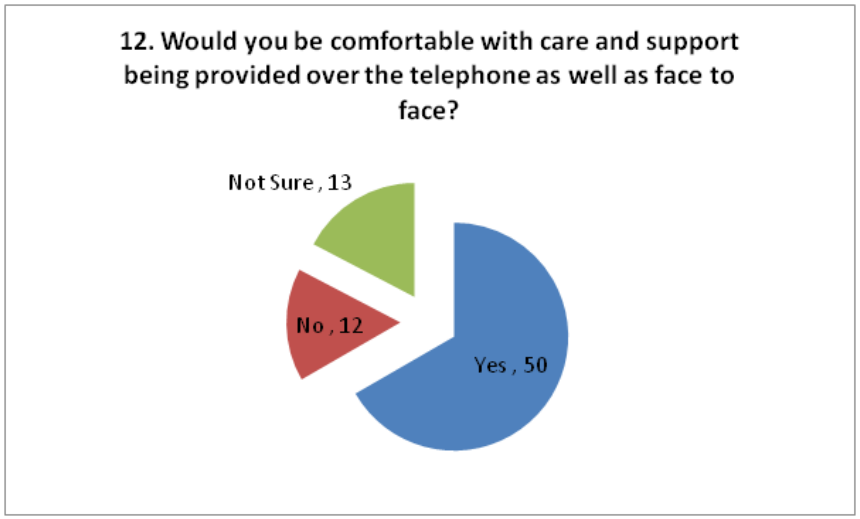
10. How do you keep mentally and emotionally well?

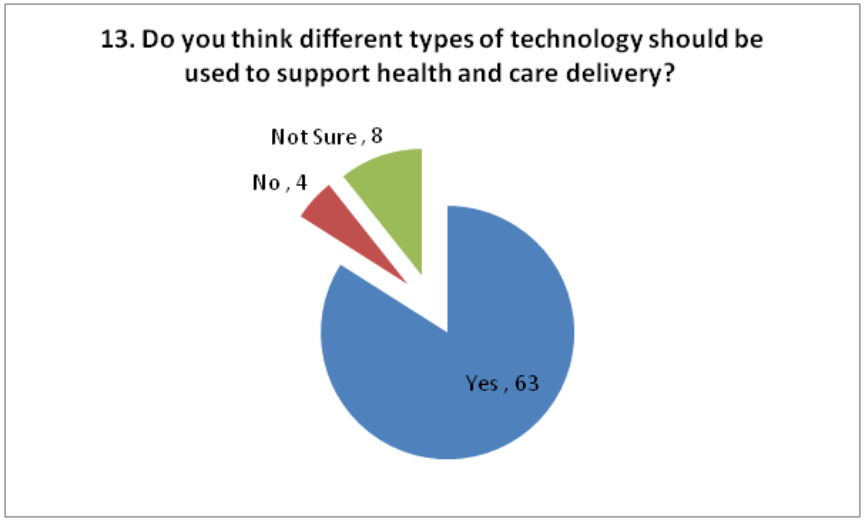
- Exercise (walking, swimming, gardening etc)
- Social involvement (friends, family, community groups)
- Healthy diet.

11. What additional support would you like to be available in Herefordshire to help people stay mentally and emotionally well?

- More personable approach to support services – based around me.
- Prevention services to stop crisis situations.
- Easy access to counselling and the ability to talk to someone.
- Accessible information that is local.
- Online advice and support services

CARE CLOSER TO HOME





Appendix E(i) - Results of Herefordshire CCG's Engagement Survey (cont.)

For example: Internet based consultations (video link), self-use monitors (e.g. blood pressure/weight) linked via internet and movement sensors (in case of fall)

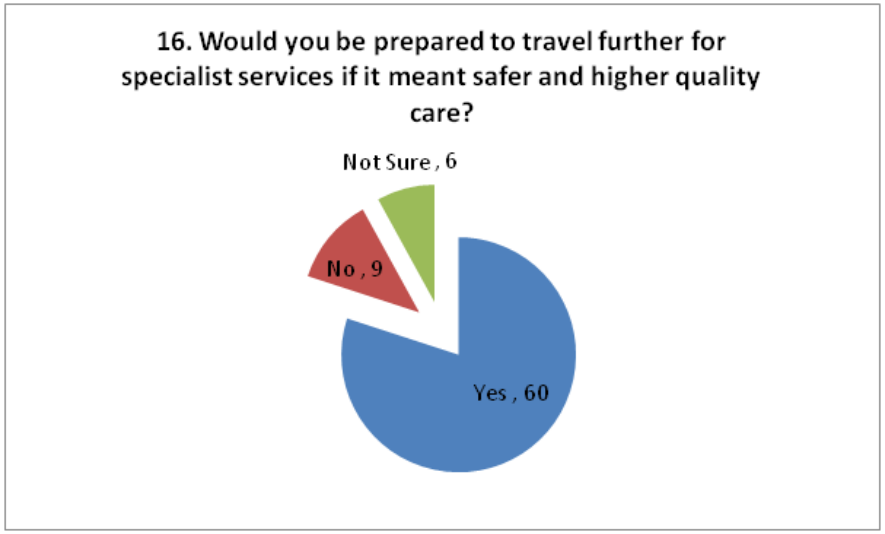
14. What parts of hospital care do you think could be provided at your home or in the community?

- Medication and other routine assessments, physiotherapy.
- Recovery following operations.
- Anything that can safely be delivered outside of hospital.

15. What are the things we need to think about if we move care into a community setting?

- Trust that people will get the care they need.
- Support and involvement of the family and carers.

HOSPITAL SERVICES



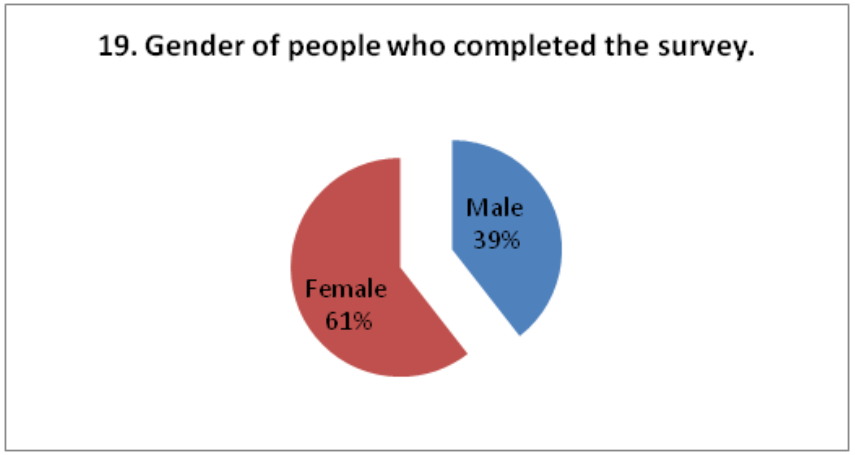
Appendix E(i) – Results of Herefordshire CCG's Engagement Survey (cont.)

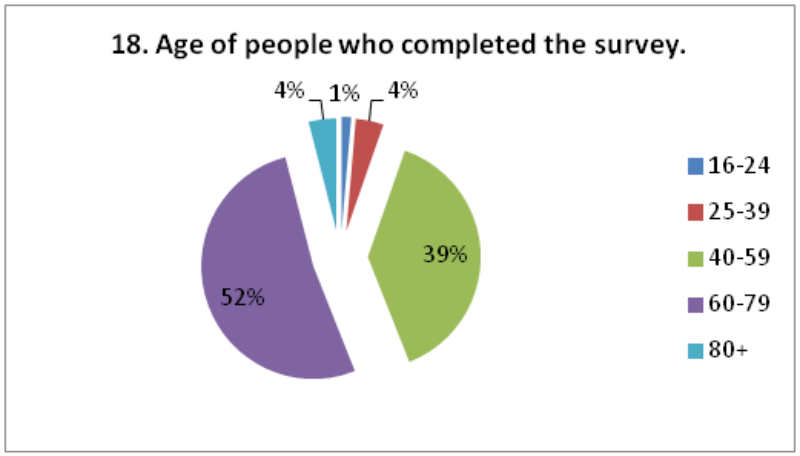
FURTHER COMMENTS

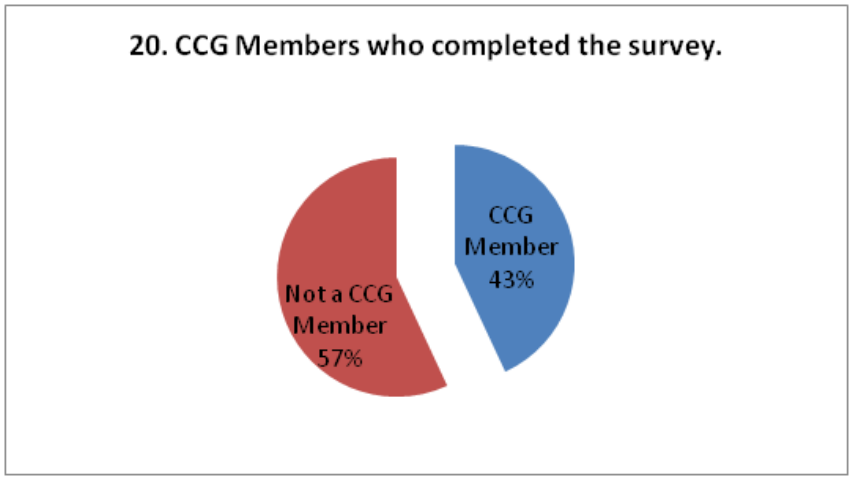
- The CCG has a chance to make a revolutionary change - a fresh approach.
- Travelling too far for health care is problematic and stressful.
- People would be prepared to travel but would prefer care closer to home.
- Simpler language is needed– easy to read.

ABOUT YOU

The information below is based on the people who completed the online survey.







Appendix F – Planning Guidance Key Lines of Enquiry Cross-reference table

Key Line of Enquiry	Page
Which organisation(s) are completing this submission?	3, 50
In case of enquiry, please provide a contact name and contact details	3
What is the vision for the system in five years' time?	5
How does the vision include the six characteristics of a high quality and sustainable system and transformational service models highlighted in the guidance? Specifically: Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care; Wider primary care, provided at scale; A modern model of integrated care; Access to the highest quality urgent and emergency care; A step-change in the productivity of elective care; Specialised services concentrated in centres of excellence (as relevant to the locality)	31
How does the five year vision address the following aims: a) Delivering a sustainable NHS for future generations? b) Improving health outcomes in alignment with the seven ambitions c) Reducing health inequalities?	7, 21, 25
Who has signed up to the strategic vision? How have the health and wellbeing boards been involved in developing and signing off the plan?	36, 37,50
How does your plan for the Better Care Fund align/fit with your 5 year strategic vision?	38
What key themes arose from the Call to Action engagement programme that have been used to shape the vision?	39,40, 41, 53-59
Is there a clear 'you said, we did' framework in place to show those that engaged how their perspective and feedback has been included?	41
Has an assessment of the current state been undertaken? Have opportunities and challenges been identified and agreed? Does this correlate to the Commissioning for Value packs and other benchmarking materials?	6, 7
Do the objectives and interventions identified below take into consideration the current state?	24
Does the two year detailed operational plan submitted provide the necessary foundations to deliver the strategic vision described here?	10, 11

Appendix F – Planning Guidance Key Lines of Enquiry Cross-reference table

Key Line of Enquiry	Page
At the Unit of Planning level, what are the five year local outcome ambitions i.e. the aggregation of individual organisations contribution to the outcome ambitions?	29, 30
How have the community and clinician views been considered when developing plans for improving outcomes and quantifiable ambitions?	39-41, 50, 53-59
What data, intelligence and local analysis was explored to support the development of plans for improving outcomes and quantifiable ambitions?	6
How are the plans for improving outcomes and quantifiable ambitions aligned to local JSNAs?	6
How have the Health and well-being boards been involved in setting the plans for improving outcomes?	36, 37, 50
Are the outcome ambitions included within the sustainability calculations? I.e. the cost of implementation has been evaluated and included in the resource plans moving forwards?	34
Are assumptions made by the health economy consistent with the challenges identified in a Call to Action?	39-40
Can the plan on a page elements be identified through examining the activity and financial projections covered in operational and financial templates?	25
Please list the material transformational interventions required to move from the current state and deliver the five year vision. For each transformational intervention, please describe the : Overall aims of the intervention and who is likely to be impacted by the intervention Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have - Investment costs (time, money, workforce), Implementation timeline, Enablers required for example medicines optimisation, Barriers to success, Confidence levels of implementation The planning teams may find it helpful to consider the reports recently published or to be published imminently including commissioning for prevention, Any town health system and the report following the NHS Futures Summit.	21-22 25
What governance processes are in place to ensure future plans are developed in collaboration with key stakeholders including the local community?	36, 37
Please outline how the values and principles are embedded in the planned implementation of the interventions	32, 33