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Foreword

Redditch and Bromsgrove Clinical Commissioning Group (NHS R&B CCG) enters 2012/13 with delegated responsibility for the local commissioning budget as a step towards formally taking on these activities from the Primary Care Trust from April 2013. As a new Clinical Commissioning Group (CCG) we are working together to ensure we establish ourselves as an effective organisation and put ourselves in as strong a position as we can to achieve our goal of authorisation later in the year.

In keeping with CCGs across the country, we recognise that this year of change will represent a considerable challenge for all concerned. The task of Clinical Commissioning Groups is to deliver a sustainable healthcare system in the face of the most significant financial challenge in generations, whilst maintaining quality, amidst a changing organisational environment. Medical advances offer increasing opportunities to treat disease but the cost of these advances together with an ageing population will prove very challenging and will require careful planning. In order to succeed, commissioners will need to carefully consider efficiencies and productivity opportunities across the whole healthcare system – from primary to secondary care, and work in partnership with other key clinicians, social services and patient representatives to integrate services and redesign pathways.

Whilst we are a new organisation we have been working together for some years now, dating back to 2006, as part of a Practice Based Commissioning Cluster. More recently as a CCG, we have been working to establish our models of working, to engage with our stakeholders and, significantly, to consider and influence the commissioning work that we will eventually take full responsibility for. With our goal to be authorised and to be recognised as a fully operational CCG we also understand the need to ensure that we deliver value for money for the care that we commission as well as the work that we do. We maintain this as a standing item on our agenda along with the quality of the care that is offered.

With the commitment from the GPs within the group and the strong relationships we already have with our stakeholders we are confident we will be in a position to proceed to the authorisation stage in good shape. However, we also recognise the need to keep our attention on the day job and to manage the changes to be as seamless for our patients and partners as possible. We are committed to ensuring that the quality of patient care does not suffer as a consequence of any of these changes.

As Chair of Redditch and Bromsgrove Clinical Commissioning Group (NHS R&B CCG), I devote 3 sessions each week to commissioning (1.5 days) and my remaining time is spent in clinical practice as a GP at Hillview Medical Centre, Redditch. Clinical leadership in commissioning will ensure that patients and public are truly represented by caring professionals who are best placed to understand the diverse healthcare system. Whilst the challenges are clear, this is also an exciting time and an opportunity to improve the quality of patient services and pathways.

We have produced this new 2012/13 Operational Plan to capture how we will operate in the coming year.

Dr Jonathan Wells
Chair and Clinical Lead, Redditch & Bromsgrove Clinical Commissioning Group
1. Introduction and vision

1.1 Introduction, context and background

The Government’s current health reforms were announced in July 2010 and include some significant changes to the way that the NHS works, particularly in how services are commissioned with the abolition of Strategic Health Authorities and Primary Care Trusts and the creation of new GP-led Clinical Commissioning Groups (CCGs). CCGs have been formed from groups of GP Practices that will, from April 2013, be responsible for commissioning local health services in England. The announcement that GPs will take over this commissioning role was made in the 2010 White Paper, ‘Equity and Excellence: Liberating the NHS’ which has since been passed in Parliament and, with Royal Assent, will become law, possibly as early as Easter. This is part of the government’s wider desire to create a clinically-driven commissioning system that is more sensitive to the needs of patients.

The GPs in Redditch and Bromsgrove have joined together to form our own CCG, this document outlines how Redditch and Bromsgrove Clinical Commissioning Group will develop over the coming year, which priorities we are working towards and how we will operate.

The West Mercia region (comprising Herefordshire, Shrewsbury, Telford & Wrekin and Worcestershire) has been grouped together as the West Mercia Cluster under the current health reforms. Redditch and Bromsgrove Clinical Commissioning Group (CCG) has been formed by the 22 GP Practices located within North-East Worcestershire. The Practices have a total registered population of just over 170,000 (roughly 30% of Worcestershire).

The CCG is already established and is working hard to develop an effective commissioning role as set out in the White Paper ‘Equity and excellence: Liberating the NHS’ and the draft Health and Social Care Bill. The CCG is working in shadow form until the assurance process by the new National Commissioning Board has been finalised and the CCG will be in a position to apply for formal authorisation as an NHS organisation, with an ability to take on full responsibility and accountability for budgets and commissioning decisions. The expectation is that the CCG will apply to be considered as part of the second wave of the authorisation process during the second half of 2012. Whilst working in shadow form, Redditch and Bromsgrove CCG has become a formal sub-committee of the West Mercia Cluster Board and has already inherited some delegated responsibility and decision making authority.

<table>
<thead>
<tr>
<th>CCG</th>
<th>Wyre Forest CCG</th>
<th>Redditch and Bromsgrove CCG</th>
<th>South Worcestershire CCG</th>
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<tbody>
<tr>
<td>Population</td>
<td>13 GP practices, population: 112,000</td>
<td>22 GP practices, population: 171,000</td>
<td>32 GP practices, population: 269,000</td>
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<td>CCG Lead</td>
<td>Simon Gates</td>
<td>Jonathan Wells</td>
<td>Carl Ellson</td>
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<td>Health and Wellbeing Board</td>
<td>Worcestershire</td>
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<td>County Council</td>
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<td>Major NHS Providers</td>
<td>Worcestershire Acute Hospitals Trust (WAHT) Worcestershire Health and Care NHS Trust</td>
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The Redditch and Bromsgrove CCG consists of the 22 Redditch and Bromsgrove GP Practices:

- Barnt Green Surgery - Barnt Green
- The Bridge Surgery - Redditch
- Catshill Village Surgery - Catshill
- Churchfields Surgery - Bromsgrove
- Cornhill Surgery - Rubery
- Crabbs Cross Medical Centre - Redditch
- Crabbs Cross Surgery - Redditch
- Davenal House Surgery - Bromsgrove
- The Dow Surgery - Redditch
- Elgar House Surgery - Redditch
- The Glebeland Surgery - Belbroughton
- Hillview Medical Centre - Redditch
- Hollyoaks Medical Centre - Wythall
- Hollywood Medical Practice - Wythall
- Maple View Medical Practice - Redditch
- New Road Surgery - Bromsgrove
- New Road Surgery - Rubery
- The Ridgeway Surgery - Astwood Bank
- St Johns Surgery - Bromsgrove
- St Stephens Surgery - Redditch
- Winyates Health Centre - Redditch
- Woodrow Medical Centre - Redditch

The practices have a history of working together as part of a Practice Based Commissioning Cluster since 2006. This has provided a strong foundation for RBCCG.

Meet the Governing Body

The Governing Body is a number of elected members who jointly oversee the activities of RBCCG.

Dr Jonathan Wells
Jonathan is Chair and Clinical Lead of Redditch & Bromsgrove Clinical Commissioning Group.

Jonathan spends 2 days a week in this role and the remaining time in clinical practice. In addition to Chair of the RBCCG Governing Body, Jonathan is also Lead GP for Community Services and Remuneration Committee.

Dr Richard Davies
Richard is Assistant Clinical Chair, Governing Body Member and Lead GP for the RBCCG Finance and Performance Committee.

Richard is Lead GP for Finance and QIPP, and also leads on Hospital Services.

Dr Catherine McGregor
Catherine is a Governing Body GP and Lead GP for Women's and Children's Services.

Dr Rupen Kulkarni
Rupen is a Governing Body GP and Lead GP for QIPP projects including: Orthopaedics, Physiotherapy, Pain Services and Ophthalmology. Rupen is also the Lead for the RBCCG Audit and Risk Committee.
Each of the Governing Body GP’s has responsibility for 3-4 practices or ‘Zones’. Adopting a ‘Zoning’ approach means that the Governing Body GP’s visit their member practices on a quarterly basis to maximise their involvement in RBCCG business. ‘Zoning’ is viewed as an important opportunity to share key commissioning information, service developments and to reflect upon individual practice performance and outstanding issues.
1.2 Vision and values

We exist to ensure that the population of Redditch and Bromsgrove enjoy lives which are as healthy as possible. To achieve this, NHS R&B CCG has the following vision: ‘Working together to promote high quality, affordable healthcare’.

NHS R&B CCG will work across organisational boundaries, accessing specialist knowledge from clinicians and managers across health and social care, to reflect the diverse complexities of patient care pathways and services.

NHS R&B CCG will:

• Improve the quality of care for patients and reduce system waste via integrated models of care wherever possible (working across organisational boundaries wherever necessary);

• Apply a population-based approach to commissioning – via Public Health needs assessment to support future commissioning intentions;

• Empower patients with the active engagement and participation of local patients in the commissioning agenda;

• Apply a systematic and proactive approach to the management of chronic disease.

To achieve our aims we have established the following values by which we will operate as a CCG. We will ensure that these values are inherent in all that we do; in planning, commissioning and delivering health care in Redditch and Bromsgrove:

NHS R&B CCG will promote a fair, ethical and transparent culture

NHS R&B CCG will place patient safety and experience at its core

NHS R&B CCG identifies that ‘partnerships matter’

NHS R&B CCG will listen and respond

NHS R&B CCG promotes evidence based practice; ‘right care, right place, right time’

Patient Choice matters to NHS R&B CCG

NHS R&B CCG will promote privacy, dignify and mutual respect

NHS R&B CCG will work together with member practices

NHS R&B CCG will promote good health and wellbeing

NHS R&B CCG will identify opportunities for service redesign and innovation

Value for money will be secured

NHS R&B CCG will be a good employer
1.3 Priorities

We have worked with our member practices to develop a clear set of priorities to work towards. The priority areas are identified as a part of an annual cyclic commissioning process. The annual process is informed by the Lead GP and Practice Manager from each of the 22 practices and is supported by evidence and data analysis derived directly from the Joint Strategic Needs Assessment for Redditch and Bromsgrove. The priorities identified cover key service improvement in areas such as improving access to A&E and securing improvements around cancer care as well as development priorities and outcome aspirations such as reducing deaths from Stroke and Heart Attacks.

On a monthly basis, progress relating to the priority areas is reported to the member practices at the Redditch and Bromsgrove Advisory Forum.

Priority One: Develop and sustain a culture of quality

Implement the NHS R&B CCG Quality/Patient Safety Strategy, with a rigorous focus on addressing key areas of weakness such as improving local stroke services and A&E performance. NHS R&B CCG will work closely with the Alexandra Hospital in ensuring improvements around digity and nutrition (as identified via CQC report 2011) are sustained.

Ensure the emerging Operating Model encompasses Quality and Patient Safety at all levels.

Priority Two: to achieve and sustain financial balance

Build upon the success of 2011/12 to sustain financial balance, including the delivery of £3.3m worth of QIPP savings.

Develop the Finance Innovation Meeting as a forum by which areas for potential innovation are identified and link with Service Innovation Meeting to secure the highest level of clinical involvement possible.

Priority Three: Reduce inappropriate unscheduled care admissions

Work with WAHT, WHACT and other partner organisations to expand the scope of services across Redditch and Bromsgrove to prevent (and manage) unscheduled admissions.

Developing a strategy for improving access to A&E, particularly around the 4 hour target.

Develop a clear lead GP role for Unscheduled Care during 2012/13.
Priority Four: Improve access and outcomes for Mental Health Services
Deliver a new programme from Mental Health during 2012/13, to include:

- Comprehensive review of counselling services and key future recommendations.
- A referral process that is easy to use - particularly for urgent cases.
- Improved local relationships and clear referral process for a range of talking therapies.
- Shared care arrangements to support GPs to look after patients (inc access to specialist and advice).
- Appointments for patients that are convenient.

Priority Five: Reduce vascular deaths (heart attack and stroke)
Undertake and act upon a comprehensive scoping exercise, including the development of an action plan and related deliverables for significantly improving outcomes on circulatory disease.

Work with partners to improve the local quality of stroke services, particularly around rapid access to high quality services.

Priority Six: Improve transfers of patient care (discharges/patient flow etc)
Continue to improve systems and processes for reducing avoidable admissions and improving discharge planning and develop the service specification for Integrated Community Services teams and the Virtual Ward.

Continue to improve capacity management arrangements via Capacity Management sub-section of the Service Innovation Meeting.

Priority Seven: Improve access, range and proportion of services within Primary Care
Establish an inter practice LES alongside a directory of services for NHS R&B CCG.

Review of enhanced services and opportunities for further service provision in Primary Care.

Priority Eight: Support and deliver the Cancer Strategy within Worcestershire
Support the delivery of the Cancer Strategy in 2012/13, ensuring that performance is radically improved from current levels.

Continue to develop lead GP arrangements.
In order to measure our progress against our priority areas, we have set out below our baseline and aspiration for the coming year:

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<th>Area</th>
<th>Baseline</th>
<th>Aspiration and success measure</th>
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| Quality       | The Quality and Patient Safety Strategy and related Implementation Plan has been developed to support the agreed approach for NHS R&B CCG. This includes the emerging role of the Lead GP for Quality and Patient Safety and the establishment of the North Worcestershire Quality and Patient Safety Committee – as a sub-committee of the NHS R&B CCG Governing Body. NHS R&B CCG has established an issues database to allow for the central co-ordination of issues. The live database acts as a feedback mechanism and a valuable source of learning for all practices. This forms the basis of any reporting repository for 2012/13. | • NHS R&B CCG will have a recognised and proactive approach to Clinical Quality and Patient Safety;  
• NHS R&B CCG will have a clearly defined role for the Lead GP for Quality and Patient Safety;  
• Via the agreed Implementation Plan, the following will be delivered by the end of 2012/13, as a minimum:  
  • Develop a single repository to report, monitor and provide feedback regarding concerns;  
  • Support involvement of GP practices and patients in quality assurance processes e.g. mystery shoppers and involvement in quality assurance visits;  
  • Scope sources of patient satisfaction surveys that are already available (commissioner and provider) and develop mechanisms to provide real-time patient feedback across the range of commissioned services;  
  • Implement a robust reporting mechanism for serious incidents across all commissioned services;  
  • Work with health care regulators, the Local Authority, LINK, HealthWatch and other commissioners to share information and support continuous quality improvement. |
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| Financial balance           | The CCG had a budget of £185m in 2011/12. The end of year position, after taking into account future practice changes, was a surplus of £252,173 or 0.1%. | • NHS R&B CCG’s 2012/13 budget for 2012/13 is £184.3 million with an internal risk reserve of £1.655 million and a fair share of a centrally held risk reserve of £1.843 million.  
• Within the 2012/13 Plan is QIPP delivery - £3.332 million. |
| Unscheduled admissions      | Capacity Management meetings between WAHT and WHACT have been established in 2011/12 to concentrate on patient flow and whole system capacity issues across NHS R&B CCG.  
A small number of NHS R&B CCG practices are currently piloting a telephone triage service which will assist the practices to appropriately manage demand and capacity within their practice, ensure all patients are seen by the most appropriate professional, as necessary. The ultimate aim is to prevent unnecessary A&E attendances and ultimately improve the patient experience.  
Via Community and Mental Health Services Committee and related workstreams, Integrated Community Teams are in operation and will be maximised further throughout 2012/13. | • The Urgent Care Lead GP role will be defined and fully functional within 2012/13;  
• Work with our WHACT Provider colleagues to further develop the role of Intermediate Care Services (and other WHACT ‘Enhanced Services’), to include the agreed approach to medical cover to support the management of more acutely ill patients within a community setting;  
• Expand and maximise the Integrated Community approach to service delivery within the community;  
• Secure a ‘joined up’ approach to capacity management with WHACT and WAHT to secure the necessary flow through the healthcare system, to challenge the culture within the hospital settings and promote a responsible and responsive approach to the appropriate discharge and transfer of patients;  
• Demonstrable reductions in unscheduled admissions and improvements in patient flow. |
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| Mental health    | Mental Health was identified as the number 1 priority area for NHS R&B CCG for 2012/13 following consideration of the Joint Strategic Needs Assessment in October 2011 and wide engagement with NHS R&B CCG Member Practices. Project Manager and related team are in place and have initiated PID and project planning stage. | Deliver a new programme for Mental Health during 2012/13, to include:  
- Comprehensive review of counselling services and key future recommendations.  
- A referral process that is easy to use - particularly for urgent cases.  
- Improved local relationships and clear referral process for a range of talking therapies.  
- Shared care arrangements to support GPs to look after patients (inc access to specialist and advice);  
- Appointments for patients which are convenient.  
- The programme deliverables will be monitored via the NHS R&B CCG Community and Mental Health Services Committee. |
| Vascular deaths  | NHS R&B CCG identified vascular disease as a priority area in October 2011, via the JSNA outputs. Scoping has been initiated. NHS R&B CCG involvement in the countywide Stroke Services Review and the decision to centralise Stroke Services on the WRI site in order to secure a safe and high quality service. | - A review of current activity and wider engagement with WAHT in exploring the potential areas of redesign is underway.  
- Lead GP for Stroke Services and Vascular Disease to lead and inform discussions. |
<p>| Transfers of care| Capacity Management Meetings established.                                  | - Agree with NHS South Worcestershire Clinical Commissioning Group (NHS SWCCG) and NHS Wyre Forest Clinical Commissioning Group (NHS WFCCG) an approach to countywide capacity management – clear definition is required to limit duplication within locality areas. |</p>
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| Primary care       | Partnership Working arrangements have been established with WAHT and WHACT in 2011/12. GP Triage pilots established with a view to maximising capacity within general practice.                                                                 | • Establish a Directory of Services within Primary Care.  
• Explore (and maximise) the potential for Inter Practice Referrals (explore the potential to establish a LES).  
• Consider the outcomes of the GP Triage pilot areas with a view to rolling out across NHS R&B CCG practices if benefits are clear around increased capacity.  
• Via Partnership Working arrangements with WAHT and WHACT, explore the potential for service redesign and maximise opportunities within the Primary Care setting.  
• Explore potential models for medical cover to support more acutely ill patients within their own homes. |
| Cancer             | Lead GP arrangements in place, supporting the radiotherapy project.                                                                                                                                       | • Maintain Lead GP arrangements.  
• Engage NHS R&B CCG Member Practices in the delivery of the Cancer Strategy.                                                                                                                                                                       |
As part of the development of the CCGs in West Mercia, Joint Strategic Needs Assessments (JSNA) have been undertaken throughout the West Mercia Cluster. The JSNAs have highlighted a number of key themes for the Cluster area that we as a CCG will also be working towards addressing, shown on the centre in the table above. More specifically for Worcestershire, the JSNA has identified areas that will require addressing by the CCGs, shown on the right in the table above. We are committed to working with our colleagues in NHS WFCCG and NHS SWCCG to ensure that we give sufficient regard and attention to these.

1.5 For NHS Redditch and Bromsgrove CCG

The JSNA has identified the following key information for the NHS R&B CCG area. Further detailed information is available within the full JSNA document.

Demography and Deprivation

- NHS R&B CCG GP practices have a total registered population of 170,774 (April 2011). The CCG has a relatively youthful population: compared to the other CCGs, it has the lowest proportion of people aged 65+ and the highest proportion of 0-19 year olds.
- There is considerable variation in deprivation in the area and four Super Output Areas (all in Redditch) are in the most deprived 10% nationally.

Disease Prevalence

- Prevalence of conditions as recorded on QOF within the CCG is generally low relative to the county average. Perhaps the more important issue is that as in the other CCGs- there is considerable variation by practice. Factors behind this are variation in recording and deprivation as well as variation in the “true” prevalence of conditions, and further investigation would be needed to assess the relative contribution of these factors.
- The particularly wide variation in recorded obesity prevalence, together with the fact that PCT recorded prevalence is well below expected prevalence, suggests that there may be an issue with under-recording. Further work will be undertaken to investigate this further. The spread of data is also very wide in other areas, for example diabetes and hypertension.

Admissions and Mortality

- NHS R&B CCG has a slightly higher rate of emergency admission to hospital than the PCT average. The rate is significantly higher in the case of circulatory disease. Further work will be undertaken to investigate the reasons for this during the course of the year.
- Mortality rates in the CCG tend to be close to or slightly higher than the county average, with the exception of cancer. The mortality rate for
circulatory diseases has risen above the national level recently though it remains to be seen if this is a permanent change.

Prevention

- The cervical cancer screening rate is slightly lower in Redditch and Bromsgrove than the county average, though the difference is not statistically significant. There are a large number of practices whose screening rate is outside control limits, which suggests that there may be inconsistencies in the approach to screening. Further work will be undertaken to address this.

Children and Young Adults

- Redditch and Bromsgrove has a relatively youthful population compared to the other CCGs.

- There is a marked difference between the teenage conception rate in Redditch (37.7 per 1000 in 2007-9) and that in Bromsgrove (25.1). Though demography and deprivation will be a factor in this, further work will be undertaken to look at this in more detail.

- Childhood immunisation rates in the CCG tend to be better than the county average. However there is considerable variation at practice level and further work will be undertaken to address this variation.

Older People

- The rate of falls admissions in Redditch and Bromsgrove is significantly higher than for the other CCGs. There is a strategic programme around the avoidance and management of falls taking place across the County and NHS R&B CCG will play an active role by attempting to address these local issues.

1.6 Reducing health inequalities

We recognise the need to tackle health inequalities in Redditch and Bromsgrove and have expressed our commitment to approaching this subject. NHS R&B CCG is engaging in ‘Joined Up Working’ with partner organisations across Redditch Borough and Bromsgrove District Councils. NHS R&B CCG will work closely with Public Health whereby on a bi-monthly basis, key public health developments will be reported to the CCG Management Team. NHS R&B CCG has identified a non recurrent £255k investment to effectively contribute towards reducing health inequalities across Redditch and Bromsgrove in a bid to improve health and well-being and thus, reduce demand on expensive public services. Detailed Investment for 2012 and beyond will be confirmed following the mapping and community engagement work.

Reducing inequalities in Bromsgrove - Community Health Hub

EPIC is a social enterprise which has been commissioned by Bromsgrove partnership to deliver the Areas of Highest Need project in the Charford and Sidemoor wards of the district. EPIC is based at the TRUNK in Charford, a multi-agency partnership bringing together a number of agencies to support the local community. The Areas of Highest Need project focuses on a programme of learning, skills acquisition, health activities and the development of community resources to service the residents of the two wards. EPIC are well respected within the local community and have experience in running a number of health activities including Sidemoor Healthy Eating Development [SHED] project and WCC reablement project for individuals with mental health issues.

Unlike the TRUNK in Charford, EPIC does not currently have a base within Sidemoor and have had difficulties in identifying suitable community facilities in the area. This is limiting the ability of EPIC to develop a strong presence within the local community reducing the impact of its work and its ability to involve other partner agencies with the area.

EPIC are seeking funding for the installation of a modular building on a plot of land adjacent to the existing community allotments. This building would have a small training room for community use, a small kitchen and a meeting room. Staff from The TRUNK would be based at the health hub to deliver a range of health related activities including stop smoking services, small group exercise classes, substance misuse services, cookery sessions for vulnerable adults...
and healthy eating workshops. In addition the space will be used to run small groups for people with mental health issues as part of the WCC Reablement project. The adjacent community allotments will also be used to engage vulnerable adults, supporting the physical activity, mental wellbeing and healthy eating agendas.

EPIC would apply the sustainability model already in use at The Trunk in terms of income generation from groups hiring the space for workshops etc. Bringing partnership agencies into the community will support further community development within the Sidemoor area. The Health Hub facilities could be made available for use by NHS professionals including health trainers and community mental health services as well as a venue for a breast feeding cafe.

Reducing inequalities in Redditch - Partnership working initiative

Actively participate in the partnership working initiative being developed by Redditch and Bromsgrove Councils and led by Kevin Dicks, Joint Chief Executive. This involves the mapping of current service provision and spend in the Winyates area and supporting the development and testing of new models of working. From a public health perspective the major gains that can be achieved are through more effective and earlier intervention.

The initiative will involve undertaking a review of existing services, working with senior managers and front line staff to identify barriers and opportunities to improved partnership working. The CCG will support the process by being engaged with the scoping and investigation exercise and allowing their own staff to participate in testing new models of working.

Community asset modelling work will be undertaken to engage local residents in the redesign of services based around their needs and experiences. Partnership working with youth organisations will enable the engagement of young people with the project to ensure their views are heard.

Following the mapping of community assets, services and demands, there needs to be a mechanism identified to keep communities engaged in designing services. The approach for doing this will be agreed with the Areas of Highest Need Board and will involve the CCG. This work will be supported by Public Health through the Community Health Improvement Coordinator and Public Health Consultant.

Reducing childhood accidents

Children living in deprived areas are at greater risk of accidental injury, with hospital admission rates almost 50% higher in these areas of Worcestershire compared to the most affluent neighbourhoods. Accidents in the home are most common in children under the age of five. Having a serious accident in childhood also increases the likelihood of experiencing further inequalities later in life through the resulting time off school and possible long term disabilities. Childhood accidents place a significant yet avoidable burden on the NHS.

A successful pilot project was undertaken in Redditch, funded by ROSPA to enable the purchase and fitting of equipment to reduce accidents in the home, including fireguards, stair gates and window locks. A total of 100 families were supported, including provision of safety advice.

The pilot project in Redditch will be extended to reach further families living in the most deprived areas of the district. In addition a similar scheme will be established in Bromsgrove in partnership with Action for Children and Barnados Children’s Centres. First aid training for parents will also be organised to reduce the burden on the NHS due to minor injuries.

Mental wellbeing and talking therapies

Mental wellbeing is a priority both nationally and for Redditch and Bromsgrove CCG. Demand for specialist mental health services is high, and there is a need for greater availability of community based services. An existing counselling service based within Children’s Centres is provided by My Time in Redditch and RELATE in Bromsgrove which have proved to be very successful. However this service is only available to parents with children under the age of five. It has been identified that there may be a need to expand this service to provide talking therapies for older children and adults.
There is a need to develop a more accurate understanding of the problems being presented and thus the expertise of any service provision, which may need to include a preventative/resilience building approach which could then reduce demand on more expensive services. This is likely to include a community based model of practice that would link into other mental health services.

In Worcester a Wellness Works programme has proved successful. The voluntary sector ran project involved the training of frontline staff to be able to recognise and deal with (on a first aid basis) common mental health problems for both adults and young people. The service also provided vulnerable local people with support to develop coping strategies and well-being skills.

Investment in community based mental wellbeing services will help reduce demand on more expensive specialist services. Improving mental wellbeing will also help enable individuals to make other positive lifestyle changes.

**Worcestershire works well**

The Worcestershire Works Well accreditation programme was launched in November 2011, supporting local businesses to improve the health and well-being of their workforce. Workplaces play a key role in promoting health and wellbeing, with the subsequent benefits of reducing absenteeism and increasing productivity. Improvements in workplace health will help reduce the significant burden of back pain and stress on primary care services in addition to helping tackle wider lifestyle health problems such as smoking and alcohol. Workplace health initiatives are particularly successful in engaging routine and manual workers with healthy lifestyles support. This should be seen as a priority due to the high incidence of vascular disease within the CCG area.

The Worcestershire Works Well programme will engage with local businesses from Redditch and Bromsgrove, particularly those with routine and manual workforces. Additional funding is required to ensure businesses receive adequate support to maximise the potential of the programme. In addition funding is sought to expand the role of the council’s environmental health and trading standards service (EHTS) in working with local food outlets to promote healthy foods. Through their regulatory and inspection work, EHTS are well placed to support the promotion of the Change4Life brand locally, including through the extension of the Truckers Tucker scheme which supports truck stop catering outlets to improve the nutritional quality of their produce.

**Physical activity and healthy diet**

Vascular disease has been identified as a priority for Redditch and Bromsgrove CCG, with excess CVD mortality in Redditch. Obesity rates are also high in the two districts, with low levels of participation in physical activity and poor diets.

A healthy eating programme will be developed to deliver both training to frontline staff working with obese patients and support to individuals living on a low income. There has been an identified need for health nutrition training to be delivered to staff working in children’s centres, general practice, voluntary organisation and schools. A training package and training resources will be developed and rolled out by the Community Health Improvement Co-ordinators working within Redditch Borough and Bromsgrove District Councils.

Support will also be given to enable individuals living on a low income to learn the practical and theoretical side of adopting a healthy balanced diet. The proposed programme will include nutrition education, cookery sessions, shop tours and the development of label reading skills. The programme will focus on working with parents of young children, young adults and the elderly community.

Staff working within children’s centres and within the ageing network will be trained to deliver the sessions on a train the trainer model. The funding will also enable healthy eating resources to be purchased which can be loaned out to other organisations.

**Exercise on referral**

The current activity on referral scheme, ran through local leisure centres, has been developed over the last three years. However referrals from primary care have not been as high as expected.
Over the 30 months the scheme has been operational 218 people have been referred from Redditch and Bromsgrove GP practices.

Patients with stable conditions are referred through their local GP’s for a 12 week programme, where they benefit from weekly lifestyle advice on nutrition, stress relief, healthy exercise and smoking cessation. Participants also benefit from gentle exercise sessions, catered to the group’s ability. The programme is led by fully qualified exercise and fitness professionals and offers free gym membership, classes and swimming, with a bonus of 2 months free membership for those that complete the course. The scheme also offers links into local walking groups, sports clubs and activities.

The 12-week programme is currently subsidised but this funding is coming to an end resulting in an increase in the programme cost, payable by patients. This may exclude individuals living on a low income from engaging with the programme. It is recommended that the CCG invest in the continuation and development of this scheme and look to increase the current referral rates to support existing weight management services within primary care. This programme will be particularly valuable with the expansion of the NHS Health Checks programme locally, enabling patients at reduce their risk of vascular disease.

**Cycle hire scheme**

Cycle hire schemes elsewhere in the country, most notably ‘Boris’s Bikes’ have proven to be successful in increasing levels of physical activity. It is proposed that a cycle hire scheme is established at Arrow Valley Country Park in Redditch, allowing individuals to use the bikes for recreational use along the existing cycle paths around the park and towards Forge Mill. It is proposed that the scheme will develop a skilled base of young people to manage and operate the scheme with a long term vision of empowering the volunteer base into a Sustainable Social Enterprise.

The proposed scheme will work with BDC & RBC acting as the “Lead Body” overseeing three existing partners in the delivery of the proposal. The scheme would work with Arrow Valley Country Park, Acorn adventures to provide mentoring and workforce development and training to the young people and BMX Premiers to support staff recruitment.

Opportunities will be sought to link the scheme with existing leisure service provision e.g. the activity on referral programme and to deliver bikeability training for adults who are not confident cyclists.

**Falls prevention**

Falls prevention work is a priority in Bromsgrove due to the large elderly population and the high number of admissions for fractured hip. The current falls prevention strategy supports individuals at the highest risk of having a fall and those who have already experienced a fall. It has been identified that there is a need to develop preventative approaches for those individuals who are at medium to high risk of having a fall. NICE guidance recommends the provision of mobility training to these individuals. The Balance Communities theme group of Bromsgrove Local Strategic Partnership has recently convened an Older Peoples subgroup to increase activity within this area. It is proposed that funding is assigned to this group to deliver falls prevention activities based on identified need, aligned with the existing falls prevention strategy work.

**1.7 Our story so far**

NHS R&B CCG has truly emerged from the ‘bottom up’. All Member Practices were individually consulted prior to any assumptions that they would form a CCG – this has resulted in a higher level of ownership and involvement.

Each of the Governing Body GPs taking responsibility for 3 – 4 practices and adopting ‘Zoning’ responsibilities which entail Member Practice visits on a 6 weekly basis – sharing key NHS R&B CCG commissioning messages, service developments and issues, and reflecting upon individual practice performance.

Taking time to engage Member Practices in the early stages of NHS R&B CCG has resulted in a cohesive CCG with clear sign up from all those involved.
NHS R&B CCG achievements to date:

- Achievement of 2011/12 QIPP (£3.4million) and financial balance for 2011/12 (following a £4million overspend in 2009/10).

Orthopaedic Pathway Developments and Improvements:

- The implementation of the Guidelines for Management of Orthopaedic Conditions within Primary Care;
- MSK ICATS established and delivering QIPP – improvements in access to primary care services;
- Community MSK Physiotherapy services – short waiting times and increased access for Redditch and Bromsgrove patients;
- The combination of orthopaedic developments have led to a reduction in OP referrals to WAHT as patients are more appropriately (and conveniently) managed within the community setting.
- Medicines Management QIPP delivered via Pharmacy Subgroup with the establishment of Scriptswitch installation and subsequent improvements in prescribing practice.
- Development and implementation of NHS R&B CCG Information Dashboard – performance related information at the fingertips of the Member Practices (developed in partnership with Member Practices following comprehensive information needs assessment process).
- NHS R&B CCG Communications Strategy and related action plan – developed in partnership with a wide range of local stakeholders to reflect the diverse requirements for NHS R&B CCG engagement and related communication. Guided by the Patient and Public Involvement Forum (PPI Forum), the action plan will be delivered and monitored via the PPI Forum and NHS R&B CCG Management Team.
- Community Ophthalmology Service established – a community service established in Bromsgrove and Redditch towns to improve access for patients for the management of simple eye conditions (via an agreed Service Specification).
- Governing Body Development and Zoning arrangements embedded as part of practice level accountability and NHS R&B CCG engagement.

Integrated Community Teams established and evolving:

- Establishment of 4 multi-professional locality teams – to maximise community service provision and promote a more integrated approach for patients within their own homes (reducing patients confusion and increasing efficiency and productivity);
- Successful introduction of Care Managers – to support hospital admission avoidance and facilitate early, supported discharges;
- Falls QIPP delivered via Community Nurses for Elderly (via the implementation of falls assessments).

Proactive Referral Management LES:

- Significant reductions in all GP OP referrals in 2011/12 were realised as a result of practices maximising opportunities for patient treatment within a primary care setting;
- Inter-practice referrals encouraged and promoted via NHS R&B CCG.

Care Home LES launched:

- Care Home patients are a particularly vulnerable group, often having multiple illnesses, yet unable to attend surgeries for ongoing management of their Long Term Conditions. It can be difficult to avoid unnecessary emergency hospital referrals, and End of Life planning is sometimes a challenge.

The outcomes of the NHS R&B CCG Care Home LES will be improved management of Long Term Conditions, a reduction in hospital admissions, and a reduction in hospital as place of death. This document outlines how we will deliver all of our priorities (both local and regional) and the actions we will take to ensure the CCG delivers all of the expectations required of it during 2012/13.
A survey by Worcestershire Viewpoint (Worcestershire CC, Nov 2011) shows more residents now expect health services to get worse or much worse compared to two years ago.

1.8 Our action plan for improvement – from very early activities

We have developed an action plan outlining the key areas of development that we have established from our very early activities:

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>Responsibility</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopaedics (NHS R&amp;B CCG a significant national outlier in terms of orthopaedic referrals)</td>
<td>Musculoskeletal Integrated Clinical Assessment and Treatment Services (MSK ICATS) was established in October 2010 on a pilot basis. The service manages patients within a community setting, securing access to all possible primary care interventions prior to any necessary secondary care referral.</td>
<td>Dr Rupen Kulkarni and Locality Team</td>
<td>Pilot service evaluation by Autumn 2012</td>
</tr>
<tr>
<td>Scriptswitch installation</td>
<td>Software installed within all NHS R&amp;B CCG practices in 2010/11 to streamline best prescribing practice. Fully supported and lead by the NHS R&amp;B CCG Pharmacy Subgroup.</td>
<td>Dr Edward Barrett and Pharmacy Subgroup</td>
<td>Annual service evaluation</td>
</tr>
<tr>
<td>Community Physiotherapy</td>
<td>Redditch and Bromsgrove patients historically experienced long waiting times and generally poor access to musculoskeletal physiotherapy services and as a direct result, a service specification was developed and services commissioned on an Any Willing Provider basis to improve access to physiotherapy service.</td>
<td>Dr Rupen Kulkarni and Locality Team</td>
<td>Annual review and re-procurement in line with national requirements</td>
</tr>
</tbody>
</table>
2 Our health economy

2.1 Introduction

We have access to one major acute Hospital on our patch – Worcestershire Acute NHS Trust. This trust is configured across three sites (Kidderminster, Worcester and Redditch) with one of its hospitals based in Redditch – a general hospital with A&E services and just under 400 beds. The Trust employs more than 4,000 staff, with about 1900 working locally.

We also have one Community and Mental Health provider – Worcestershire Health and Care Trust. This trust has five Community Hospitals, one of which is a relatively new hospital (compared to many community hospitals in the country) based in Bromsgrove.

A key challenge for CCGs is to embrace their responsibility for ensuring that there is a viable health economy from which to commission services. This means more than simply negotiating contracts that save commissioners money; it means leading transformational change that leads to high quality services being provided from financially viable providers. We have identified in this section the key health providers operating in Redditch and Bromsgrove along with developments taking place in public health and how NHS R&B CCG will be contributing to them.

2.2 Worcestershire Acute Hospital Trust (WAHT)

Despite delivering a recurrent 4.4% cost improvement plan, the Worcestershire Acute Hospital Trust required £7m of non-recurrent support in 2011/12. For 2012/13 similar levels of support have been requested. To compound this current financial challenge, the organisation is also trying to recover from a history of difficulties and is currently carrying an £18.4m cumulative deficit, largely due to poor financial performance between 2000 and 2007.

The legacy debt is a barrier to the Trust achieving Foundation Trust status and whilst temporary actions are being sought to resolve the problems in the short term, the position remains where there is no clear long term solution in place to achieve the necessary liquidity position over the medium term.

The financial challenges are significant in their own right, but unfortunately these coincide with poor service performance and quality in a number of areas. For example the Trust has consistently failed to achieve A&E and cancer wait targets and has been subject to a highly critical Care Quality Commission review around elderly services in our part of the county.

Our challenge as a CCG will be to work directly with the Trust to address all of these issues, something we are determined to do successfully. The first, and very significant, step towards achieving this will be our active participation in the Joint Services Review (further details are to follow in this section).

2.3 Worcestershire Health and Care Trust

WHCT is working towards becoming a Foundation Trust and submitted its Integrated Business Plan in March 2012. In order to achieve this, the Trust needs to increase its overall surplus, create a stronger contingency and successfully resolve the legacy issues transferred from its predecessor organisations. In order to achieve its financial ambitions in 2012/13 the Trust needs to deliver a full year cost improvement plan (CIP) equating to £8.0m.

2.4 Joint Services Review

A strategic system-wide approach is being taken to fundamentally review the options for securing a high quality financially sustainable provider environment. We are actively involved in this process and will participate fully. The review is chaired by Bryan Smith, previously Chairman, Worcestershire PCT.
Dr Jonathan Wells (NHS R&B CCG Chair and Clinical Leader) and Dr Richard Davies (NHS R&B CCG Assistant Clinical Chair) are also involved in the process and report to NHS R&B CCG Governing Body and Member Practices on an ongoing basis.

The results of the Joint Services Review will not be known until later in the year and therefore our focus in the coming year is on participating in the review to the fullest extent and we will outline our response to the major issues in next year’s operational plan. However, right now we have a clear understanding of what we want the JSR to achieve for our community and patients. Our ambitions are to:

- Achieve sustainable, high quality services that are as close to home as possible;
- Involve local patients and key stakeholders as early on in the JSR process as possible to secure a firm understanding of the rationale underpinning the need for any change;
- Use the opportunity to expand and enhance the quality and range of services available to people within their own homes;
- Address any gaps in community services provision to ensure that care can be safely and effectively carried out within people’s own homes;
- Promote a culture by which people are primarily managed within their own homes unless it is absolutely necessary for a hospital admission;
- Ensure that Redditch and Bromsgrove residents have access to services within reasonable travelling times;

- Improve access for patients in need of urgent care;
- Improve local access to diagnostics and outpatient facilities;
- Promote a culture of preventative medicine.

NHS R&B CCG recognises that change is an inevitability, however, the JSR is viewed as an opportunity to maintain and improve quality and patient safety in a bid to secure a high quality and sustainable local healthcare system.

2.5 Strategic Transformation

The financial planning assumptions, defined nationally and applied locally, required NHS PCT Clusters to withhold a 2% fund to be used for investing in delivering transformational change to secure long term sustainable improvement. Locally, within Worcestershire, this 2% equates to almost £17m.

NHS West Mercia Cluster has laid down clear requirements for accessing this money, these requirements include:

- Receiving organisations have signed 2012/13 contracts.
- Evidence that mandatory performance measures are being delivered.
- Board level sign up to West Mercia Concordat.
- Expenditure plans demonstrate transformational change.
- Integration across the whole health and social care system is demonstrable e.g. receiving

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**R&BCCG has the following representatives contributing directly to the review:**

| Emergency Care                      | Dr Edward Barrett  
|-------------------------------------|--------------------
|                                     | Dr Marion Radcliffe|
| Planned Care                        | Dr David Law       
|                                     | Dr John Cassidy    |
| Women and Children’s Services       | Dr Catherine Mcgregor  
|                                     | Dr Helen Boon      |
| Elderly Care                        | Dr Steve Miskin    
|                                     | Dr Rupen Kulkarni  |
organisation will be required to evidence whole system support.

- Plans demonstrate a clear commitment to reducing overall acute hospital cost base and investing in community based services.

- Plans identify dedicated clinical leadership and programme management capacity to support the change.

- Receiving organisations either have a robust improvement programme or are participating in a development process.

It is our intention to submit a request for access to this funding to submit our key transformational ambitions to:

- Further investment in Intermediate Care Services;

- Possible investment in medical cover to secure more robust community services in line with ‘Virtual Ward’ deliverables;

- RAID (as part of countywide service – as formally agreed with NHS WFCCG and NHS SWCCG);

- Mental Health Services – to be informed by the outputs from the NHS R&B CCG Mental Health Programme.

2.6 Midlands and East Strategic Health Authority Priorities

The Midlands and East SHA (M&E SHA) has identified a series of priorities that it wishes to see its local commissioners and providers deliver in the coming months and years. We recognise that we have an important role to play in delivering these and will work with West Mercia Cluster to ensure that the actions laid out in their plan as requiring CCG leadership will be delivered.

These priorities are:

Zero tolerance of pressure ulcers

We recognise the role we have to play in supporting the lead being taken by West Mercia Cluster Director of Nursing and Quality in this area. When the prevalence of pressure ulcers is used as direct measure of the quality of care our population receives then our responsibility to see that they are eliminated is clear.

Improving quality and safety in primary care

This is at the heart of what we are trying to achieve and as a CCG we will work the West Mercia Cluster and SHA to deliver milestones and actions set out in the Cluster Integrated System Plan in the following five key areas:

- Creating, supporting and demonstrating the primary care improvement environment between CCGs and our member practices.

- Reduce cephalosporin and quinolone prescribing to within a 15% tolerance of national best practice.

- Improve safety of care for patients receiving warfarin.

- Improve care for patients with diabetes.

- Learning lessons from primary care failure.

Radically strengthening partnerships with local government

We will continue to build upon the strong history of partnership working in Worcestershire that can be seen through a robust joint commissioning unit, an effective Health and Well Being Board and a joined up approach to system transformation.

Making every contact count

Making Every Contact Count (MECC) is about achieving lifestyle behaviour change and the benefits this has to people’s health. Locally, we have undertaken work to support reductions in smoking and alcohol consumption and the objective of MECC is to expand the offer of brief advice to a much wider range of care settings.

The CCG and member practices have a substantial contribution to make, both in the delivery of this advice in direct service provision but also through the way in which secondary care services are commissioned and used.
In order the support this, the CCG is committed to:

- Ensuring that member practices and other care providers make use of face to face contacts to deliver brief, simple and structured healthy lifestyle advice and to signpost to relevant services as appropriate.

- Promote the increase of healthy lifestyle behaviours amongst our own staff and those that we commission services from.

- Work towards reducing inequalities in health outcomes associated with lifestyle behaviour.

Provider organisations have already nominated their lead officers to drive this programme forward.

Create a patient revolution

We will work with the Cluster to develop an action plan in line with SHA guidance for implementing the patient revolution. NHS West Mercia Cluster has outlined a commitment to ensuring that the ‘net promoter’ is used by all providers and that use will be monitored by commissioners. The CCG recognises the importance of its role in this respect and will participate actively in the development of the Cluster wide plan to implement this strategy.

2.7 Implementing the Cluster Big Bets

There are substantial challenges facing the NHS. Even with growth in resources, our health economy will struggle to deal with the demands placed upon it in the future unless we transform the way we work. Our short term focus as we develop as an organisation will be to deliver this plan. However, over the medium to longer term we will develop a more transformational plan containing our proposals for achieving the radical shift required to deliver a high quality, financially sustainable local health system in the years ahead.

There are some things that we can begin to work on immediately. One of those is how we can contribute to and, where appropriate, lead the delivery of the West Mercia Cluster Big Bets. These are planned care, urgent care, primary care and doing the ordinary extraordinarily well. Our plan covers many of these areas, but during the course of the year we will be holding a series of workshops to engage local stakeholders in how we can drive these forward in a more coordinated fashion.

Working alongside other CCG’s in the health economy, these workshops will be scheduled to begin from October 2012 and will be managed through our QIPP planning process to ensure that they are properly built into future plans. The aim of the workshops will be to generate truly transformational ideas that can be taken forward into properly managed and resourced implementation projects.

We are beginning to do this already and have good local examples, but we need more. One such example is MSK ICATS and developments within our Integrated Community Teams. With a carefully constructed approach, clear aims and proper facilitation, it is our intention to develop more ideas like this through the workshop process.

2.8 Public Health Transition

Public health has resided within the NHS since 1974, most recently within SHAs and PCTs. During this time the profession has assumed the lead for three ‘domains’ of responsibilities on behalf of the NHS and local communities: health improvement, health protection and healthcare advice to commissioners.

With the implementation of the Health and Social Care Bill, responsibility for health improvement and health protection will transfer at national level from the NHS to Public Health England (PHE), and at local level from PCTs to Worcestershire County Council (WCC) and the NHS Commissioning Board NHSCB). Responsibility for commissioning of NHS services will transfer to the NHSCB and CCGs, and responsibility for providing population healthcare advice to commissioners will fall at national level to PHE and at local level to WCC.
<table>
<thead>
<tr>
<th>Area</th>
<th>Summary of implications for CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health improvement</td>
<td>The Bill gives WCC a new statutory duty from April 2013 ‘to take such steps as it considers appropriate for improving the health of the people in its area’. CCGS will be given duties to secure continuous improvement and reduce inequalities in the outcomes achieved by health services. WCC, WPH and the CCGs therefore have a collective interest in health improvement, both during the transition period and subsequently.</td>
</tr>
<tr>
<td>Health protection</td>
<td>The Bill gives CCGs a duty to ensure that they are properly prepared to deal with relevant emergencies. The Secretary of State will retain emergency powers to direct any NHS body to extend or cease functions, and is likely to discharge these through PHE.</td>
</tr>
<tr>
<td>Advice to commissioners</td>
<td>The Bill and accompanying regulations will require WCC to provide a ‘core offer’ of public health expertise, support and analysis to CCGs. This will include a requirement to ensure that this provided by appropriately trained and accredited public health professionals. The Bill establishes CCGs as the local commissioners of NHS services and gives them a duty to obtain advice from a broad range of professionals, including public health, and for using this advice to inform commissioning decisions. WCC, WPH and the CCGs will need to develop a partnership which integrates population healthcare advice seamlessly into commissioning processes.</td>
</tr>
</tbody>
</table>
2.9 Our commitment to public health transition

The three areas of the public health transition are shown below along with our commitment to each of them:

<table>
<thead>
<tr>
<th>Health Improvement</th>
<th>Health Protection</th>
<th>Healthcare Advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Work in partnership to develop and deliver health improvement strategies and plans.</td>
<td>• Commission antenatal and postnatal screening programmes to agreed national service specifications.</td>
<td>• Co-opt the identified public health consultant onto their Boards.</td>
</tr>
<tr>
<td>• Contribute actively to the HWBB.</td>
<td>• Promote awareness and informed uptake of screening, and immunisation.</td>
<td>• Work in partnership to develop the JSNA, by providing resources, information and advice, and ensuring that NHS data is available.</td>
</tr>
<tr>
<td>• Invest in prevention and early intervention, targeting services to reduce inequalities in outcomes and access.</td>
<td>• Ensure that care pathways for screen positive patients are robust.</td>
<td>• Ensure that the JSNA and public health advice is incorporated into decision making processes.</td>
</tr>
<tr>
<td>• Encourage constituent practices to maximise their contribution to prevention.</td>
<td>• Ensure that systems for immunisation programmes for high-risk individuals are robust.</td>
<td>• Make use of public health expertise, support and analysis to CCGs to inform commissioning plans and decisions.</td>
</tr>
<tr>
<td>• Support health education and social marketing campaigns.</td>
<td>• Contribute to emergency planning where needed.</td>
<td>• Identify any requirements for ‘operational’ public health support – e.g. individual funding requests, management of health service incidents.</td>
</tr>
<tr>
<td>• Work with WPH to support local communities to improve their own health and promoting community engagement and social networks.</td>
<td>• Work towards ensuring that commissioned services are resilient in the face of major incidents and threats to health.</td>
<td></td>
</tr>
</tbody>
</table>
2.10 Joint Commissioning

In April 2009, Worcestershire County Council and NHS Worcestershire developed an innovative partnership to deliver integrated and co-ordinated health and social care. The Joint Commissioning Unit covers the following areas:

**Learning Disability**

Services for adults with learning disabilities to ensure that they maintain good health and live as independently as possible within their communities.

**Mental Health**

Services for adults over 18 and older adults over 65, covering the full range of services including eating disorders, dementia care, inpatient services, community services, prisons and many more.

**Older People, Physical Disability and Sensory Impairment**

Services for older adults and adults with physical disabilities and sensory impairments including home care, day care and transport.

**Children’s Services**

Services for children under the age of 18.

**Sexual Health Services**

Sexual health services for the population of Redditch and Bromsgrove.

We are planning to continue the work that is currently undertaken by the Joint Commissioning unit and explore areas where work could be expanded to be of mutual benefit to both organisations that results in improved care to our population.

2.11 Workforce

The PCT Cluster Integrated System Plan provides more detail on the system wide workforce requirements for the future. In general NHS R&B CCG’s strategy is to identify ways of delivering more care and a greater range of services either within primary care or within community settings.

The Joint Services Review is intended to provide an overall framework for the future delivery of acute services within the county and this will have very obvious workforce implications. The expectation will be that workforce figures show a reduction in staff employed in acute settings and an increase in staff employed in primary care and within community providers. NHS R&B CCG also expects that Worcestershire Health and Care Trust will develop an Integrated Business Plan which will demonstrate their 4% year on year minimum efficiency which includes a reduction in staffing resource as productivity and capacity increases. The overall net workforce figures will need to take this into account.

For the coming 12 months we are expecting an overall reduction in workforce at our main providers to be 252, with almost of the reductions coming from the Worcestershire Acute Trust (220), but these being in non clinical areas:
Looking ahead, there is a significant workforce challenge facing our providers. The Foundation Trust application process requires aspirant trusts to submit financial plans that show a recurrent 4% efficiency gain each year. This will inevitably have an impact on their workforce numbers and costs. For example, in the coming 12 months the Worcestershire Acute Hospitals Trust has identified that it expects to incur up to £3m on workforce reduction costs through voluntary redundancies and early retirements.

A detailed breakdown of the planned workforce numbers for our two main providers are shown below. As key commissioners for services provided at these organisations it will be our responsibility to ensure that the quality of services is maintained during this period of transition.

### Worcester Acute Staffing Plan

<table>
<thead>
<tr>
<th></th>
<th>Start of 2012/13</th>
<th>End of 2012/13</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Staff</td>
<td>583</td>
<td>583</td>
<td>No change</td>
</tr>
<tr>
<td>Nursing and Midwifery Staff</td>
<td>1,616</td>
<td>1,611</td>
<td>-5 (0.3%)</td>
</tr>
<tr>
<td>Scientific, Therapeutic and Technical</td>
<td>575</td>
<td>516</td>
<td>-59 (10.3%)</td>
</tr>
<tr>
<td>Clinical Staff Support</td>
<td>1,055</td>
<td>1,008</td>
<td>-47 (4.5%)</td>
</tr>
<tr>
<td>Infrastructure Support</td>
<td>821</td>
<td>712</td>
<td>-109 (13.0%)</td>
</tr>
</tbody>
</table>

### Worcester Health and Care Trust Staffing Plan

<table>
<thead>
<tr>
<th></th>
<th>Start of 2012/13</th>
<th>End of 2012/13</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Staff</td>
<td>126</td>
<td>120</td>
<td>-6 (4.8%)</td>
</tr>
<tr>
<td>Nursing and Midwifery Staff</td>
<td>1,774</td>
<td>1,703</td>
<td>-71 (4.0%)</td>
</tr>
<tr>
<td>Scientific, Therapeutic and Technical</td>
<td>475</td>
<td>456</td>
<td>-19 (4.0%)</td>
</tr>
<tr>
<td>Clinical Staff Support</td>
<td>2</td>
<td>2</td>
<td>No change</td>
</tr>
<tr>
<td>Infrastructure Support</td>
<td>921</td>
<td>885</td>
<td>-36 (3.9%)</td>
</tr>
</tbody>
</table>
2.13 Health visitors

In Worcestershire the work to deliver the increased number of health visitors required by government is being led by the Children’s Joint Commissioning Unit, which leads on all community health services under a formal Section 75 Partnership Agreement.

Worcestershire is on track to meet all targets in the county’s SHA approved Health Visiting Implementation Plan. A data analysis exercise is being undertaken currently to consider child protection and children in need rates, population and deprivation rates, breastfeeding rates, and contact rates. This will be used to ensure that the additional capacity in the health visiting service is effectively able to increase support to the most vulnerable families and improve health outcomes. Plans are also being developed to introduce a new service model which will be more closely aligned to Children’s Centres, early years services, GPs, midwives, and specialist services.

The Healthy Child Programme is already embedded within Worcestershire. The Family Nurse Partnership (FNP) programme has not been introduced in the county but the commissioner is undertaking an evaluation of a similar local scheme targeting vulnerable first time teenage mothers and their children against local and national experience of FNP.

It is our intention to support the implementation of the actions being taken in this area.
### 3 Leadership, governance and transition arrangements

#### 3.1 Introduction

CCGs will work with patients and healthcare professionals in partnership with local communities and local authorities. On their governing body CCGs will have, in addition to GPs, at least one registered nurse, one hospital specialist, the Accountable Officer, Chief Finance Officer and two lay members. The formation of CCGs as statutory bodies is dependent on the Health and Social Care Bill receiving parliamentary approval which is now a step nearer with the Bill now only requiring Royal Assent to become law. In the meantime, NHS R&B CCG operates as a sub-committee to the NHS West Mercia Cluster Board and will take on full responsibility and function on 1st April 2013.

Worcestershire Clinical Senate acts as an advisory forum for NHS R&B CCG and the other 2 Worcestershire CCGs. It has a key role in quality assurance and service redesign. Support from Clinical Senate for NHS R&B CCG business planning will be necessary. NHS R&B CCG will be represented by 2 GPs (1) Assistant Clinical Chair and (2) LMC. NHS R&B CCG Governing Body GP Observer/non-governing body GP.

Worcestershire Health and Wellbeing Board (HWB) has a key role in understanding and supporting NHS R&B CCG challenges and business planning. NHS R&B CCG is represented by the Chair and Clinical Lead on HWB and via this route there is two-way communication and an opportunity to inform the HWB strategy and priority setting process. HWB provides a crucial opportunity to engage the wider stakeholder group including County Council. Agreed HWB priority areas shape and underpin the local priority setting process for NHS R&B CCG.

#### 3.2 The Operating Model

The NHS reforms are about creating clinically led organisations and making sure clinicians use their unique insight and training to be able to more effectively commission services for local people. It is important that this remains at the forefront of the development of our new ways of working and that our organisation becomes truly clinically led.

---

**The groups are constructed as follows:**

```
West Mercia Cluster Board

Health and Wellbeing Board

Registered Population

PPI Forum

Redditch and Bromsgrove Board

Remuneration Committee

Audit and Risk Committee

Finance and Performance Committee

Quality and Safety Committee

Pharmacy Subgroup

Service Innovation Meeting

Finance Innovation Meeting

Clinical Senate

Constituent Practices

Advisory Forum

Management Team
```
3.3 Collaborative Commissioning Arrangements

3.3.1 In partnership with NHS Wyre Forest Clinical Commissioning Group and NHS South Worcestershire Clinical Commissioning Group, NHS R&B CCG has agreed upon a collaborative approach to managing its commissioning portfolio. In order to reduce transactional costs, yet optimise the existing expert commissioning skills available locally, the three CCGs in Worcestershire have agreed to work collaboratively in the commissioning of healthcare services. To this end, there is a small CCG Commissioning Team who will lead the commissioning of contracts for the three CCGs with the support of Arden Commissioning Support Organisation. Working within this framework will ensure consistency in the quality of services for all patients in Worcestershire and avoid unnecessary duplication of effort and resource from both a provider and commissioner perspective. Furthermore collegiate working will make best use of clinical time ensuring that where service reviews, audit etc are conducted one CCG clinical lead may represent their partner organisations. As each CCG is still responsible for retaining accountability for the commissioning of services robust governance arrangements are in place for collaborative commissioning.


The ‘Worcestershire Clinical Commissioning Groups Commissioning Intentions 2012 – 2014’ places emphasis upon integrated care with seamless pathways and builds upon the existing 2012/13 Commissioning Intentions. The ‘Worcestershire Clinical Commissioning Groups Commissioning Intentions 2012 – 2014’ brings together acute services and community services commissioning intentions into one combined document which concentrates upon whole patient pathways. This document will inform the contract negotiations and plans for each of the three CCGs in Worcestershire in 2013/14 and beyond.

This document is a work in progress and whilst concentrating, at this time, on short term ambitions will be further developed to include longer term strategic direction.

3.4 The CCG Governing Body and committees

The precise membership arrangements can be formed by local agreement. However, they must comprise the following as a minimum:

- At least 50% of voting members to be GPs. How these members are chosen will be outlined in the R&B CCG Constitution.
- A GP Chair and Clinical Lead.
- 2 Lay members – one leading Governance, Audit and Remuneration; one leading Patient and Public Involvement.
- A Chief Financial Officer.
- A Lead Executive Nurse.
- A Hospital Doctor.
<table>
<thead>
<tr>
<th>Area: NHS R&amp;B CCG Governing Body</th>
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<tr>
<td>Frequency: Monthly</td>
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<tr>
<td><strong>Responsibility:</strong></td>
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| • Support the overall strategic direction for healthcare commissioning across Redditch and Bromsgrove throughout the transitional period in partnership with NHS Worcestershire (NHSW), assuming overall responsibility for mutually agreed areas of the commissioning portfolio.  
• Review overall performance across the commissioning portfolio including: finance and performance report; quality performance; QIPP and prescribing (via pharmacy subgroup).  
• Effectively manage the delegated budget in order to commission and secure appropriate healthcare services across Redditch and Bromsgrove.  
• Responsibility for appropriate reports to enable the NHS R&B CCG Governing Body to exercise effective management of delegated commissioning budgets.  
• Support and fulfil accountability requirements for constituent practices via robust GP Commissioning arrangements as agreed within the ‘Zoning’ GP role and monthly feedback via agreed reporting format/mechanism.  
• Comprehensive review of the commissioning portfolio, identifying and rationalising the potential for disinvestment and investment.  
• Overall ownership of the NHS R&B CCG QIPP agenda, including the review of QIPP initiatives and the contingency planning for those failing QIPP initiatives.  
• Agree, monitor and maximise Redditch and Bromsgrove based community services.  
• Clinically-led redesign of patient pathways and local services based upon effective dialogue and partnership with hospital and community specialists.  
• With the application of appropriate risk stratification tools and needs assessment, work in partnership with the Local Authority and Public Health to align strategic planning and maximise efficiencies and partnership working. |

<table>
<thead>
<tr>
<th>Core Membership</th>
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</table>
| Dr Jonathan Wells, Chair and Clinical Lead  
Dr Richard Davies, Assistant Clinical Chair  
Dr Rupen Kulkarni  
Dr Edward Barrett  
Dr Stephen Miskin  
Dr David Law  
Dr Catherine Mcgregor  
Simon Hairsnape, Chief Officer  
Tony Hadfield, Deputy Chair (Lay Member)  
Mary Walters, Chief Finance Officer  
Jo Galloway, Lead Executive Nurse  
Linda Pratt, Lead Practice Manager  
Judy Adam, PPI Lead (Lay Member)  
TBC - Hospital Doctor. |

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<thead>
<tr>
<th>Additional Membership</th>
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</table>
| Andrea Guest, Head of Business Development and Operations - NHS R&B CCG  
Karen Hunter, Head of Corporate Affairs (Governing Body Secretary)  
Bethan Flynn, Executive Support  
Margaret Jackson, West Mercia Cluster Observer  
Shaun Pike, LMC Observer. |
<table>
<thead>
<tr>
<th><strong>Area:</strong></th>
<th>Remuneration Committee (joint with NHS WFCCG)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency:</strong></td>
<td>As required</td>
</tr>
<tr>
<td><strong>Responsibility:</strong></td>
<td>The Remuneration Committee shall make recommendations to the governing body on determinations about pay and remuneration for employees of Redditch and Bromsgrove Clinical Commissioning Group and people who provide services to the Clinical Commissioning Group and allowances under any pension scheme it might establish as an alternative to the NHS pension scheme.</td>
</tr>
<tr>
<td><strong>Membership</strong></td>
<td>Tony Hadfield – NHS R&amp;B CCG Deputy Chair and Chair of Audit &amp; Risk Committee NHS WF CCG Deputy Chair Dr Jonathan Wells – Lead GP for Remuneration Committee NHS WF CCG Chair and Clinical Leader</td>
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<table>
<thead>
<tr>
<th><strong>Area:</strong></th>
<th>Audit and Risk Committee</th>
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</thead>
<tbody>
<tr>
<td><strong>Frequency:</strong></td>
<td>Quarterly</td>
</tr>
<tr>
<td><strong>Responsibility:</strong></td>
<td>The duties of the Audit and Risk Committee will be driven by the priorities identified by NHS R&amp;B CCG and the associated risks. It will operate to a programme of business as agreed by NHS R&amp;B CCG and will be flexible to new and emerging priorities and risks. The key duties of the Audit and Risk Committee are broadly as follows:</td>
</tr>
</tbody>
</table>

1. Integrated governance, risk management and internal control:
The committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of NHS R&B CCG's activities that support the achievement of the CCG's objectives. Its work will dovetail with that of the Clinical Quality and Patient Safety Committee to seek assurance that robust clinical quality is in place.

2. Internal audit:
The committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the audit committee, accountable officer and NHS R&B CCG.

3. External audit:
The committee shall review the work and findings of the external auditors and consider the implications and management's responses to their work.

4. Other assurance functions:
The audit committee shall review the findings of other significant assurance functions, both internal and external and consider the implications for the governance of NHS R&B CCG.

5. Counter fraud:
The committee shall satisfy itself that NHS R&B CCG has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme. |
Responsibility continued:

6. Management:
The committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

7. Financial reporting:
The audit committee shall monitor the integrity of the financial statements of NHS R&B CCG and any formal announcements relating to NHS R&B CCG’s financial performance.

The committee shall ensure that the systems for financial reporting to NHS R&B CCG, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to NHS R&B CCG.

The Audit and Risk Committee shall review the annual report and financial statements before submission to NHS R&B CCG Board and NHS R&B CCG.

The Audit and Risk Committee shall review the annual report and financial statements before submission to NHS R&B CCG Governing Body and NHS R&B CCG.

Membership

Tony Hadfield – NHS R&B CCG Deputy Chair and Chair of Audit & Risk Committee
Linda Pratt – Lead Practice Manager
Dr Rupen Kulkarni – Lead GP for Audit and Risk Committee
IN ATTENDANCE - Mary Walters, Chief Finance Officer; Karen Hunter, Head of Corporate Affairs; nominated internal and external auditors.

Area: Finance and Performance Committee
Frequency: Monthly
Responsibility: The Finance and Performance Committee will undertake the following duties:

1. Financial Management:

Revenue:
• Approve the budget setting process;
• Monitor financial performance against budgets;
• Ensure that action plans are drawn up and implemented to recover any in-year variances;
• Formulate and implement appropriate recovery plans in order to set a balanced budget against the resource limit for formal ratification of the CCG Governing Body.

Financial Control:
• To oversee and review the performance of the CCG against its key financial duties.

Performance:
• Monitor the process of performance management within the CCG including the development of effective performance monitoring frameworks, targets and plans, and report on delivery against them.
• To review and analyse reports on the performance of the commissioning function of the CCG as appropriate.
• Monitor the overall performance of the CCG against national and local economy targets, making recommendations for actions undertaken as a result of any recommendations made, reporting as required to the CCG Board.
**Responsibility continued:**

Reporting Arrangements:
The Committee shall receive the minutes from performance review groups within the CCG.

The Secretary will submit the minutes of the Finance and Performance Committee’s meeting to the NHS R&B CCG Governing Body for consideration at the next available meeting.

**Membership**

Dr David Law – Chair of Quality and Patient Safety Committee
Jo Galloway – Executive Nurse
Further membership to be confirmed.

<table>
<thead>
<tr>
<th>Area:</th>
<th>Quality and Patient Safety Committee</th>
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<td>Frequency:</td>
<td>Frequency to be confirmed</td>
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<tr>
<td>Responsibility:</td>
<td>The duties of the Quality and Patient Safety Committee will be driven by the priorities for NHS R&amp;B CCG and any associated risks or areas of quality improvement. It will operate to a programme of business agreed by NHS R&amp;B CCG Governing Body which will be flexible to new and emerging priorities and risks.</td>
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</table>

**Areas for inclusion:**

- Seek assurance that the commissioning strategy for NHS R&B CCG fully reflects all elements of quality (patient experience, effectiveness and patient safety), keeping in mind that the strategy and response may need to adapt and change.

- Provide assurance that commissioned services are being delivered in a high quality and safe manner, ensuring that quality sits at the heart of everything NHS R&B CCG does. This may be extended to include jointly commissioned services.

- Oversee and be assured that effective management of risk is in place to manage and address clinical governance issues.

- Have oversight of the process and compliance issues concerning serious incidents requiring investigation (SIRIs); being informed of all Never Events and informing the governing body of any escalation or sensitive issues in good time.

- Seek assurance on the performance of NHS organisations in terms of the Care Quality Commission, Monitor and any other relevant regulatory bodies.

- Receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans.

- Ensure a clear escalation process, including appropriate trigger points, is in place to enable appropriate engagement of external bodies on areas of concern.

**Membership**

Tony Hadfield – NHS R&B CCG Deputy Chair and Chair of Finance and Performance Committee
Simon Hairsnape – Chief Officer
Dr Richard Davies – Lead GP for Finance and Performance Committee
Mary Walters – Chief Finance Officer
### Area:
**Service Innovation Meeting**

### Frequency:
Monthly

### Responsibility:
The main objectives of the Service Innovation Meeting are:

- Promote partnership working and maximise service integration opportunities;
- Clinically directed consideration of pathway opportunities across major local Providers;
- Act as the conduit and gatekeeper for all NHS R&B CCG workstreams and pathway developments;
- Identify service gaps or opportunities for delivering services differently across the whole patient pathway;
- Bring together appropriate agencies to ensure an ability to develop integrated services;
- Take forward any pathway and/or service redesign resulting from NHS R&B CCG workstream developments;
- Report into the contractual processes any changes to the contract resulting from the service reviews/clinically led service/pathway redesign workstreams allowing sufficient time for any changes to the contract to be made in accordance with the requirements of the contract (via NHS R&B CCG Account Manager);
- Explore opportunities for the delivery of Health Economy efficiencies, enhancing the delivery of the QIPP agenda;
- Inform and develop commissioning intentions and recommendations for submission to NHS R&B CCG Management Team;
- The service innovation meeting will work in direct partnership with the finance innovation meeting.

### Reporting Arrangements:

- To NHS R&B CCG Management Team and NHS R&B CCG Governing Body where appropriate.

### Membership

- Dr Jonathan Wells
- Dr Richard Davies
- Dr Marion Radcliffe, (NHS R&B CCG Urgent Care Lead)
- Linda Pratt, Lead Practice Manager
- Andrea Guest, Head of Business Development and Operations
- Simon Gartland, NHS R&B CCG Account Manager
- WHACT Clinical Director
- WAHT Clinical Director
- WAHT Hospital Director
- Other clinicians co-opted to represent their specific programme area, as agreed.
### Finance Innovation Meeting

**Area:** Finance Innovation Meeting  
**Frequency:** Monthly  
**Responsibility:**

The main objectives of the Finance Innovation Meeting are:

- Provide a consistent approach to potential business development opportunities and any business cases submitted;
- Monitor NHS R&B CCG workstream delivery to ensure they are in line with strategic direction and QIPP agenda/QIPP deliverables;
- Make recommendations to NHS R&B CCG Management Team following consideration of potential business development opportunities and business cases submitted;
- Provide information and financial support to Service Innovation Meeting;
- Act as the conduit and gatekeeper for all NHS R&B CCG workstreams and pathway developments (in partnership with the Service Innovation Meeting);
- Identify service gaps or opportunities by identifying areas of increased/questionable activity and finance – provide clear challenge/steer to the Service Innovation Meeting;
- Consider the potential impact of any pathway and/or service redesign emerging from the Service Innovation Meeting;
- Report into the contractual processes any changes to the contract resulting from the service reviews/clinically led service/pathway redesign workstreams allowing sufficient time for any changes to the contract to be made in accordance with the requirements of the contract (via NHS R&B CCG Account Manager);
- Explore opportunities for the delivery of Health Economy efficiencies, enhancing the delivery of the QIPP agenda;
- Inform and develop commissioning intentions and recommendations for submission to NHS R&B CCG Management Team;
- THE FINANCE INNOVATION MEETING WILL WORK IN DIRECT PARTNERSHIP WITH THE SERVICE INNOVATION MEETING.

**Reporting arrangements:**

To NHS R&B CCG Management Team and NHS R&B CCG Governing Body where appropriate.

**Membership**

Dr Richard Davies (Chair)  
Mary Walters - Chief Finance Officer  
Linda Pratt - Lead Practice Manager  
Andrea Guest - Head of Business Development & Operations  
Sarah Harris - Information Manager  
Jan Clossick - Finance Manager  
Stuart Bourne - Public Health Consultant  
Vicki Moulston - Primary Care Engagement Manager  
Simon Gartland - NHS R&B CCG Account Manager
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<tr>
<th>Area: Pharmacy Sub Group</th>
<th>Frequency: Monthly</th>
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<tbody>
<tr>
<td><strong>Responsibility:</strong></td>
<td>Pharmacy Subgroup reports directly to NHS R&amp;B CCG Management Team and has core responsibility for the following:</td>
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<tr>
<td></td>
<td>• Ongoing review of NHS R&amp;B CCG prescribing spend;</td>
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<td></td>
<td>• Ongoing review of Medicines QIPP;</td>
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<td></td>
<td>• Develop innovative approaches to prescribing practice;</td>
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<td></td>
<td>• Overarching leadership and support to NHS R&amp;B CCG practices and ‘Zoning’ arrangements;</td>
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<td></td>
<td>• Links with Area Prescribing Committee;</td>
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<td></td>
<td>• Links with the CSO and the countywide arrangements for medicines management.</td>
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<tr>
<td>Membership</td>
<td>Dr Edward Barrett - Medicines Management/Pharmacy Lead</td>
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<td></td>
<td>Mary Shaw - Pharmaceutical Advisor</td>
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<td></td>
<td>Jan Clossick - NHS R&amp;B CCG Finance Manager</td>
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<tr>
<td></td>
<td>Vicki Moulston - NHS R&amp;B CCG Primary Care Engagement Manager</td>
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<tr>
<th>Area: Patient and Public Involvement Forum</th>
<th>Frequency: Monthly</th>
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<td><strong>Responsibility:</strong></td>
<td>The PPI Forum represents the NHS R&amp;B CCG patient and public community either via direct engagement or via the strategies adopted to raise awareness and involvement within the NHS R&amp;B CCG agenda.</td>
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<td>The PPI Forum is charged with developing the Community Engagement and Communications Strategy for NHS R&amp;B CCG and ensuring that is adopted and its principles are implemented.</td>
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<td></td>
<td><strong>Key activities in relation to this work will include:</strong></td>
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<td></td>
<td>• Advising on approaches to public and patient engagement;</td>
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<td></td>
<td>• Identifying and addressing the training, educational, information and support needs for patients, public and staff so they are able to play an active part;</td>
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<td></td>
<td>• Integrating the involvement work of NHS R&amp;B CCG with both developing and established involvement activities of other local partners, including Local Authorities, community &amp; voluntary sector;</td>
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<td>• Ensuring that involvement activities reflect the diverse needs of local communities;</td>
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<td></td>
<td>• Identifying the resources needed to implement the strategy, including an agreed policy for reimbursing out of pocket expenses incurred by service users;</td>
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<td></td>
<td>• Supporting and encouraging NHS service providers to capture the experiences of service users and improve services in line with contractual arrangements;</td>
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<td>• Ensuring regular feedback is given to all those who contribute;</td>
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<td></td>
<td>• Identifying and sharing examples of good practice.</td>
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<tr>
<td>Membership</td>
<td>Judy Adams – PPI Chair/NHS R&amp;B CCG Lay Governing Body Member</td>
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<td></td>
<td>Selina Lavictoire - Social Marketing Manager</td>
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<tr>
<td></td>
<td>Andrea Guest - Head of Business Development &amp; Operations</td>
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<td></td>
<td>Dr Stephen Miskin – Lead GP for Patient and Public Involvement</td>
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<tr>
<td></td>
<td>Bethan Flynn - Executive Administrator</td>
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<tr>
<td>Area:</td>
<td>Redditch and Bromsgrove Advisory Forum</td>
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<tr>
<td>Frequency:</td>
<td>Monthly</td>
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<tr>
<td>Responsibility:</td>
<td>The NHS R&amp;B CCG Advisory Forum provides a regular opportunity for NHS R&amp;B CCG Member Practices to meet together to discuss NHS R&amp;B CCG business and to hold NHS R&amp;B CCG Governing Body to account. Chaired by a non-governing body GP to reflect good governance, representatives from Member Practices are either Lead Commissioning GPs or Practice Managers. The agenda is built around Governing Body and Management activity and the latest Primary Care developments.</td>
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</table>

**Membership**
- Dr Marion Radcliffe - Nominated Non Governing Body GP Chairperson
- NHS R&B CCG Governing Body GPs and Lead Practice Manager
- NHS R&B CCG Head of Business Development and Operations
- Finance Manager
- NHS R&B CCG Locality Team members
- NHS R&B CCG Lead GPs and Practice Managers
3.5 The Management Team

The structure of the management team is shown below. It will be chaired by the Chief Officer and will have a quorum of four members. Other Board members, officers and representatives from partner organisations will be invited to participate on an “as and when” basis.

The Management Team is the executive committee of the CCG Governing Body and has been established to allow the CCG Governing Body to focus on leadership, clinical engagement, strategy governance and delivering health improvements for the patients and people of Redditch and Bromsgrove. The Management Team will be directly accountable to the governing body through the Chief Officer. The Management Team will operate within the powers delegated to it by the Governing Body under Standing Financial Instructions. The minutes of the Management Team will be received by Governing Body.

The Management Team has a critical role in ensuring that commissioning decisions are in line with CCG Governing Body strategies and within the PCT’s (and eventually the CCG’s) scheme of delegation. This separation of governance and executive roles is fully in line with corporate governance good practice.
### Responsibility:

- Ensure that commissioning decisions are consistent with the overall strategies set by the Governing Body.
- Offer advice to the Governing Body on the content and direction of strategies.
- Receive and approve outline business cases. Ensure that cases reflect agreed policies and strategies, are consistent with care pathways agreed (or to be agreed) with providers and that procurement proposals are consistent with the Governing Body’s strategy.
- Initiate reviews of services where it appears existing services are not meeting the needs of patients appropriately. This will include when there are concerns about safety, quality, clinical effectiveness, value for money or patient experience. The Management Team will seek advice from the Clinical Senate when initiating reviews, and refers details of any reviews to the Advisory Group and/or GPA for advice on appropriate levels of public and stakeholder consultation.
- Agree proposed incentives and CQUIN schemes.
- To make operational and other decisions consistent with the effective running of the CCG.

### Membership

- Chief Officer
- Senior Management Team
- Head of Business Development and Operations
- NHS R&B CCG Chair and Clinical Lead
- NHS R&B CCG Assistant Clinical Chair
- Chief Finance Officer (or nominated deputy)
- Executive Nurse
- Lead Practice Manager
- Executive Administrator.
4 Communications and engagement

4.1 Introduction

The Government’s aim to create a clinically-driven commissioning system which is more sensitive to the needs of patients will mean that important decisions on local healthcare will be made by CCGs. Informing and engaging the public and stakeholders in setting our priorities and delivering our services against these will be fundamental to our success. Our challenge will be to communicate and interact with a wide range of audiences, ensuring we convey the right messages via the right platforms to the right people. A clear approach to communications and engagement will be an important element to this and our strategy is built on a two-way process of educating, informing, sharing, listening and responding.

Central to our approach is the establishment of NHS R&B CCG as the ‘the public voice’ on local healthcare services, seeking support and feedback from local people so they feel included and can ‘have their say,’ as well as building their trust in what we decide. Our communications campaign will educate people about the purpose of NHS R&B CCG and demonstrate transparency in decision making processes. Our messaging will explain who takes the decisions and how, be open about challenging or sensitive issues and how they are handled. Equally, it must be realistic in managing expectations on maintaining high quality and affordable services. Importantly, we will communicate in clear, easy to understand language about the policies and principles that guide our decisions.

4.2 Communication approach

Our approach is informed by independent research we’ve undertaken among key stakeholders, influencers and CCG Governing Body members on the communications requirements, challenges, considerations and goals (see Communications and Engagement Strategy for full details). Within our approach we have allowed for alignment of our strategy with our neighbouring CCGs in Worcestershire – Wyre Forest and South Worcestershire.

We have developed a separate communications strategy, the key elements of which include:

- Proactively and effectively communicating our purpose, priorities, messages and values.
- Developing effective two-way communications systems where we share news, we listen and respond, and are visible.
- Ensuring that we evolve as a CCG and develop a positive culture of consistent, open and clear communication.
- Identifying relevant and effective communication tactics with key audiences and stakeholders.
- Developing an achievable action plan for our communications priorities.

4.3 Core objectives and messages

We have set out our core messages below, along with who is responsible for creating and delivering the action plan underpinning this objective. Our expectation is that each of these objectives will have an underpinning action plan in place by Autumn 2012, and that implementation of this action plan will be routinely monitored by the management team.

4 Communications and engagement
## Our objective

**Proactively build continuous and meaningful engagement with the public, patients and stakeholders to shape high quality, affordable services and improve the health of people in Redditch and Bromsgrove.**

## Our message

As a new GP-led management team we are different to PCTs - we have a fresh perspective on keeping the people of Redditch and Bromsgrove healthy.

We are ambitious and committed to a sustainable, high quality NHS – your local NHS is safe in our hands.

## Desired Outcome

The public understands who we are, what our purpose is and what we aim to achieve, they feel informed, they understand our ambitions and they know their contribution will be valued.

Stakeholders feel informed and know what is expected of them.

## Responsibility/Date

Social Marketing Manager / PPI Chair Autumn 2012.

---

## Our objective

**Build trust and credibility in NHS R&B CCG as a responsible, responsive, approachable, accessible and innovative organisation.**

## Our message

We exist to ensure the people of Redditch and Bromsgrove enjoy lives which are as healthy as possible.

We are committed to providing a high standard of healthcare to patients, and that people feel confident in our decisions.

## Desired Outcome

The public and stakeholders have confidence in us as a responsible CCG, and they know we are acting in their very best interests.

## Responsibility/Date

Social Marketing Manager / PPI Chair Autumn 2012.

---

## Our objective

**Promote a positive culture of open engagement externally, so people feel they have a voice on important decisions and want to get involved in shaping their local services.**

## Our message

We have open dialogue with the public, we listen and respond to the views of local people and act in their best interests.

## Desired Outcome

People in Redditch and Bromsgrove feel they have a voice in our decisions.

They know how their say has impacted on local healthcare services.

## Responsibility/Date

Social Marketing Manager / PPI Chair Autumn 2012.

---

## Our objective

**Be open and transparent in our decision making processes, and be honest about what can be achieved.**

## Our message

We are open and honest with people on the need for change, the challenges facing health services, the choices we make, and that we are fair.

## Desired Outcome

The public feel included, they understand our decisions and have realistic expectations of what is achievable.

## Responsibility/Date

Social Marketing Manager / PPI Chair Autumn 2012.
4.4 Key audiences

Our key audiences and stakeholders have been identified as:

- Patients and the public
- GPs and the wider clinical teams
- Provider organisations and local hospitals, specialist Trusts/Centres and local Mental Health Trusts
- Partners from local government, MPs, County Councils, Parish Councils, regulatory bodies, health and wellbeing boards, neighbouring Clinical Commissioning Groups, and potentially police, prison service and probation.

Further details can be found in our Communications and Engagement Strategy which outlines on how we will take a different approach to each group to ensure that the best method is used to either gather information or deliver the key messages.

These different approaches are based on the premise that different groups have different communication requirements, and the approaches can be summarised as:

<table>
<thead>
<tr>
<th>Manage</th>
<th>Key stakeholders who should be fully engaged through communications and consultation.</th>
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<tbody>
<tr>
<td>Inform</td>
<td>Keeping interested people/groups informed. Those in this section may need to have their influence increased depending on the subject/work programme.</td>
</tr>
<tr>
<td>Monitor</td>
<td>This group needs to be monitored for communications and engagement need.</td>
</tr>
</tbody>
</table>

Manage Key stakeholders who should be fully engaged through communications and consultation.
Inform Keeping interested people/groups informed. Those in this section may need to have their influence increased depending on the subject/work programme.
Monitor This group needs to be monitored for communications and engagement need.
4.5 Methods of engagement

**Our strategy outlines how we intend to make the most of the wide range of communication media available to us:**

<table>
<thead>
<tr>
<th>Website and digital media</th>
<th><a href="http://www.redditchandbromsgroveccg.nhs.uk">www.redditchandbromsgroveccg.nhs.uk</a> is our website.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Twitter: Username = RB_CCG</td>
</tr>
<tr>
<td></td>
<td>Facebook: Username = Redditch and Bromsgrove Clinical Commissioning Group</td>
</tr>
<tr>
<td></td>
<td>Consideration will also be given during the year to the potential use of YouTube and LinkedIn.</td>
</tr>
</tbody>
</table>

| Proactive media campaign | We will adopt a proactive approach with the local media. We will build relationships by regularly informing local print and broadcast media (offline and online) with a “drip feed” of positive news. When appropriate, we will hold ‘friendly’ briefings and operate a 24/7 press desk to ensure all media requests are dealt with effectively and immediately. Equally, we will be prepared to respond to any negative issues or situations with guidance from our ‘user friendly’ crisis manual. This manual will identify our crisis team, procedures and out of hours contacts. |

| Media spokespeople | Only chosen members have authority to speak to the press on behalf of NHS R&B CCG. Our elected media spokespeople are: Andrea Guest, Head of Business Development and Operations; Jonathan Wells, GP and NHS R&B CCG Chair and Clinical Lead; Richard Davies, GP and NHS R&B CCG Assistant Clinical Chair, Simon Hairsnape; NHS R&B CCG Chief Officer and Linda Pratt, NHS R&B CCG lead practice manager. Media training will ensure our media representatives are confident and competent in handling any media interview situation. |

| Traditional communications | Newsletters - We will develop our newsletters (Patient and Public, GP and Stakeholder) and increase their accessibility via our website, digital media platforms (Facebook and Twitter), GP surgeries, hospital waiting rooms and at key events. Face-to-Face - We will broaden our presence at key launch events, focus groups, roadshows, summits and debates. Questionnaires and surveys - We will use questionnaires and surveys to gain the views of patients, the public and stakeholders about current services and possible changes to services. |
4.6 Patient and public involvement

Patient and public involvement goes well beyond communications and is the means by which we intend to proactively ensure that we design and procure services that truly meet the requirements of our community. We will not assume that we know what is best, we will actively seek out viewpoints, perspectives and evidence to inform our decision making.

Our detailed approach to this is outlined in our Communications and Engagement Strategy, but the main features are outlined below:

Our aim is “To maintain an engagement and involvement framework that ensures all local citizens have the opportunity to contribute to decision making and maximise opportunities to build local ownership of health services.”

Our key priorities are to:

- Build communications and engagement into the commissioning process and ensure that all commissioned schemes have been developed considering patient and stakeholder feedback.
- Proactively work with partners inside and outside of the health economy to achieve joined up engagement, messages and campaigns.
- Work with the NHS R&B CCG management team to influence an organisational culture that involves patients and the public at all levels of decision making and facilitates a customer and marketing orientation.
- Assist the organisation to develop a real understanding of the local population and significant ideas and opinions amongst communities.
- Develop processes, infrastructure and capacity to deliver effective engagement function.
- Ensure that all engagement is accessible and take into account the varying needs of different groups of the local population.
- Support the planning and delivery of campaigns and initiatives.
- Provide and promote a professional, empathic and efficient Patient Relations Service (complaints).

Our approach will be built upon:

- Collaborative working with partners to ensure good practice is shared, duplication avoided and that we make the most of our resources.
- Identifying processes, systems and infrastructure that are convenient and suit the community’s capacity to get involved.
- The need for involvement to be on an informed basis, with participants at varying levels, from ‘armchair’ to formal attendance at regular meetings and being actively involved in reviewing services and seeking the views of patients. We recognise that not everyone will have a view or an opinion on every issue and that the important aspect is that there should be opportunity for local people to get involved if and when they want to do so.
- Ensuring that the community is at the heart of our development, planning, decisions and services we deliver. All communications will be in ‘plain English’ in a way which all patients and the public can access.
- Ensuring that we identify and to access hard to reach groups, whilst ensuring that all communications and engagement events reflect our responsibilities and obligations around equality and fairness.
- Capitalising on pre-existing groups, such as the R&B Patient and Public Involvement Group (PPI Forum), Local Involvement Networks (LINK), Neighbourhood Forums, Youth Groups, Special Interest Groups and other relevant community groups.
- Encouraging GP practices to build their own Patient Participation Groups (PPGs).
- Creating new forums for engagement such as a Patient Relations Service, a body to work alongside “NHS Choices” and “Patient Opinion” in dealing with complaints and concerns. We will also look to recruit PPI Advocates and Champions who we can train up to work with us on a voluntary basis to run engagement events.
- Finally, we plan to launch a PPI Membership scheme where people can actively register to be contacted in regard to PPI requirements – ranging from active roles at meetings and focus groups (Gold Membership) through to simply being happy to receive surveys and participate in consultations (Silver Membership).
<table>
<thead>
<tr>
<th>Action</th>
<th>Audiences</th>
<th>Timescales</th>
<th>Roles and responsibilities</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Media Training</td>
<td>N/A</td>
<td>July 2012</td>
<td>Andrea Guest, Head of Business Development and Operations; Jonathan Wells, Chair and Clinical Lead; Richard Davies, Assistant Clinical Chair; Simon Hairsnape Chief Officer and Linda Pratt, Lead Practice Manager.</td>
<td>Competence in handling media interviews.</td>
</tr>
<tr>
<td>Website</td>
<td>All</td>
<td>Launch 13th June / on-going</td>
<td>Social Marketing Manager / NHS R&amp;B CCG Lead Practice Manager</td>
<td>Increased traffic and enquiries, feedback.</td>
</tr>
<tr>
<td>24/7 Press desk</td>
<td>All</td>
<td>On-going</td>
<td>*WHACT comms (SLA)</td>
<td>Responding to all media requests.</td>
</tr>
<tr>
<td>(reactive)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Media campaign</td>
<td>All</td>
<td>On-going</td>
<td>Social Marketing Manager</td>
<td>Volume coverage (online and offline).</td>
</tr>
<tr>
<td>(proactive)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis manual</td>
<td>n/a</td>
<td>TBC</td>
<td>*WHACT comms (SLA) / Social Marketing Manager</td>
<td>Ability to respond to challenging issues.</td>
</tr>
<tr>
<td>PPI newsletter</td>
<td>Patients and public</td>
<td>Monthly</td>
<td>Executive Administrator / Social Marketing Manager</td>
<td>Increased readership and responses.</td>
</tr>
<tr>
<td>GP newsletter</td>
<td>GPs</td>
<td>Monthly</td>
<td>Executive Administrator / Social Marketing Manager</td>
<td>Increased readership and responses.</td>
</tr>
<tr>
<td>Stakeholder newsletter</td>
<td>Stakeholders</td>
<td>Bi-monthly</td>
<td>Executive Administrator / Social Marketing Manager</td>
<td>Increased readership and responses.</td>
</tr>
<tr>
<td>Twitter</td>
<td>All</td>
<td>On-going</td>
<td>Social Marketing Manager</td>
<td>Number of mentions, interactions and followers.</td>
</tr>
<tr>
<td>Facebook</td>
<td>All</td>
<td>On-going</td>
<td>Social Marketing Manager</td>
<td>Increased likes, interactions and information shared with others.</td>
</tr>
<tr>
<td>Action</td>
<td>Audiences</td>
<td>Timescales</td>
<td>Roles and responsibilities</td>
<td>Measurement</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------------------</td>
<td>---------------------</td>
<td>-------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>LinkedIn</td>
<td>Stakeholders</td>
<td>On-going</td>
<td>Social Marketing Manager</td>
<td>Increased engagement and responses.</td>
</tr>
<tr>
<td>Face-to-face (ad hoc) (Internal and external)</td>
<td>All</td>
<td>On-going</td>
<td>NHS R&amp;B CCG</td>
<td>Increased awareness, response and interaction.</td>
</tr>
<tr>
<td>Consultant event</td>
<td>Consultants</td>
<td>Bi-annually</td>
<td>TBC</td>
<td>Increased engagement.</td>
</tr>
<tr>
<td>Stakeholder event</td>
<td>Stakeholders</td>
<td>September 2012 /</td>
<td>TBC</td>
<td>Increased engagement.</td>
</tr>
<tr>
<td>GP zoning</td>
<td>GPs</td>
<td>bi-annually</td>
<td>GP Governing Body members</td>
<td>Increased engagement with local GPs, practices and clinical staff.</td>
</tr>
<tr>
<td>Advisory Forum</td>
<td>Internal</td>
<td>On-going</td>
<td>TBC</td>
<td>Increased communication and greater awareness.</td>
</tr>
<tr>
<td>Questionnaire and surveys</td>
<td>All</td>
<td>On-going</td>
<td>Social Marketing Manager</td>
<td>Increased response levels.</td>
</tr>
<tr>
<td>Developing the representation of our PPI Forum</td>
<td>Members of PPI</td>
<td>On-going</td>
<td>PPI chair NHS R&amp;B CCG PA</td>
<td>Wider representation</td>
</tr>
<tr>
<td>Building a relationship with Local Involvement Network - LINk (Healthwatch from April 2013)</td>
<td>Patients and public</td>
<td>TBC</td>
<td>Social Marketing Manager</td>
<td>Accessing views from specific audiences.</td>
</tr>
<tr>
<td>Interacting with local groups and forums</td>
<td>Patients and public</td>
<td>TBC</td>
<td>Social Marketing Manager</td>
<td>Applying views from wider audience groups.</td>
</tr>
<tr>
<td>Developing NHS R&amp;B CCG Membership Scheme</td>
<td>Patients and public</td>
<td>TBC</td>
<td>Social Marketing Manager</td>
<td>Increased membership, enquiries and responses.</td>
</tr>
<tr>
<td>Reaching hard-to-reach groups</td>
<td>Hard-to-reach</td>
<td>TBC</td>
<td>Social Marketing Manager</td>
<td>Increased interaction.</td>
</tr>
<tr>
<td>Patient Relations Service</td>
<td>Patients and public</td>
<td>On-going</td>
<td>Lead Executive Nurse</td>
<td>Increased response rate.</td>
</tr>
</tbody>
</table>
5 Finance

5.1 Introduction

The financial plans contained in this section set out how we will manage our finances through the transition period of 2012/13 as we take on more responsibility for commissioning budgets and, therefore, the financial requirements of the CCG will increase. It also looks further ahead at the financial challenges that will face the CCG given the current economic climate.

Worcestershire PCT has a very sound financial history delivering planned surpluses since its inception. It was in 2011/12 that the PCT delegated budgets to each of its three CCGs and in that year Redditch and Bromsgrove CCG ended the year with a surplus of £252,173 after taking into account future practice changes. In 2012/13 the CCG commenced the year with a budget of £184.3m equating to nearly 30% of the countywide CCG budget.

5.2 The 2012-13 Financial Plan

The Operating Framework and PCT allocations were published in December 2011 and these were built into our financial plans. The West Mercia Cluster set a number of planning assumptions that we have used for 2012-13, these included:

- Delivering a 1% CCG Insurance Risk Reserve to be held centrally by the cluster
- Delivering an internal 1% CCG Operational Risk Reserve
- Factoring in the impact of 2012-13 Quality, Innovation, Productivity and Prevention (QIPP) schemes

5.3 Planning and Prioritisation

The CCG will ensure we allocate time to oversee this important function. This includes reviewing existing expenditure, assessing bids for new investment, identifying areas for disinvestment and assessing areas where efficiencies can be made through QIPP schemes.

The Joint Strategic Needs Assessment (JSNA) has been used to assess key areas for targeting QIPP work. The JSNA draws on a number of benchmarking indicators, including the atlas of variation, and has enabled the group to identify areas where the PCT is an outlier in terms of expenditure or delivery of outcomes.

The delivery of QIPP will be a key role for the CCG going forward.

5.4 2012/13 budgets

The CCG budget for 2012/13 is based on the historic percentages from the old “Practice Based Commissioning” budgets, with Redditch and Bromsgrove taking nearly 30% of the overall CCG allocation.

An uplift of 3.6% was applied to the 2011/12 budget to give a total CCG budget of £184.3m. Individual lines within the budget were derived following the agreement of secondary healthcare contracts and assessments of future expenditure on areas such as continuing healthcare.

The following were taken into account:

- Demography at 1.15%
- Previous year’s forecast outturn
- The national tariff deflator of 1.5%
- The 1% increase in CQUIN
- Specialised services budget transfers
- Known cost pressures, such as new drugs and technologies
- The CCG QIPP requirement of £3.3m.

The resultant position for the CCG allows an internal £1.655m Operational Risk Reserve. In addition the CCG will have access to the PCT centrally held Insurance Risk Reserve; Redditch and Bromsgrove's share being £1.84m.
5.5 Quality, Innovation, Productivity and Prevention (QIPP) 2012/13

QIPP is a large scale transformation programme being run within the health service. It has been developed to improve the quality of care as well as to release efficiency savings through improved health delivery and better coordination of health interventions.

Redditch and Bromsgrove CCG, as part of the wider Worcestershire CCGs, has contributed significantly to the development of QIPP schemes in our area for 2012/13 and will ensure that we manage and monitor the schemes to deliver the targets set for them.

The QIPP Schemes in Worcestershire are worth £11.4m in total with the Redditch and Bromsgrove element equivalent (based on population) to £3.3m.

<table>
<thead>
<tr>
<th>Project</th>
<th>Reduction</th>
<th>Value</th>
<th>NHS R&amp;B CCG will:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orthopaedics Programme - reducing activity by finding more suitable treatments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce first OP app’ts</td>
<td>719 new app’ts</td>
<td>£106k</td>
<td>Practices will comply with the Commissioning Guidelines for the Management of Orthopaedic Conditions, adhering to treatment protocols for orthopaedic conditions and fully utilising services available within primary care. NHS R&amp;B CCG will continue to commission high quality community based MSK physiotherapy services.</td>
</tr>
<tr>
<td>Reduce elective and day case work</td>
<td>262 fewer IP spells</td>
<td>£700k</td>
<td>Practices will continue to refer to the NHS R&amp;B CCG Musculoskeletal Integrated Clinical Assessment and Treatment Service (MSK ICATS): A comprehensive evaluation of the MSK ICAT service will be undertaken by Autumn 2012. Key considerations will be overall savings since service initiation and overall patient experience. Opportunities to effectively develop the Service Specification will be considered, to include other potential conditions such as hand surgery/carpal tunnel thus further reducing the burden on hospital day case work by enhancing services available within the community setting.</td>
</tr>
<tr>
<td>Reduce follow up (f/ups)</td>
<td>157 f/ups</td>
<td>£12k</td>
<td>A combination of the above initiatives will support a reduction in follow up activity.</td>
</tr>
</tbody>
</table>

**Outpatients - managing demand through more effective referral management**

<table>
<thead>
<tr>
<th>Project</th>
<th>Reduction</th>
<th>Value</th>
<th>NHS R&amp;B CCG will:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce first app’ts in other specialties</td>
<td>1,235 f/ups</td>
<td>£203k</td>
<td>Partnership Working Groups are in the process of being established to enable GPs and consultants to consider patient care pathways and identify potential community solutions for patients who would otherwise have been managed within a hospital setting. Referral Management and NHS R&amp;B CCG Dashboard LES: An agreed Referral Management and NHS R&amp;B CCG Dashboard LES is in place which allows practices to prospectively review all possible routine patient cases prior to any referral being made. Peer review is made available via ‘Zoning’ arrangements and the NHS R&amp;B CCG Dashboard has a dedicated reporting system which considers referral rates by practice. Gynaecology – Mennoraghia Pathway developed as part of QP in QOF to appropriately manage patients within Primary Care and reduce unnecessary outpatient appointments.</td>
</tr>
<tr>
<td>Reduce f/ up app’ts in other specialities</td>
<td>2538 f/ups</td>
<td>£188</td>
<td>PSA LES: A Urology Partnership Working Group has been established. A PSA LES is in the final stages of development which will allow for follow ups within the community setting – an improvement for patients in general which will lead to a reduction in follow up activity.</td>
</tr>
<tr>
<td>Reduce f/ups in Ophthalmology</td>
<td>644 f/ups</td>
<td>£24k</td>
<td>Community Ophthalmology Service: The existing Service Specification is being further developed to include a wider range of conditions including the management of low risk glaucoma. Re – tendering of the service is imminent.</td>
</tr>
<tr>
<td>Reduce f/ups in Mental Health</td>
<td>727 f/ups</td>
<td>£160k</td>
<td>As an identified NHS R&amp;B CCG Priority Area for 2012/13, the NHS R&amp;B CCG Mental Health Programme is in progress: A series of projects are underway with the overall aims of (1) improving the interface between primary and secondary care; (2) implementation of a Shared Care Model; (3) provision of equitable access to services across Redditch and Bromsgrove; (4) implementation of a formal process to secure future counselling services for Redditch and Bromsgrove.</td>
</tr>
</tbody>
</table>

Urgent care schemes - avoiding non elective admissions by proactively managing risks and putting in place better preventions

| COPD | 25 n/e spells | £49k | The COPD pathway has been identified as a QP in QOF pathway for 2012/13. A Pathway for Undiagnosed COPD patients is under development and will be implemented by the Autumn of 2012. |
| PPCI | 16 n/e spells | £102k | Smoking cessation services and healthy weight programmes will continue to be promoted at individual practice level. |
| End of Life | 44 n/e spells | £152k | EoL LES: practices who are not signed up to the EoL LES will be encouraged to do so. The ‘just in case’ boxes and the enhanced care for EoL patients supports patients to die at home and prevents unnecessary admission to hospital. Further developments to EoL pathways will be considered for implementation during 2012/13. |
| Falls | 38 n/e spells | £122k | NHS R&B CCG Care Home LES: Will lead to a reduction in the incidence of falls as part of the process is the appropriate prescribing and referral to occupational therapy and physiotherapy. In addition, the impact of falls will be minimised with the appropriate identification and related treatment of osteoporosis. Falls Service: NHS R&B CCG practices continue to refer to Nurse Advisors for falls assessment and related action. |
TBC  
508 n/e spells  
£966k

Integrated Care (and implementation of a ‘Virtual Ward’ model): Further developments around community services in terms of ‘Enhanced Care’ – maximising Intermediate Care services by aligning them with the activity within POWCH – creating a seamless service. Possible medical models are under consideration which will support patient flow, the management of patients within the community (be they within their own homes, a care home or the community hospital) and GPs in clinical decision making and support in general. Risk Stratification has been previously piloted on a very small scale. Other examples of risk stratification application will be considered to ensure we identify the best possible way of proactively identifying patients at risk and support them accordingly.

Improving Access in Primary Care: GP Triage systems being piloted in 2012/13 to improve access to GP appointments and prevent patients from inappropriately accessing A&E in hours.

Urology workstream: NHS R&B CCG is also considering other possible options around the management of acute urinary retention to avoid unnecessary A&E attendances. A QP in QOF pathway is under development.

Undiagnosed COPD Pathway: a QP in QOF pathway is under development to assist the reduction of A&E attendances by proactively identifying previously undiagnosed COPD patients (15% of COPD patients are initially diagnosed in A&E).

Care Home LES: Enhancing the overall management of patients within care homes to: deliver pro-active health care based upon regular routine visits to the care home to reduce further disability and reduce crisis management; avoid unnecessary emergency admissions; increase the quality and co-ordination of care given.

Medicines Management - better procurement and prescribing practice to reduce costs

Medicines Management  
£548k

Scriptswitch: practices continue to reap the benefits of the scriptswitch software, resulting in appropriate prescribing which is cost and clinically effective.

Pharmacy Subgroup: The activity from Pharmacy Subgroup continues to support NHS R&B CCG in terms of advice and action relating to prescribing practice.
5.6 Delivering QIPP

R&BCCG recognises the importance of owning and delivering the QIPP agenda, not just because of the contribution it makes to the financial health of the CCG, but also because of the opportunity it provides to significantly improve quality and genuinely transform the way in which some services are delivered.

Equally, we recognise the importance of having strong project management arrangements to monitor our achievements and to this end we will be working the NHS West Mercia Cluster PMO and the CSS to identify how best to deliver an effective Programme Management Office (PMO) locally.

To monitor the impact and delivery of QIPP we will actively participate in the West Mercia Cluster QIPP review process that is facilitated by their Programme Management Office. This will include:

- Monthly review of financial, activity and quality indicators associated with the QIPP schemes.
- A face to face monthly “challenge” discussion between the PMO and QIPP leads from CCGs.
- A report to the West Mercia Cluster Board on the QIPP delivery, a copy of which will also be routinely presented to the R&BCCG Board.

5.7 Clinical lead resources for QIPP

The time commitment set aside by clinical leads to focus on their agreed responsibilities are shown in the table below. In total, there are 5.5 days per week of clinical time set aside for NHS R&B CCG related activity, all of which is built around QIPP delivery and other related activities.

Dr Jonathan Wells, NHS R&B CCG Chair and Clinical Lead in partnership with Simon Hairsnape, Chief Officer and Accountable Officer, have overall responsibility for the delivery of QIPP, a clear statement of commitment to this vital element of our Operational Plan. The individual scheme leads for the Worcestershire QIPP schemes are shown in Error! Reference source not found. The clinical input for QIPP in Redditch and Bromsgrove is as follows:

<table>
<thead>
<tr>
<th>Clinical Lead</th>
<th>Dedicated Time (sessions per week)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Jonathan Wells</td>
<td>3 sessions/wk</td>
</tr>
<tr>
<td>Dr Richard Davies</td>
<td>2 sessions/wk</td>
</tr>
<tr>
<td>Dr David Law</td>
<td>2 sessions/wk</td>
</tr>
<tr>
<td>Dr Edward Barrett</td>
<td>1 session/wk</td>
</tr>
<tr>
<td>Dr Rupen Kulkarni</td>
<td>1 session/wk</td>
</tr>
<tr>
<td>Dr Stephen Miskin</td>
<td>1 session/wk</td>
</tr>
<tr>
<td>Dr Catherine Mcgregor</td>
<td>1 session/wk</td>
</tr>
<tr>
<td>Dr Marion Radcliffe</td>
<td>2 sessions/wk</td>
</tr>
<tr>
<td>Dr Anil Joshi</td>
<td>Ad hoc</td>
</tr>
<tr>
<td>Dr Mark Talbot</td>
<td>Ad hoc</td>
</tr>
</tbody>
</table>
5.8 Financial Health of Local Economy

There are two major NHS providers within Worcestershire; Worcestershire Acute Hospitals Trust and Worcestershire Health and Care Trust.

Worcestershire Acute Hospitals Trust is in a seriously challenged financial position. Their breakeven position for 2011/12 was after significant financial support from the PCT. Going forward the impact of the tariff efficiency requirements year on year and the need for internal cost improvements have resulted in the Joint Strategic Review which will have serious financial implications across the health economy. The outcome of this review will be known before April 2013 when the CCG become established formally.

Worcestershire Health and Care Trust are in a healthy financial position as they head towards Foundation Trust status with authorisation planned for July 2013. In 2011/12 the trust delivered its planned surplus of £1.5m and is planning a £2m surplus for 2012/13.

It is essential that plans, including QIPP, going forward for Worcestershire Acute Hospitals Trust, Worcestershire Health and Care Trust and the CCG triangulate and the CCG will focus on the delivery of this target.

5.9 Financial Outlook

The current economic climate will require ongoing significant QIPP savings for a number of years to come for both this CCG and secondary healthcare providers. The PCT has a QIPP programme going forward which the CCG will utilise and refresh. In the autumn of last year public health produced a countywide report identifying PCT areas of saving; this is currently being broken down by CCG. This report will identify specific areas where the CCG can target its effort in terms of QIPP.

In terms of future additional funding, knowledge suggests 2.5% is a realistic assumption per year going forward. The Government have indicated above inflation rises for the NHS going forward; however this is unlikely to be more than 0.2% and is included within the 2.5% assumption. Given the current economic climate the CCG financial strategy will look at the impact of receiving less than 2.5%.

Further information is contained within the CCG’s draft Medium Term Financial Strategy.

5.10 Running Costs

The CCG has now received its draft running costs figure for 2013/14 based on £25 a head; this totals just over £4m. The CCG has a shared management structure with Wyre Forest CCG and will be buying commissioning support services (CSS) from Arden Commissioning Support Service. Detailed costing have been undertaken to ensure that the CCG delivers its management function within the £25 a head. The key will be to ensure the functions provided by the CCG, and service outputs produced by CSS will ultimately meet the objectives of the CCG.
6 Human resources

6.1 Introduction

Successful organisations are underpinned by having a competent workforce with effective structures, good quality management and appropriate policies and processes to support them in their daily operation. In common with other CCGs our employed workforce will be small, consisting of a senior executive team with a small administrative support.

CCGs have been set a running cost ceiling of £25 per head of population (broadly the costs of running the CCGs including staff and CSS arrangements). We have agreed with Wyre Forest CCG to operate a single management team, including a single Chief Officer (Accountable Officer) who will be jointly accountable to the two Governing Body Chairs. The proposed structure for this single team is shown later in this section. This proposed structure has been provisionally agreed by both CCG Governing Bodies and has been costed alongside commissioning support needs within the £25 per head running cost allowance using indicative Agenda for Change bands.

The formal functions of Human Resources (HR) will be contracted out to the CSS; however, the CCG will need to have confidence in the policies, procedures and processes that will be described in a service level agreement.

All employees within the CCG will be afforded the rights as outlined in the NHS constitution for staff, which are:

- “Have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives”
- “Have a fair pay and contract framework”
- “Be involved and represented in the workplace”
- “Have healthy and safe working conditions and an environment free from harassment, bullying or violence”
- “Be treated fairly, equally and free from discrimination”
- “Can raise an internal grievance and if necessary seek redress, where it is felt that a right has not been upheld”
- “Have employment protection”
- “Can join the NHS Pension Scheme”
6.2 Leadership and supporting the workforce

The CCG is committed to ensuring a smooth transition for staff transferring to new organisations, whether this be in the National Commissioning Board, the Commissioning Support Service or the Clinical Commissioning Group itself. The overall aim is to develop a climate in which every employee feels valued and understands their roles within the CCG and CSS.

Commissioning will be clinically led and supported by appropriately competent managers who will ensure that the strategies approved by the CCG Governing Body are delivered. All Governing Body members will be assessed according to an approved and appropriate Leadership Framework. An Organisational Development Programme is under development and will include Personal Development Plans.

Formal responsibilities will be set out for Governing Body Members and for other lead areas to ensure that there is clarity in expectations; both for individuals and for the CCG. Effective leadership will ensure colleagues being brought together to deliver improved outcomes and value for money which have arisen from a shared vision of the future health and social care economy feel valued in the organisation and feel able to contribute effectively to its success.

We consider the views of staff to be a fundamental source of information and, as such, staff surveys will be undertaken and the CCG will analyse results and respond to its findings.

6.3 Workforce transition in the CCG

Managing workforce and our staffing resource through the transition will undoubtedly be a significant task and challenge during 2012/13. There has been much uncertainty over the last 18 months for many staff working in NHS Worcestershire roles. This uncertainty has been driven in part by national debate about the NHS reforms and the associated national policies that have been under development.

Within Worcestershire the situation is further complicated by the planned transition from one PCT to three CCGs and the subsequent need for many staff whose functions are being distributed accordingly to identify their preferred organisation and location. Whilst the CCG has been operating as a Sub Committee of the NHS Worcestershire Board, and with delegated authority, the transfer of staff has been a slower process, held up by a lack of clarity. This though has been addressed and draft structures were published for local consultation at the beginning of March.

The likely timeframe for workforce transition during 2012/13 is set out below:

<table>
<thead>
<tr>
<th>Month</th>
<th>Actions to be achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>Appointments, job slotting, induction, appraisal process, individual training needs, corporate training plan, etc</td>
</tr>
<tr>
<td>May</td>
<td>Preparations</td>
</tr>
<tr>
<td>June</td>
<td>CCG senior team in place</td>
</tr>
<tr>
<td>July</td>
<td>Majority of CCG staff appointed/CSO Service Specifications in place</td>
</tr>
<tr>
<td>August</td>
<td>All CCG staff in place/clarity around functions and partnership working</td>
</tr>
<tr>
<td>September</td>
<td>Shared Management Team move into Bromsgrove premises</td>
</tr>
</tbody>
</table>
6.4 Skills

We have undertaken a review of skills required to operate the organisation effectively. This is not a one off exercise but will be revisited in the future to ensure that our organisational development plan is having a positive impact.

The skills identified during the initial review include:

- **Clinical Focus**
  - Commissioning, leadership, clinical, clinical governance, communication

- **Organisational Capacity and Capability**
  - Organisational development, Human Resources, Succession planning, learning, Clear and Credible Planning, Programme and project management, organisational development, Governance, Finance

- **Engagement with patients / Communities**
  - Communication and Leadership

- **Leadership capability and capacity**
  - Leadership, communication, development

- **Collaborative arrangements**
  - Communications

- **Education and training**
  - Autonomy and accountability for planning and developing the workforce.

The new structure will allow for these skills to be understood, evidenced and, therefore, ensuring there is a workforce that is skilled and competent to deliver the transformational reforms required.

6.5 Equality and Diversity

The CCG will comply with the Equality Act 2010 by having due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

In addition, the CCG is also subject to the public duty contained in the Act which requires organisations to consider how they could positively contribute to the advancement of equality and good relations. It requires equality considerations to be reflected into the design of policies and the delivery of services, including internal policies, and for these issues to be kept under review.
7 Clinical engagement

7.1 The First Steps in developing a CCG

In developing a CCG, the approach adopted in Redditch and Bromsgrove was truly ‘bottom up’. GP Leaders did not wish to make any assumptions about the CCG configuration and as such, a full engagement exercise was carried out to ensure that a true mandate was obtained for the emerging Redditch and Bromsgrove Clinical Commissioning Group. Governing Body GPs visited each practice, and engaged in discussions with GPs and Practice Managers about forming a CCG based upon the previous Practice Based Commissioning and PCT configurations. Emphasis was placed upon the fact that practices had options (particularly those on the periphery of the locality) in terms of engaging in discussions with other embryonic CCGs.

Following consultation over a 2 month period, all practices signed up to joining NHS R&B CCG. The arrangements around ‘Zoning’ were formalised alongside the Lead GP arrangements for each practice in a bid to keep member practices as involved in clinical commissioning as possible.

7.2 Using clinical engagement to drive commissioning

Emphasis remains on clinical leadership and clinical engagement in order to inform, drive and own the commissioning agenda.

The following key approaches will secure ongoing clinical engagement:

a) Zoning arrangements - bi-monthly visiting arrangements between Governing Body GPs and Practice Managers. Core commissioning messages and service developments are shared. The Zoning arrangements provide a valuable opportunity to engage all GPs in discussion around service related issues (captured and feedback via the NHS R&B CCG Issues Database) and engage member practices in action around performance related issues. QIPP delivery and financial position feature highly in Zoning discussions.

b) Service Innovation Meeting (SIM) - the monthly SIM agenda and related workstreams are clinically driven and will provide a platform to explore pathway developments and service change. Working hand in hand with the Finance Innovation Meeting (FIM), proposals will be considered based upon clinical effectiveness and possible cost improvement (feeding into NHS R&B CCG QIPP initiatives).

c) Redditch and Bromsgrove Advisory Forum – monthly meeting with all member practices to provide an opportunity for engagement, consultation and where the Governing Body can be held to account by its constituents.

d) Programme management – the NHS R&B CCG Locality Team will hold a directory which will identify lead arrangements for all initiative work. Each area of NHS R&B CCG business is supported by an agreed Lead GP. Lead GP arrangements will be further developed and sustained.

e) Partnership Engagement – 6 monthly engagement events are planned to allow GPs, hospital consultants and community services consultants to come together to share possible considerations for pathway development, local issues and developments. The wider Partnership Engagement is particularly pertinent given the challenges associated with the Joint Services Review and the potential impact upon local services.

f) Lead GP arrangements – each of the Governing Body GPs take a lead role in a clinical area. Non Governing Body GPs are encouraged to lead key priority workstreams. This provides a perfect opportunity to start planning for potential business continuity in terms of generating interest from non-governing body GPs.
<table>
<thead>
<tr>
<th>Clinical Lead</th>
<th>Clinical Area of Lead Responsibility</th>
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<tbody>
<tr>
<td>Dr Jonathan Wells</td>
<td>Community Services</td>
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<tr>
<td>Chair of NHS R&amp;B CCG Governing Body</td>
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<tr>
<td>GP Lead for Remuneration Committee</td>
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<tr>
<td>Dr Richard Davies</td>
<td>Finance Lead GP, Acute Services Lead, QIPP delivery</td>
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<td>Assistant Clinical Chair</td>
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<tr>
<td>Dr David Law</td>
<td>Quality and Patient Safety Lead</td>
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<td>GP Lead for Quality and Patient Safety Committee</td>
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<tr>
<td>Dr Edward Barrett</td>
<td>Medicines Management Lead</td>
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<tr>
<td>GP Lead for Pharmacy Subgroup</td>
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<tr>
<td>Dr Rupen Kulkarni</td>
<td>Community Service Development including: Orthopaedic Lead, Ophthalmology Lead,</td>
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<tr>
<td>GP Lead for Audit Committee</td>
<td>Dermatology Lead</td>
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<tr>
<td>Dr Stephen Miskin</td>
<td>Patients and Public Involvement Lead, Mental Health Lead</td>
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<tr>
<td>Dr Catherine McGregor</td>
<td>Women's and Children's Lead</td>
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<td>Dr Marion Radcliffe</td>
<td>Urgent Care Lead and Intermediate Care Lead Chair of the Redditch and Bromsgrove Advisory Forum</td>
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<td>Dr Anil Joshi</td>
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<td>Dr Mark Talbot</td>
<td>Stroke and Circulatory Disease Lead</td>
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<td>Dr Tim Lee</td>
<td>Mental Health Programme Lead</td>
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<tr>
<td>(Non Governing Body GP)</td>
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</table>

7.3 Clinical engagement in practice - a case study

Full details of Case Studies are detailed within the document ‘Redditch and Bromsgrove Case Studies’. One example is related to Orthopaedics:

Redditch and Bromsgrove was identified as a significant national outlier in terms of Orthopaedic admissions. The challenge was embraced by the Lead GP for Orthopaedics and options for service developments were considered. A clinically led visit to a Musculoskeletal Integrated Clinical Assessment and Treatment Service (MSK ICATS) resulted in the desire to establish a local service along the same lines.

The Redditch and Bromsgrove MSK ICAT Service was established in October 2012. The outputs from the service have resulted in significant savings in orthopaedics and enhanced services for patients in a primary care setting.

The clinical leadership within the MSK ICATS example has secured ‘buy in’ from member practices which would not have been achieved in the absence of strong clinical leadership. The strong clinical leadership also secured the best possible service specification and will support its future development.
8 Performance and quality

8.1 Introduction

Redditch and Bromsgrove CCG is fully aware of the need to understand performance and quality indicators and to act on information and feedback received. We have developed, in partnership with the other two CCGs in Worcestershire, a Commissioning Quality and Patient Safety Strategy which is progressing via an agreed action plan which we will finalise over the coming weeks and review during the coming year. The strategy sets out the CCGs’ respective ambitions for their patients, together with their commitment to work together and in their individual CCGs to commission high quality health care for the patients of Wyre Forest, Redditch and Bromsgrove and South Worcestershire. This section of our plan highlights the key aspects of our strategy and how we will monitor its performance in 2012/13.

8.2 Background

Equity and Excellence: Liberating the NHS (DH, 2010) set out an ambition to reduce mortality and morbidity, increase safety and improve patient experience and outcomes for all. Maintaining and Improving Quality during the Transition: Safety effectiveness and experience (National Quality Board, 2011) provides guidance on how best to maintain quality during the transition and once the new system architecture is in place. It states ‘NHS organisations should ensure that an open and honest culture, where all staff feel empowered to make improvements and feel able to raise concerns, prevails’.

NHS commissioning is the process of identifying the health needs of local people, setting priorities for investment, purchasing services and monitoring them to ensure that they represent high quality and good value for money.

8.3 Areas of focus

The strategy focuses on the three domains of quality defined in High Quality Care for All (2008) and reflects the five domains of the NHS Outcomes Framework (2011) (see diagram below).

Quality will be the key consideration in the commissioning of services and the strategy will both support the implementation of Quality, Innovation, Productivity and Prevention (QIPP) and quality assurance of services. Implementation of the strategy will also address the quality priorities outlined in The Operating Framework for the NHS in England 2012/13.
8.4 Aim of the Strategy

The aim of the strategy is to ensure continuous improvement of quality outcomes respective to the needs of local people and develop robust quality assurance mechanisms in order to provide assurance to CCG Governing Bodies regarding the standard of quality and patient safety in commissioned services.

8.5 Vision

NHS Worcestershire’s vision is of a county where people live longer and live better, have the support they need to adopt healthy lifestyles and have a choice of high quality services which are delivered as close to home as possible.

‘Healthcare services we would be happy for our children, parents, grandparents and friends to receive’.

8.6 Strategic Objectives

The Commissioning Quality and Patient Safety Strategy has five strategic objectives:

• Create a culture of continuous quality improvement across CCGs and all commissioned services;

• Develop a quality framework that brings together quality, safety and patient experience information from a range of sources and provides assurance regarding the quality of care delivery in commissioned services;

• Commission services that are both clinically effective and represent good value for money;

• Include clinicians and patients in the monitoring, inspection and quality improvement of commissioned services;

• Encourage feedback and value the role of patients in shaping and improving services.

8.7 Implementing the Strategy

A number of actions have been identified to support the achievement of each of these strategic objectives:

Objective One - Create a culture of continuous quality improvement across CCGs and commissioned services

Set clear and ambitious quality improvements for patients within Commissioning for Quality and Innovation (CQUIN) and Quality Schedules, and challenge areas of poor performance and mediocrity

Provide opportunities to share best practice and learning across commissioners and providers

Monitor the staff experience and set clear areas for quality improvement in workforce metrics within commissioned services

Value, promote and support research within the health economy, working with and through the West Midlands (South) Comprehensive Local Research Network
### Objective Two - Develop a quality framework that brings together quality, safety and patient experience information from a range of sources and provides assurance regarding the quality of care delivery in commissioned services

- Design an evidence-based dashboard for CCG Governing Bodies that provides both assurance and early warning of quality concerns in commissioned services.
- Review the quality assurance mechanisms that are in place across the range of commissioned services and ensure appropriate quality monitoring and governance arrangements in all areas.
- Work with healthcare regulators, the Local Authority, LINK, HealthWatch and other commissioners to share information and support continuous quality improvement.

### Objective Three - Commission services that are high quality, safe, clinically effective and represent good value for money

- Ensure continuous improvement in quality outcomes of commissioned services through the use of quality schedules, CQUINs, and learning from incidents and complaints.
- Define and agree quality outcomes and trajectories with providers to reduce harm e.g. pressure ulcers, falls and Clostridium Difficile etc.
- Implement a robust reporting mechanism for serious incidents across all commissioned services.
- Develop policies and a training framework for safeguarding adults and children.
- Lead the development of a quality strategy for care homes.

### Objective Four - Include clinicians and patients in the monitoring, inspection and quality improvement of commissioned services

- Develop a single repository to report, monitor and provide feedback regarding concerns.
- Provide a framework and training to support involvement of GP practices and patients in quality assurance processes e.g. mystery shoppers and involvement in quality assurance visits.
Objective Five - Encourage feedback and value the role of patients in shaping and improving services

Scope sources of patient satisfaction surveys that are already available (commissioner and provider) and develop mechanisms to provide real-time patient feedback across the range of commissioned services.

Utilise Patient Focus Groups, Patient Reference Groups and other community groups to support patient experience feedback.

8.8 Provider performance

We have identified below a number of priority areas that will require attention during 2012/13.

8.8.1 Accident and emergency

The performance of our local Acute Trust provider in meeting the 4 hour target is unacceptable and addressing this will be one of our top performance priorities for 2012/13. The Trust has failed to achieve the 95% minimum standard for waiting times consistently throughout 2011/12, in many months by a substantial amount.
Improvements are being realised in 2012/13. In order to sustain performance and to address previous poor performance we will take the following actions during the course of the year:

**Reduce demand**
- Increase MAU and SAU capacity and flexibility
- Fast track ENT referrals
- Introduce GP streaming for all minors
- Commission clinical support service for all care homes

**Improve efficiency**
- Increase pharmacy availability at weekends
- Increase HCA availability in A&E
- Review 24/7 skills mix and introduce blended A&E/MAU approach to staffing

**Effective discharge**
- Extend in-reach to include medical support
- Review CHC checklist process & reduce delays when discharging to nursing homes

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8.8.2 Improving stroke care

The performance of our local Acute Trust provider in meeting stroke access targets needs to improve. 80% of patients should be spending the vast majority of their time in hospital in a specialist stroke bed (more than 90% of their stay). Locally this performance was only achieved in 2 months during 2011/12.
Similarly for Transient Ischaemic Attacks (TIAs) performance has been poor. The 60% threshold for patients being seen within the first 24 hours after the attack has not been achieved in any of the first 9 months in 2011/12.

In order to address these performance issues we will:

- Introduce 7 days TIA assessment service for high risk patients
- See all high risk TIA patients within 24 hours
- Extend Carotid Doppler scanning to weekends

There is also a current proposal to centralise stroke services at Worcestershire Royal Hospital, which is due to go to the Health Overview and Social Care Committee in May 2012. In addition to this an NHS Midlands & East Strategic Stroke Review will be carried out in 2012/13

8.8.3 Hospital acquired infections

Hospital acquired infections are frequently in the news and can be a serious concern for patients going into hospital. Thankfully our local providers have performed well in the area of MRSA in 2011/12.

It is important to recognise that this data only shows our main local providers, but working alongside NHS West Mercia Cluster, we monitor the full range of providers that our community uses from the NHS, independent sector and care homes. During 2011/12, there have been a number of C-difficile cases identified within the community across and addressing this will be a priority going forward.
Monitor infection rates across providers with stretching trajectories set within 2012/13 contracts.

Monitor and review infection prevention and control processes within our providers, including staff training and audit results.

Scrutinise all infection related serious incidents.

Review antibiotic prescribing in primary and secondary care to ensure it complies with local guidelines.

8.8.4 Preventing “Never Events” and serious incidents (year end position)

As is clear in the name, “Never Events” should never happen. They are very serious issues of poor clinical care or performance. Whilst there have only been two in our provider it must remain at the top of our list of priorities to ensure that there are systems in place to avoid them occurring.

By definition, serious incidents are events to be avoided, but their severity of consequence is less than “Never Events”. During the course of 2011/12 our providers have had worryingly high number of serious events, particularly in Health and Care Trust where the number reported as frequently been 15 or more per month.

In order to reduce the risk of these events happening in future we will:

- Review all incidents in a confidential session of the NHS R&B CCG management executive meeting and follow up to ensure that specific actions which need to be taken following these incidents are implemented.

- We will seek information on NEs and SIs from other parts of the Cluster and beyond to review whether there are any learning points to be applied to our local services.

- We will use information from our engagement programme and through feedback from our practice network and other patient contact programmes to inform our understanding of potential risk areas.

- Proactively seek information from providers in areas of risk, identified either from local intelligence or as a result of our actions above, to reassure us that suitable arrangements are in place.
8.8.5 Zero tolerance of pressure ulcers

Eliminating pressure ulcers is one of our objectives and is in line with one of the SHA’s top five priorities. We are determined to help deliver on their commitment. On too many occasions there have been multiple reports. If the occurrence of pressure ulcers is used as a barometer of the quality of care that patients receive then this is clearly an area for concern.

In order to reduce the risk of these events happening in future we will:

• Include stretching targets for the elimination of all avoidable grade 2, 3 and 4 Pressure Ulcers in provider quality schedules, in line with the SHA ambition.

• Support and monitor the implementation of pressure ulcer care bundles by local providers.

• Include the implementation of the NHS Safety Thermometer in CQUIN schemes for 2012/13.

• Explore ways in which we can engage care homes in the ambition to eliminate avoidable pressure ulcers, through specialist support, training and monitoring.

8.8.6 Quality and Safety in Primary Care

We start from a strong base when it comes to quality in Primary Care, particularly when national comparisons are used. However, when compared to areas with similar populations we are average performing. We are determined to drive improvement in this area.

Of greatest significance to us is the importance of addressing unwarranted variation across and between practices in our own area.

In order to achieve further improvement in these areas we will use the PCT GMS/PMS resource pack for comparing practices across a number of indicator areas, including:

• Chronic disease management
• Prevention
• Prescribing
• Patient satisfaction.

These can be combined to present an overall analysis for comparison between practices in order to inform where improvement support should be focused.

2012/13 marks year two of the PCT’s GMS/PMS Commissioning and Contracting Framework – an approach which aligns PCT and CCG priorities of improving quality, health outcomes, and reducing variation. These goals are translated into objectives incorporated into the practice contracts held by the PCT, as shown.

Practice performance has been benchmarked and discussed by a team comprising CCG Clinicians and the Head of Primary Care visits to each practice. Further visits are scheduled for May and June 2012 to review achievements and objectives of the year ahead. Through changes to the Quality Outcomes Framework in 2011/12 we have enhanced our approach by making the delivery of improved quality an integral element of local QIPP Schemes, notably Orthopaedics, Ophthalmology, A&E and a range of ACS Conditions. New pathways have been jointly produced with reflecting where outpatient and emergency admissions can be reduced through behavioural change in Primary Care. Practices have selected areas to focus on through analysis of current referral patterns and external peer review.

Further work will be undertaken from April 2012 onwards to explore additional means of improving performance where most gain can be made (eg reduction in A&E and emergency admissions).
### Table: PCT Score Comparison 2009/10 to 2006/07

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### Table: PCT Score Comparison 2009/10 to 2006/07

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<td>98.3%</td>
<td>2</td>
<td>98.7%</td>
<td>14</td>
<td>97.8%</td>
<td>9</td>
</tr>
<tr>
<td>Worcestershire</td>
<td>95.7%</td>
<td>17</td>
<td>97.3%</td>
<td>12</td>
<td>98.8%</td>
<td>9</td>
<td>97.7%</td>
<td>9</td>
</tr>
<tr>
<td>South Gloucestershire</td>
<td>95.6%</td>
<td>19</td>
<td>96.5%</td>
<td>48</td>
<td>98.1%</td>
<td>44</td>
<td>96.9%</td>
<td>9</td>
</tr>
<tr>
<td>Nottinghamshire County</td>
<td>95.4%</td>
<td>26</td>
<td>96.7%</td>
<td>35</td>
<td>98.1%</td>
<td>41</td>
<td>96.1%</td>
<td>17</td>
</tr>
<tr>
<td>South Staffordshire</td>
<td>95.3%</td>
<td>29</td>
<td>97.2%</td>
<td>17</td>
<td>97.7%</td>
<td>58</td>
<td>96.1%</td>
<td>31</td>
</tr>
<tr>
<td>North Somerset</td>
<td>95.2%</td>
<td>32</td>
<td>96.9%</td>
<td>30</td>
<td>98.4%</td>
<td>32</td>
<td>96.5%</td>
<td>21</td>
</tr>
<tr>
<td>Buckinghamshire</td>
<td>94.9%</td>
<td>38</td>
<td>96.8%</td>
<td>34</td>
<td>98.5%</td>
<td>27</td>
<td>98.2%</td>
<td>18</td>
</tr>
<tr>
<td>North Lancashire</td>
<td>94.8%</td>
<td>41</td>
<td>97.2%</td>
<td>19</td>
<td>98.7%</td>
<td>13</td>
<td>98.3%</td>
<td>17</td>
</tr>
<tr>
<td>Swindon</td>
<td>94.5%</td>
<td>53</td>
<td>96.2%</td>
<td>61</td>
<td>97.2%</td>
<td>70</td>
<td>95.9%</td>
<td>20</td>
</tr>
<tr>
<td>Bristol</td>
<td>94.4%</td>
<td>56</td>
<td>96.5%</td>
<td>49</td>
<td>98.0%</td>
<td>47</td>
<td>96.8%</td>
<td>18</td>
</tr>
<tr>
<td>Camden</td>
<td>92.1%</td>
<td>120</td>
<td>93.8%</td>
<td>127</td>
<td>92.8%</td>
<td>151</td>
<td>85.9%</td>
<td>25</td>
</tr>
<tr>
<td>Milton Keynes</td>
<td>91.4%</td>
<td>132</td>
<td>94.1%</td>
<td>121</td>
<td>97.1%</td>
<td>71</td>
<td>96.5%</td>
<td>64</td>
</tr>
<tr>
<td>Hammersmith and Fulham</td>
<td>90.0%</td>
<td>146</td>
<td>94.5%</td>
<td>110</td>
<td>95.8%</td>
<td>117</td>
<td>95.3%</td>
<td>77</td>
</tr>
<tr>
<td>Coventry</td>
<td>89.8%</td>
<td>149</td>
<td>92.2%</td>
<td>146</td>
<td>93.2%</td>
<td>149</td>
<td>91.7%</td>
<td>83</td>
</tr>
<tr>
<td>Westminster</td>
<td>82.5%</td>
<td>142</td>
<td>88.4%</td>
<td>152</td>
<td>89.4%</td>
<td>152</td>
<td>87.7%</td>
<td>84</td>
</tr>
</tbody>
</table>
9 Informatics

9.1 Overview

We recognise the importance of accurate and timely information to support the effective commissioning and delivery of healthcare services. We also recognise that there are a number of strategic initiatives that, if successfully implemented, could revolutionise the way in which services are provided. Our chosen Commissioning Support Services Organisation will provide all the required support on Informatics locally and they will support us to develop and implement an informatics strategy that will meet our requirements in all these areas.

Key aspects of the Cluster strategy are enhanced online access to medical records and implementation of the summary care record. Locally we are also keen to see a number of other developments, including improved consistency of system use between GP practices and development of a long term plan to enable improved information sharing between GPs, Accident and Emergency and ultimately Social Care. However, we recognise that these longer term strategic intentions can only start to be considered once there is a function Informatics capability in place that is meeting our core needs of commissioning and service delivery.

9.2 Online access to medical records

Across Worcestershire there is a project in place to improve online access to medical records. Our contribution to this will be:

- To facilitate engagement with member practices in the increased use of repeat prescription facilities and online booking of appointments for the first phase.

Beyond this first phase to facilitate the roll out of online access to medical records.

We are committed to helping the Cluster achieve its targets set out below, please note that the numbers quoted in the following tables are for Worcestershire as a whole, not just Redditch and Bromsgrove:

<table>
<thead>
<tr>
<th>By</th>
<th>...we will be providing this...</th>
<th>...in this many practices...</th>
<th>...to this many patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2012</td>
<td>Online appointment booking and repeat prescriptions</td>
<td>37</td>
<td>289,000</td>
</tr>
<tr>
<td>March 2013</td>
<td>Access to online medical records</td>
<td>37</td>
<td>289,000</td>
</tr>
</tbody>
</table>

In addition to this we will support the project to explore the options for a solution to enable patients to access appropriate components of their entire medical record (primary care, community and acute hospital). A review of progress in this area will be made in April 2013.

9.3 Summary Care Record

We are also committed to supporting the project around the development of the summary care record and plan to work with the Cluster Strategy towards the following milestones. Please note that the number of practices and patients referred to in the tables below are for Worcestershire as a whole.
<table>
<thead>
<tr>
<th>By</th>
<th>No. Of practices uploading SCR</th>
<th>No. Of SCR uploads</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2012</td>
<td>5</td>
<td>46,763</td>
</tr>
<tr>
<td>July 2012</td>
<td>14</td>
<td>139,968</td>
</tr>
<tr>
<td>October 2012</td>
<td>23</td>
<td>185,269</td>
</tr>
<tr>
<td>March 2013</td>
<td>26</td>
<td>202,484</td>
</tr>
</tbody>
</table>

### 9.4 More effective communication between systems

In addition to the Cluster-wide informatics plan, there are a number of additional areas that we will be exploring locally in the coming 12 months:

**By June 2012** we will ensure that 20% of practices, covering half of our population, will have committed to implementing a risk profiling tool and develop a plan to systematically respond to the results.

**By Sept 2012** we will have explored the options around standardising the use of Primary Care IT systems to enable enhanced data sharing and provide a base for rolling out data sharing with secondary care and social care.

**By Oct 2012** we will review the impact of the tele-health equipment pilot involving 5 practices, with a view to wider roll out if the anticipated impact materialises.

**By Oct 2012** we will review the 6 month pilot programme involving 5 practices to explore the automated link between the GP core systems and the Tele-health system.
Appendix A:

Risk Assessment and Governing Body Assurance Framework

**Review that identified actions are completed - Assurance**

<table>
<thead>
<tr>
<th>Internal sources of assurance (examples)</th>
<th>External sources of assurance (examples)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal audit</td>
<td>External audit</td>
</tr>
<tr>
<td>Key Performance Indicators</td>
<td>Audit Commission</td>
</tr>
<tr>
<td>Performance reports</td>
<td>Strategic Health Authority reports/reviews</td>
</tr>
<tr>
<td>Sub-committee reports</td>
<td>External benchmarking</td>
</tr>
</tbody>
</table>

NHS Redditch And Bromsgrove Clinical Commissioning Group Governing Body Assurance Framework July 2012

Risk Rating

- **Low Risk** 1 to 3
- **Moderate Risk** 4 to 6
- **High Risk** 8 to 12
- **Extreme Risk** 15 to 25
<table>
<thead>
<tr>
<th>Risk Owner (Name and Title)</th>
<th>Simon Hairsnape, Chief Office/Karen Hunter, Head of Corporate Affairs</th>
<th>Karen Hunter, Head of Corporate Affairs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Rating before Controls</td>
<td>Residual Risk Score</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Consequence (Severity)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Likelihood (Probability)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Corrective Action/ Action Plan (incl. cost of mitigation and target date)</td>
<td>Project plan details actions and milestones. Specific actions relating to development of Commissioning Support Services specifications.</td>
</tr>
<tr>
<td></td>
<td>Gaps in Controls/ Assurance</td>
<td>No</td>
</tr>
<tr>
<td>Risk Rating after Controls</td>
<td>Residual Risk Score</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Consequence (Severity)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Likelihood (Probability)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td><strong>Assurances on Controls</strong></td>
<td>Quarterly SHA reviews of readiness for authorisation.</td>
</tr>
<tr>
<td>Risk Score</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Consequence (Severity)</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Likelihood (Probability)</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Risk Description</td>
<td>Insufficient capacity and capability to deliver all authorisation requirements specified by the NHS Commissioning Board to become a fully authorised within Wave Two timescales.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Governance arrangements with the capacity and capability to deliver all statutory duties are not robust.</td>
<td></td>
</tr>
<tr>
<td>Source</td>
<td>CCG</td>
<td></td>
</tr>
<tr>
<td>Type of Risk:</td>
<td>R, C</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R, L, O</td>
<td></td>
</tr>
<tr>
<td>Opened</td>
<td>Jul-12</td>
<td></td>
</tr>
<tr>
<td>Strategic Objective</td>
<td>To achieve authorisation by December 2012 and become an established statutory organisation on 1st April 2013</td>
<td></td>
</tr>
<tr>
<td>Risk Reference Number</td>
<td>BAF 1.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>BAF 1.2</td>
<td></td>
</tr>
<tr>
<td>Strategic Objective</td>
<td>Establish clear delivery plans with milestones and implement to deliver QIPP savings in year.</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Source</td>
<td>CCG Management Team</td>
<td></td>
</tr>
<tr>
<td>Type of Risk:</td>
<td>F, R, C, O</td>
<td></td>
</tr>
<tr>
<td>Opened</td>
<td>Jul-12</td>
<td></td>
</tr>
<tr>
<td>Risk Reference Number</td>
<td>BAF 2.3</td>
<td></td>
</tr>
<tr>
<td>Risk Owner (Name and Title)</td>
<td>CFO, Mary Walters</td>
<td></td>
</tr>
<tr>
<td><strong>Assurances on Controls</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Rating after Controls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residual Risk Score</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Consequence (Severity)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Likelihood (Probability)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Corrective Action/ Action Plan (incl cost of mitigation and target date)</td>
<td>Performance management processes to be reviewed. Incorporate within CCG SLA negotiations.</td>
<td></td>
</tr>
<tr>
<td>Gaps in Controls/ Assurance</td>
<td>Reporting mechanisms not always able to report at CCG level. Lack of co-here provider specific delivery plan with defined milestones.</td>
<td></td>
</tr>
<tr>
<td>Source</td>
<td>CCG Management Team</td>
<td></td>
</tr>
<tr>
<td>Type of Risk:</td>
<td>F, R, C, O</td>
<td></td>
</tr>
<tr>
<td>Opened</td>
<td>Jul-12</td>
<td></td>
</tr>
<tr>
<td>Risk Reference Number</td>
<td>BAF 2.3</td>
<td></td>
</tr>
</tbody>
</table>
### CCGs and PCT are continuing to work with providers to ensure appropriate actions plans are in place and progress is evidenced and monitored. Working jointly with WCC on quality assurance of care homes and domiciliary care providers to strengthen monitoring arrangements. Quality Committee Terms of Reference drafted with plan to implement from September 2012.

Controls not in place for all providers. Progress has been achieved to improve controls at other providers, such as nursing homes and intermediate care services. CCG quality Committee not yet in place.

<table>
<thead>
<tr>
<th>Y</th>
<th>Y</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>12</td>
</tr>
<tr>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

CCG Governing Body receives regular reports on quality and patient safety. Reports also to Cluster QPR, Audit Committee, Finance and Performance Committee and Cluster Board.

Suite of national and local quality and patient safety indicators in contracts. Review of performance against quality and patient safety indicators through Contract Management Board (CMB) and Clinical Quality Review meetings (CQR). Representation of CCG at these meetings. Programme of scheduled Quality Assurance visits and unannounced visits, with representation from CCG. A number of unannounced visits have taken place to local providers focusing on patient safety, quality of services, cleanliness and infection prevention. The findings from those visits have been included in quality reports to CCG and QPR. Process led by Lead Nurse/Head of Quality and Patient Safety. CCG Governing Body receives regular quality reports, including reporting on identified significant quality issues. Risks included on Risk Register. The Cluster Board has received updates from QPR highlighting risks. Development of Quality Strategy and shared CCG Quality Assurance Framework. GP Clinical lead for quality identified and working collaboratively with other CCGs in Worcestershire. Concerns shared with CQC.

<table>
<thead>
<tr>
<th>20</th>
<th>16</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Failure to effectively measure and monitor all quality and patient safety indicators in all providers.

Failure to engage the public, patients and stakeholders in review of services and future reconfiguration.

<table>
<thead>
<tr>
<th>CCG quality and performance reports</th>
<th>CCG Governing Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>R, F, C</td>
<td>F, R, L, O, C</td>
</tr>
</tbody>
</table>

Jul-12

To ensure the improvement in the quality and safety of services and patient experience.

Actively participate in the Joint Services Review (JSR) of acute hospital services provided by Worcestershire Acute Hospitals NHS Trust, ensuring it is clinically led and clear decisions are made and agreed that are in the best interest of our community.

| BAF 3.1 | BAF 4.1 |
Redditch and Bromsgrove Clinical Commissioning Group

<table>
<thead>
<tr>
<th>Risk Owner (Name and Title)</th>
<th>Simon Hairsnape, Chief Officer/Jonathan Wells, Clinical Lead</th>
<th>Chris Emerson, Head of Commissioning and Service Redesign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target risk rating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residual Risk Score</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Consequence (Severity)</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Likelihood (Probability)</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Corrective Action/Action Plan (incl. cost of mitigation and target date)</td>
<td>Ensure all providers have robust plans in place and progress actions accordingly.</td>
<td>The PCT and CCGs have worked proactively with major provider to identify and progress action plans addressing specific issues.</td>
</tr>
<tr>
<td>Gaps in Controls/Assurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive Assurance Y/N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Residual Risk Score</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Consequence (Severity)</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Likelihood (Probability)</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Assurances on Controls</strong></td>
<td>Regular reporting to CCG and cluster. Health Overview and scrutiny Committee and the Health and Wellbeing Board will provide external scrutiny of engagement and consultation as part of the formal process. Scrutiny will also occur through the CCG PPI forum.</td>
<td>Cluster monthly Review and Challenge meetings scrutinise progress against plans. CCG participates in SHA Cluster performance and challenge meetings.</td>
</tr>
<tr>
<td>Existing Controls in Place</td>
<td>Specific meetings with key leaders of the Save the Alex Campaign in Redditch to ensure open dialogue, better understanding of the process and the opportunity to strengthen the engagement with the local population in the months to come.</td>
<td>A&amp;E access targets included in operating plan. GP clinical lead and programme lead in place. Performance and quality reports to CCG Governing Body highlight provider performance. Regular clinically led performance meeting with provider. Mitigating actions agreed and being implemented. Collaborative approach being taken across the CCGs given the common link to one main provider.</td>
</tr>
<tr>
<td>Risk Before Controls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Score</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Consequence (Severity)</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Likelihood (Probability)</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Risk Description</td>
<td>Loss of confidence in the CCG by the local population and stakeholders.</td>
<td>Clinically led programmes fail to achieve measurable improvements in access to A&amp;E services.</td>
</tr>
<tr>
<td>Source</td>
<td>CCG Board</td>
<td>CCG quality and performance reports.</td>
</tr>
<tr>
<td>Opened</td>
<td>Jul-12</td>
<td>Jul-12</td>
</tr>
<tr>
<td>Strategic Objective</td>
<td>Actively participate in the Joint Services Review (JSR) of acute hospital services provided by Worcestershire Acute Hospitals NHS Trust, ensuring it is clinically led and clear decisions are made and agreed that are in the best interest of our community.</td>
<td>Establish a Worcestershire-wide urgent care strategy and implement clinically led programmes to achieve measurable improvements in access to A&amp;E services.</td>
</tr>
<tr>
<td>Risk Reference Number</td>
<td>BAF 4.2</td>
<td>BAF 5.1</td>
</tr>
<tr>
<td>BAF 4.2</td>
<td>Cluster monthly Review and Challenge meetings scrutiny to progress against plans. CCG participates in SHA Cluster performance and challenge meetings.</td>
<td>CCG and Locality Clinical leads identified. Lead roles confirmed. Operational model endorsed by Board, including implementation of Zoning model. Organisational Development plan being developed.</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>6</td>
<td>Ensure all providers have robust plans in place and progress actions accordingly.</td>
<td>OD plan being developed. Deadline for submission mid-August.</td>
</tr>
<tr>
<td>3</td>
<td>The PCT and CCGs have worked proactively with major provider to identify and progress action plans addressing specific issues.</td>
<td>OD plan still in development.</td>
</tr>
<tr>
<td>12</td>
<td>Stroke service quality and access targets included in operating plan. Performance and quality reports to CCG Board highlight provider performance. Regular clinically led performance meeting with provider. Mitigating actions agreed and being implemented. Engagement in Options Appraisal regarding Stroke Services re-configuration.</td>
<td>CCG quality and performance reports</td>
</tr>
<tr>
<td>4</td>
<td>Clinically led programmes fail to achieve measurable improvements in access to Stroke services.</td>
<td>CCG fails to achieve a strong clinical and professional focus which brings real added value.</td>
</tr>
<tr>
<td>3</td>
<td>CCG quality and performance reports</td>
<td>CCG</td>
</tr>
<tr>
<td>16</td>
<td>Implement clinically led programmes to achieve measurable improvements in stroke services, patient outcomes and experience.</td>
<td>Creation of a strong, clinically led CCG with active engagement of all member practices.</td>
</tr>
<tr>
<td>3</td>
<td>R, C, Q</td>
<td>R, O, C</td>
</tr>
<tr>
<td>Jul-12</td>
<td>Jul-12</td>
<td>Jul-12</td>
</tr>
<tr>
<td>BAF 7.1</td>
<td>BAF 7.2</td>
<td>BAF 8.1</td>
</tr>
</tbody>
</table>
### Appendix B:

**Commissioning, quality and patient safety plan**

<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>Progress since January 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create a culture of continuous quality improvement across CCGs and all commissioned services</td>
<td><strong>Creating a culture of Quality – Jo Galloway</strong>&lt;br&gt;A workshop has been set up in partnership between the three Worcestershire CCGs with invited Executives from the Health and Care Trust and Worcestershire Acute Hospitals Trust. The event is scheduled for 19th July 2012 and will be facilitated by Yvonne Sawbridge and Russell Manion from Health Services Management Centre, University of Birmingham. The aim is to engage executive leaders to look at how we can work collectively to create a culture of continuous quality improvement.</td>
</tr>
<tr>
<td>Research – Karen Hunter</td>
<td>CCGs are required to promote research and the treatment costs of patient participation in research. This is reflected in the Declaration of Compliance to be signed as part of the authorisation process. In support of the Declaration of Compliance, each CCG will benefit from nominating a Research Champion to provide a local voice to promote and encourage research in primary care and to support the approval process of research applications. Funding is available from the Comprehensive Local Research Network (CLRN) to support the Champions in 2012/13 with options currently being drawn up for consideration. The outline role description for CCG Research Champions is as follows: registered clinician; having an interest in research with particular focus on primary care; a willingness to work with other Research Champions in the county to promote and encourage research in primary care; participating in the approval process/decisions for submitted research project (CLRN undertake the necessary checks); liaise with the Primary Care Research Unit at University of Warwick to support and promote research in the local health economy; work with the CCG executive lead for research to monitor and review the research projects implemented and sharing best practice. SWCCG has identified one of their GPs to take on this role and a similar nomination is needed for WFCCG and R&amp;BCCG.</td>
</tr>
<tr>
<td>Develop a quality framework that brings together quality, safety and patient experience information from a range of sources and provides assurance regarding the quality of care delivery in commissioned services</td>
<td><strong>Quality Assurance Framework – Jo Galloway and Patrick Keady</strong>&lt;br&gt;Progress and principles n the development of a Quality Assurance Framework across the three Worcestershire CCGs was presented to Cluster Quality, Performance and Resources Committee and CCG Management Executive meetings in June 2012. The Framework is being developed, with an emphasis on measurement of outcomes. The Framework integrates patient safety, clinical effectiveness and the patient experience and focuses on leadership and culture in addition to more traditional key performance indicators. The Framework will pull together a number of pieces of work that include an escalation process to manage provider performance; a quality assurance visit framework; and wider reporting and assurance mechanisms. <strong>Evidence-Based Dashboard – Jo Galloway and Patrick Keady</strong>&lt;br&gt;This is being developed to focus on the key indicators that will help CCGs to qualitatively and quantitatively measure in real time, the development of quality (or otherwise) services in Worcestershire. A suite of quality indicators are currently available for main providers and afford the opportunity for a ‘pick and mix’ approach. These indicators will identify areas for quality improvement and compliment the Quality Assurance Framework. Indicators are also in the process of being developed for non-NHS providers to include care homes, domiciliary care providers and independent providers.</td>
</tr>
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</table>
**Strategic Objective**

**Progress since January 2012**

**Quality Assurance Mechanism – Jo Galloway and Patrick Keady**

The purpose of quality assurance is to ensure that services are fit for purpose. With this in mind, the CCGs are taking three complimentary approaches to improve quality assurance:

- Clinicians need to be among the people leading change
- Techniques such as ‘lean’ and methods such as clinical audit and research
- Relationships, coalitions of support, communicating the vision to staff patients the public and other stakeholders, and countering resistance to change.

The Quality Assurance mechanism will include patient stories, on-site visits, GP-led clinical quality reviews, online reporting of concerns, committees and evidence-based dashboard.

**Commission services that are both clinically effective and represent good value for money**

**CQUINs and Quality Outcomes**

The Commissioning for Quality and Innovation (CQUIN) payment framework enables CCGs to reward excellence by linking a proportion of providers’ income to the achievement of local quality improvement goals. The CQUIN goals for 2012/13 are now agreed. The CQUIN goals that are common to WAHT and WHCT are: VTE risk assessment, Safety Thermometer, dementia assessment and care planning, patient experience and making every contact count. The other WAHT goals are: communication between secondary and primary care, reduction in falls resulting in harm, swallow assessments for stroke patients, palliative care and antimicrobial prescribing. The other WHCT goals are: CAMHS developments, expansion of availability of mental health services in the primary care setting, and improved engagement of patients with mental health problems in their care planning.

This year’s quality standards within the NHS Provider contracts include indicators with a focus on outcome, including the SHA Elimination of avoidable grade 2, 3, 4 Pressure Ulcers by December 2012. NHS Providers are committed to achieving the target. Failure to meet the target will result in a financial penalty of £500 for every reported event from January 2013. The Acute Trust is required to reduce mortality rates as measured by the HSMR and SHMI.

Further work is needed to identify and refine a suite of appropriate outcome measures for next year’s contract negotiations.

**Safeguarding Adults and Children - Catherine Whitehouse and Lesley Cochrane**

Policies for Safeguarding Vulnerable Adults and Children are in draft form and are out for consultation. A training framework for safeguarding is contained within each policy. Safeguarding Vulnerable Adults and Children Policies will be submitted to CCG Governing Body for ratification following the consultation period.

Worcestershire Safeguarding Health Forum for Adults and Children was established in January 2012 to provide support to Designated and Named Professional’s across the Worcestershire Health Economy. The forum has been developed to provide robust quality assurance processes in relation to safeguarding across health organisations.

The Adult Safeguarding Lead Nurse is working with partner agencies on a Safeguarding Health Forum Project on Pressure Ulcers and Thresholds. The scope of the project will:

- Look at current thresholds and agree local thresholds in line with Pan West Midlands Safeguarding Adults Policy and procedures
- Improve reporting of pressure ulcers to safeguarding/adult protection
- Provide a strategic vision that promotes the prevention of pressure ulcers across Worcestershire health economy
- Reduce the incidence of avoidable pressure ulcers
- Timescale of the project is December 2012.

A programme of themed quality assurance visits to Providers is planned for 2012/2013. Safeguarding adults and children will form one of these themed visits in Autumn 2012.
Strategic Objective | Progress since January 2012
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**Serious Incident Online Reporting Database - Annie Coyle**
Since its formation in 2006, NHSW has used the national Strategic Executive Information System (STEIS) to manage the reporting of Serious Incidents. In 2011, the PCT procured the Serious Incident Online Reporting Database (SORD) because of its enhanced capability for the management of Serious Incidents (SIs):
- Scoring of the quality/robustness of an SI report
- Calculating accurately working days taken to complete
- Recording a clock stop and including that in any 45 working day calculation
- List clock stopped SIs
- Easily lists Never Events
- Highlights which open SI’s are overdue
- Creates simple reports
- Create a chronological note function for an SI
- Send an email to key people when an SI is logged including to specific individuals for HCAI, pressure ulcer and safeguarding cases
- Highlights to CCGs which SI reports are ready for their review
- Allows users to upload documents associated with the SI such as policies, action plans etc.

The introduction of SORD at WHCT and WHAT is likely to take place later in July following a follow-up demonstration to the Trusts from a West Mercia Cluster Quality & Performance Manager on the 3rd July 2012.

The NHSW Quality & Patient Team has introduced SORD in April 2012 to help with the management of SIs within WHCT and plan to roll this out for all the other Providers for which NHSW is the Lead Commissioner.

**Quality strategy for care homes – Lisa Levy, Hilary Green and Kathy Dale**
Progress continues with work undertaken in two work streams, Holistic Support and Quality Assurance. Within the Holistic support work stream a mapping exercise has been completed which details all the organisations that currently support care homes within Worcestershire. This work has revealed some potential duplication and some gaps in support for care homes. A development plan is being compiled which identifies the issues and actions required to bridge the gaps and reduce duplication.

Alongside the mapping exercise, joint visits have been made to a number of care homes by members of the quality and safety teams in NHS Worcestershire and Social Care. The purpose of these visits was to explore what support care homes staff would value in maintaining the safety of their residents and enhancing the quality of residents’ care. It was identified that care homes require support and advice in making decisions relating to clinical situations. There was some confusion and misunderstanding about CQC compliance and decisions care home staff felt able or unable to make. As an outcome of the visits a number of simple visual tools (flow charts) are being developed to aid decision making, identifying who, when and how to escalate concerns. These tools are being developed in partnership with colleagues in Social Care, Care Home Managers, Health and Care Trust, and General Practitioners. The CQC area manager has been made aware of the findings from these visits and is supportive of the work being undertaken.

The Quality Assurance Work stream has concentrated efforts on improving assurance processes surrounding Tissue Viability and the reporting and investigation of pressure ulcers. Two study days have been arranged for July and September to provide support, education and guidance in these areas. For Nursing Homes a new Quality Assurance reporting process will commence in September. Nursing Homes will be required to complete a report on a monthly basis and returned to NHS Worcestershire. The reports will require information on the number of quality measures. This information will be collated on a three monthly basis and shared during review meetings with the relevant provider.
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<th>Strategic Objective</th>
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| Include clinicians and patients in the monitoring, inspection and quality improvement of commissioned services | **Online Feedback form – Patrick Keady**  
While this is objective overlaps with the other four objectives, GPs from each of the CCGs have agreed on what they would like the pilot online form to look like. It is intended to be easy to access and easy to use. GPs will be asked to describe the concern, commendation or near miss. As well as the Provider organisation that the feedback relates to, and the expectations of the GP in terms of knowing the outcome, wanting the feedback noted, formal investigation, or for CCG/PCT to decide. The draft online form will be piloted from mid-July.  

Full roll-out of the new system is scheduled for September 2012, and the system will be transferred to the three CCGs from 2013. Each practice will be able to see the incidents and reports for their own practice only, each CCG will be able to see incidents and reports for the whole of their area (for example Wyre Forest CCG will be able to see all reports across the GP practices within the Wyre Forest catchment area) and will be able to closely monitor local trends and there will also be a facility to view across the health economy.  

**Patient and Public Involvement Membership Scheme – Hilda Bertie and Helen Perry**  
This is being developed and Hilda Bertie is project managing its development one day a week with a respective lead in each CCG. A product and project plan has been devised and a project team and steering group has been established. The project will be run over 6 months to October 2012 and will include the development of communications and marketing, webpages, volunteer policies, recruitment, training and a sustainability plan to ensure that volunteers can be involved at a range of levels, including being trained to visit a variety of health settings gathering intelligence such as patient stories. The challenge for the project team is to implement the scheme for the three CCGs, including their individual specifications and to link with existing work, such as the LINks Enter-and-View visits.  

This work will also link in with the Quality Assurance Framework visiting programme development which is initially focusing on the involvement of clinicians and other staff. |
| Encourage feedback and value the role of patients in shaping and improving services | **Patient satisfaction surveys – Sara Woffenden and Mary Taylor**  
NHSW is involved with WHCT in a county-wide programme to improve access to psychological therapies for stroke survivors. A survey (in conjunction with an Open Day at the new Stroke Association building in Bromsgrove) is under construction to establish what types of support and treatment patients and their carers have experienced following a stroke in the last twelve months. The results of the survey will be used to improve and develop services offered to stroke survivors of the future.  

NHSW has extended membership of the ‘Patient Opinion’ website until March 2013. This enables patients to share their experiences of all Worcestershire NHS services. The details are anonymised when it is placed onto the site by the Patient Opinion team. The data can then be collated and themes/areas of particular concern can be easily identified, compared and contrasted with data available from previous months all via the site itself.  

An independent patient survey was commissioned by NHSW and undertaken at WAHT replicating the national Patient Survey with an increased sample size and a shorter turnaround timescale. The results are due imminently and will be closed reviewed by both the Trust and commissioners to identify any areas for improvement. WAHT undertakes a monthly survey of patients on all wards with reports presented to the Clinical Quality Review group on a 3 monthly basis. This provides more timely feedback against which actions can be taken.  

Methodology for Patient Stories will be developed as part of the Quality Assurance Framework. This will recommend how stories can be incorporated into Board meetings or other quality assurance processes. |
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| Encourage feedback and value the role of patients in shaping and improving services | Patient Focus Groups, Patient Reference Groups and other patient experience feedback – Helen Perry  
Engagement work continues within each of the CCGs, forming their engagement plans and structures and conducting engagement exercises. The team has assisted the developing of Redditch and Bromsgrove’s Communications and Engagement Strategy and attends their PPI Forum. They continue to support the Wyre Forest Advisory group and Patient Group, incorporating the ongoing work into an engagement plan. The Engagement Plan for South Worcestershire which conducts engagement with key stakeholders during its development has been completed. During the formation of these strategies engagement on individual projects has continued. For example, the team has enabled South Worcestershire to gain feedback on mental health services via a survey and focus groups, and worked with the Primary Care Team enabling practices to fulfil feedback on mental health services via a survey and focus groups, and worked with the Primary Care Team enabling practices to fulfil the Patient Participation DES by supporting their Patient Reference Groups. Supporting the three CCGs has been a challenge due to capacity issues, however, as staff are recruited to the CCGs this work will be able to develop and flourish. |
Appendix C:

Worcestershire QIPP Schemes and related Lead Arrangements

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<th>Scheme</th>
<th>Lead</th>
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<tr>
<td>Prescribing</td>
<td>Jane Freeguard</td>
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<tr>
<td>Orthopaedics - First OP</td>
<td>Chris Emerson</td>
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<tr>
<td>Orthopaedics - Follow Up OP</td>
<td>Chris Emerson</td>
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<tr>
<td>Orthopaedics - Electives/Day Cases</td>
<td>Chris Emerson</td>
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<tr>
<td>Mental Health - FU OP</td>
<td>Sue Harris</td>
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<td>Unnecessary OP - First OP</td>
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<tr>
<td>Unnecessary OP - Follow up OP</td>
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<td>Nisha Sankey</td>
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<td>Falls</td>
<td>Ruth Davoll</td>
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<td>Gynaecology and Hysterectomy</td>
<td>Chris Emerson</td>
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<td>Ophthalmology</td>
<td>Chris Emerson</td>
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<tr>
<td>End of Life</td>
<td>Debbie Westwood</td>
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<tr>
<td>Non Elective CCG work</td>
<td>R and B CCG</td>
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<td>Impact of Public Health Schemes</td>
<td>R and B CCG</td>
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Redditch and Bromsgrove Clinical Commissioning Group has agreed with member practices how they would like to receive communications from the Consortium. They will also ensure that other partners who want to be kept informed have access to the same information.

If you would like any further information on the content in this Operational Plan please contact in the first instance:

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