Thinking Differently

NHS
Dudley
Clinical Commissioning Group

Commissioning Intentions 2019/20

Introduction

1) This document sets out our commissioning intentions for 2019/20.

Background

2) In September 2016 NHS England published planning guidance covering the two year period 2017/18 and 2018/19. Contracts with NHS providers covered the same two year period. Consistent with this guidance the CCG published 2-year commissioning intentions in 2016 and a commissioning intentions update in October 2017.

3) The Government has announced increases in NHS funding over five years, beginning in 2019/20 and has asked NHS England to develop a 10 year plan for how this funding will be used. It is proposed, therefore, that we prepare commissioning intentions for 2019/20 only, recognising that a longer-term plan will need to be developed – including a review of priorities and plans for 2019/20 – following publication of the national 10 year plan.

4) The CCG will need to agree new contracts with all NHS providers where current 2-year contracts end on 31 March 2019. We have not yet seen guidance from NHS England regarding any changes to the national standard contract or expectations regarding deadlines by which contract agreements for 2019/20 must be in place.

5) Our intention is to publish Commissioning Intentions for 2019/20 in September. This gives six months' notice of proposed changes to providers, which is a contractual requirement for some types of contract change. This does not preclude changes being made by mutual agreement after this date.

6) In producing commissioning intentions the CCG is intending to enter into contracts with an explicit intention of transferring a number of services to the newly established Multispecialty Community provider (MCP) at the earliest possible date following the procurement process. Wherever possible commissioning intentions will reflect the clinical model for the MCP but the CCG reserves the position of the MCP once established to change the model of delivery and issue supplementary intentions for the services for which it will become responsible.

National Policy

7) We can anticipate that demonstrating how we are delivering local implementation of national policy in relation to the development of Integrated Care Systems will continue to be a key requirement for local plans.

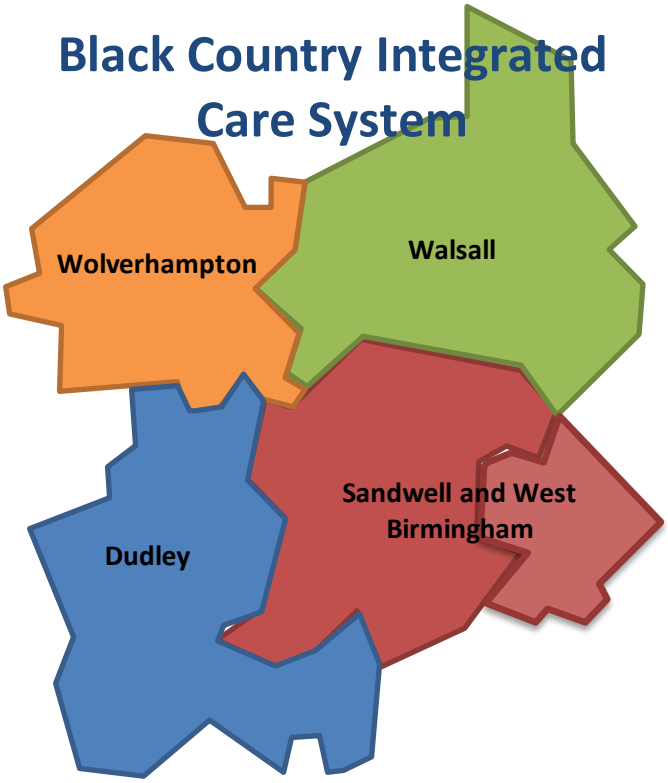
8) In line with this direction of travel we can also expect that, as well as developing our plans as a CCG, we will also be contributing to the development of plans at an STP level and our commissioning intentions will need to reflect both our place and STP-level priorities.

9) We can also expect a continuing requirement to meet national constitutional standards and to implement key national strategies.

Black Country STP

10) **Developing the Black Country Integrated Care System**

The Black Country ICS is a system that is made up of four places. Each of the four places are developing an Integrated Care Partnership and/or Integrated Care Provider which incorporates local primary and community care; local mental health and acute services; working together with local council care and public health services and the local CCGs. Those four ICPs then come together, with the collaboration of acute, mental health and ambulance services at scale, to form our Black Country ICS.



Our combined CCG commissioning intentions are designed to support the ongoing development of our ICS and are based upon four main themes from our wider system strategy:

1. Each CCG has set out their own commissioning intentions to progress the development of their local ICP.
2. The CCGs have agreed a suite of services which we are seeking to commission strategically, at scale
3. We are collaborating on key system-wide service review and development initiatives which are set out in our shared Black Country Clinical strategy as developed by the Black Country and West Birmingham Sustainability and Transformation Partnership (STP).
4. We are seeking to make a stepped-change in the way we commission emergency and urgent care services – with a focus on ambulance services as the key shared connecting service that operates across the system and its interface with all other providers.

This document sets out our shared approach to themes 2, 3 and 4 and illustrates our common agenda between the four CCGs in the development of each local ICP.

1. Developing our Local Integrated Care Partnerships / Providers

The attached appendices set out the intentions for each CCG in how we are seeking to develop each of our local ICPs and how our local plans each relate to the wider Black Country system agenda.

However, whilst there are differences in design and pace of development with each local ICP there are also many common themes which we will be increasingly collaborating on as four CCGs. These themes include:-

- health and care services being brought together as a means of responding to the needs of a growing frail elderly population displaying multiple co-morbidities;
- creating a more resilient primary care system and placing the patient registered with general practice at the centre of the care model;
- a population health approach to the management of demand;
- a move away from activity based contract models to our integrated care partnerships/providers being responsible for the delivery of a set of health and wellbeing outcomes.

Each CCG has begun work on developing an Outcomes Framework to look at improvement in patient health over time. We are committed to working together to align these frameworks which predominantly focus on the health management of our local populations; with a view to agreeing an overall common outcomes framework for the Black Country ICS.

2. Strategic Commissioning in the Black Country

There are a number of priority services on which our CCGs have been collaborating to develop strategic commissioning plans. We intend to collectively agree with our providers both: the specification and performance requirements for these services; and their expected pace of development.

These are:

Mental Health Services:

Following a joint workshop with providers in May, the services which have been collectively identified - from an STP perspective - are those which are:

- Specialist in nature;
- Can be provided with greater economies of scale and scope across a larger footprint;
- Demonstrate there is variation and/or service deficits in quality and provision respectively;
- Which are (in some instances) imperatives as part of the MH 5YFV Delivery programme
- Which can be addressed in the relatively short term

Cancer:

We are working as part of the West Midlands Cancer Alliance to deliver the national Cancer Priorities, including:

- Working with providers to ensure the implementation of nationally agreed rapid assessment and diagnostic pathways for lung, prostate and colorectal cancers.
- Working with partners to achieve improvements in cancer screening uptake and early diagnosis.
- Commissioning cancer services that offer consistent and high quality services, including meeting national waiting time standards for diagnosis and treatment
- Improving patient experience, including through implementation of the national Recovery Package

We will work with partners across the STP to create a cancer plan for the Black Country, looking in particular to explore opportunities to develop local services to enable more people to be treated in the STP.

Maternity*:*

All four CCGs are adopting the same maternity specification, with local changes to reflect demographics and population needs.

This approach is supported by the LMS which will reflect the summarised specification. The LMS plan for our STP is assured by regulators as a comprehensive, honest and robust system approach to improving maternity services across the system.

Transforming Care:

The LD service (as part of the Transforming Care Programme) will be a single delivery model across the Black Country. It will support the discharge of patients from hospital with intensive community, case support and forensic staff as well as acting in a preventative manner to minimise future hospitalisation of this cohort of patients.

Care Homes:

We want to build on the excellent example from NHS Walsall CCG on their working with the Care Home Sector to improve their capabilities and reduce conveyances to A&E and develop this work with Local Authority Partners.

Empowering People and Communities through Personalisation:

Each ICP places more importance on harnessing the renewable energy of people and communities and the need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services.

The Black Country has been successfully selected as a Demonstrator Site for Personalised Care and Support (PCS) by NHS England (NHSE). Personalised Care relates to a number of interventions.

As commissioners we will see Personal Health Budgets as our default position for Continuing Health Care and Wheelchair provision from the 1st April 2019. It is our intention to increase the number of people benefiting from PHBs and wider personalised care across the Black Country and we will be encouraging providers to actively seek opportunities to increase personalised care and support for patients when reviewing any pathways of care.

3. Shared Service Agendas as Identified in our Clinical Strategy

Our joint clinical strategy, developed by our STP, sets out a number of service issues which we intend to progress collectively. These include:

- Primary Care
- Children and Young People
- Cardiovascular Disease
- MSK
- Respiratory Disease
- Frailty - specifically the Care Homes agenda
- Histopathology
- Interventional radiology

The Clinical Strategy is in the final stages of drafting and will be available for consideration in October and November by the whole STP. We will expect to establish a set of shared priorities arising from the clinical strategy in partnership with the rest of our STP.

4. Joint Development of Emergency and Urgent Care

We are seeking to make a stepped-change in the way we commission emergency and urgent care services – with a focus on ambulance services as the key shared connecting service that operates across the system and its interface with all other providers. We commission ambulance services jointly with all other CCGs across the West Midlands and in partnership with them we intend to change the way we commission this service. However as part of this we also intend to develop the Black Country model for Emergency and Urgent Care which sets out how the ambulance service will be able to interface with each local hospital and each local ICP as these develop – in order to improve the experience of patients, reduce avoidable conveyances and provide enhanced care to people in the community.

Dudley – Thinking Differently

11) Dudley CCG has prepared its commissioning intentions based on 6 key principles:

a) Patient and public involvement

The meaningful involvement of patients and public is fundamental. The patient is usually the co-ordinator of their own care and holds many of the answers to how to manage their own health better (co-production). We believe that the personalisation of this care is key, that contact with healthcare professionals should be valuable and that the barriers to this co-production should be removed. Shifting the conversation from, ‘what is the matter with you’ to ‘what matters to

you' underpins much of our work. We will support people to build resilience, reduce social isolation and increase independence. When people do need to use services, we want them to have clearer information about the quality of services in order to inform their choices; and we will create opportunities for them to report on whether services are working for them.

b) Clinically led

Dudley people register with their GP who helps to coordinate the access to healthcare services to meet their needs. So our future health system will be organized around this key relationship between patient and their GP; providing a personalised service. Similarly, all population-based healthcare will be commissioned on a registered- population basis and will be organized to work effectively with our GP and CCG structures (so around practices, localities and borough-wide). This approach will ensure a clear, clinically-led approach to healthcare delivery.

c) Primary care at our heart

The vast majority of care is either delivered by General Practice or is accessed through it. The success of primary care is therefore central to the future success of our health services locally. There are challenges in recruitment and retention for our GPs, so we want Dudley to have a national reputation as the best place to work for GPs along with their extended primary care and community staff. We will continue to develop our shared commissioning of primary care with NHS England to ensure that this can be achieved. A sustainable primary care system lies at the heart of our new care model and the development of Dudley Multi-speciality Community Provider (MCP).

d) Working with our partners in the communities

We recognize the need to network our GPs, patients and associated primary care/community services, social care and the voluntary sector to respond to the variable needs of different communities across the Borough. Health inequalities can only be addressed through a jointly targeted community-based approach. We are committed to building our partnership relationships.

e) Focus on quality and continuous improvement

We will take a developmental approach to quality improvement that encourages openness and transparency by all our service providers. With this approach we will work together to reduce variations in care and outcomes; and to aim for best practice performance. We will expect every service to be able to demonstrate the value and quality that it provides to patients. We will use a continuous evaluation process that will ultimately ensure that we do not commission any service that cannot demonstrate value; and we will actively promote those that can demonstrate best outcomes for patients.

f) Live within available resources

We will spend every pound of public money wisely to meet our financial responsibilities and address the reasonable needs of our population within

available resources. This will mean we need to be as efficient as possible and to use the resources we do have effectively. In order to focus on outcomes the CCG will develop new contractual forms with Providers to move away from transactional commissioning to whole population allocations. The contracts will incentive the best possible quality of care and allow Providers to develop innovative practice to improve patient care.

12) As a system we can work together to build community connectivity. We will be looking for provider support to encourage Dudley to create a movement around community connectivity recognising the difference behaviour change can make to all areas of demand in our system. We will also be encouraging providers to play a part in empowering people and communities following the principles of:

- Care and support is person centred: personalised and empowering
- Services which are created in partnership with citizens and communities
- Focus is on equality and narrowing health inequalities
- Carers are identified, supported and involved
- Voluntary, community, social enterprise and housing sectors as key partners and enablers
- Volunteering and social action are recognised as key enablers.

Quality Assurance

13) A new Quality Assurance Framework will be required for the MCP, with agreement from all partners, in terms of priorities and an explicit governance structure with clarity regarding monitoring, oversight, assurance and accountability.

14) The development of any new model of care will create potential risks in terms of quality and safety for patients during the transition and therefore a robust process will be required to ensure that there is adequate oversight of quality and safety risks and sufficient mitigations are in place.

15) Quality assurance will be required with regards to safety, clinical effectiveness and patient experience with system-wide oversight from all partner organisations. The structure of which is yet to be established, but will learn from best practice in all sectors.

Dudley MCP

16) At the heart of the commissioning intentions is the procurement of a MCP which includes a different approach to outcomes. The Dudley MCP will introduce a truly outcomes-focused framework which is much broader in scope and more ambitious in aspiration than traditional targets and quality requirements.

17) Services will be increasingly commissioned to support the development of 10 Integrated Care Teams (ICTs) serving populations of c. 30,000 patients across the 5 Dudley localities.

18) To support the development of the MCP, the CCG will commission a range of services to support an increased provision of care in the community, together with the capability to manage capacity and access in a more streamlined way. This is likely to impact on existing services commissioned by the CCG, as well as additional capacity.

19) Early changes are expected to be made in the shape of community services to integrate around the 10 ICTs, and to the provision of Single Points of Access to coordinate into a single MCP Communications Centre. The CCG will work with the MCP partner organizations to enable changes to be made in advance of the MCP organization being formed. This may require resources to be moved between organizations where a coordinating body is agreed prior to transfer to the MCP.

    It is expected that more detailed commissioning intentions will be developed by the MCP Transition Board. As this is a partnership body, it is proposed that changes agreed by this body will be accepted by all organizations as a variation to the commissioning intentions without contractual notice periods being sought.

A New Health and Care System

20) The implementation of the MCP contract will see c. £240m of commissioning resource and capability contained within a single Whole Population Budget managed by one organisation and linked to a set of outcomes.

21) It is our intention to develop similar arrangements covering the rest of the planned and urgent care system (with the exception of the ambulance service). This will reflect the features of the MCP contract:-

- a Whole Population Budget
- a set of contracted outcomes
- a longer contractual length

Both contracts will be linked by a gain/loss share agreement.

22) We intend to agree the underlying system financial model during the remainder of 2018/19 and establish "shadow" contract arrangements for the two elements of the system by 1 April 2019.

Primary Care

23) Over the past three years we have developed a strong emphasis on putting the patient at the centre of our planning and encouraging primary care to work together innovatively to achieve improved population based health and well-being.

24) Over the next two years our intentions are focussed on continuing this work with an emphasis on the following

- Improving the standards and the quality of primary care
- Enabling patients to have better access to services, with better continuity and co-ordination of their care
- Addressing unwarranted variation
- Enabling primary care to develop and integrate with the MCP
- Collaborating across the Black Country to support sustainable and resilient primary care

In summary, this will be achieved through our work in the following areas:

Commissioning

- The commissioning of the Dudley Quality Outcomes for Health Framework (DQOFH) to deliver improvements, access and the continuity and co-ordination of services for patients with long term conditions
- The DQOFH will be reviewed and revised to incorporate further evidence based population outcomes measures
- There will be greater emphasis on setting outcomes that support patients managing their own condition and setting personalised goals, supported by health coaches
- The commissioning of extended access to GP appointments to provide flexible, seven day GP appointments available in each locality. This includes supporting practices to work together within their locality networks to provide this service

Development

- The implementation of our General Practice Forward View (GPFW) plan and high impact actions to deliver sustainable and resilient primary care.
- Developing and supporting a range of training and education programmes to support the delivery of the GPFW and high impact actions.
- Supporting practices develop their locality networks with a view to

    - workforce development plans at a locality network level
    - commissioning services that can be organised and delivered at a locality network level – supporting practices to collaborate to deliver those services

- supporting the development of Integrated Care Teams (ICTs) and their interface with general practice

There are a range of projects already in place, and a range of projects that will be developed to support these aims.

MCP

The MCP related primary care development work is GP led and driven by a Steering Group on behalf of a Collaborative of Dudley GPs. In supporting their work the CCG will ensure that

- The commissioning and development of primary care will be aligned to the MCP model of care, and in particular, ensure that that the development activities and implementation of the GPFW plan reflect the way in which the MCP is developing its primary care operating model.

Contracting

- We will continue our rolling programme of contract review. The process for 2018/19 is focussed on monitoring the key themes that have either been highlighted from previous monitoring exercises or are new contractual obligations.
- We will work closely with the Care Quality Commission (CQC) and the Quality and Safety team within the CCG to provide support, training, education and peer mentorship to ensure that practices meet their contractual obligations, and provide services that are safe, effective and of a high quality.

Collaborative Working across the Black Country

- We will continue to develop and contribute to the delivery of the Black Country Sustainability and Transformation Plan (STP). This will involve contributing to a range of joint projects and initiatives that relate

    - Collaborative workforce planning
    - Increasing the number of GPs retained in the Black Country
    - Bidding and securing additional resource to support the training and development of primary care staff
    - Closer joint working with the Black Country training hub

Engagement

We are recognised for the extensive and effective engagement without member practices and will continue to review and develop our engagement activities specifically;

- We will produce a membership engagement plan each year, to be approved by the Governing Body, in response to the CCG stakeholder feedback.
- The plan will include details of how we will engage at a practice, locality network and borough wide basis through our programme of practice engagement visits, locality network meetings and membership events. It will also consider and address any opportunity to increase our engagement of primary care

RightCare

25) The CCG has been supported in previous years by the NHS RightCare programme. The CCG will continue to commission to address unwarranted variation in care pathways. In 2018/19 the CCG has recommissioned pathways in:

    a) Musculo-skeletal (MSK) triage
    b) Ophthalmology
    c) Trauma and Injuries
    d) Rheumatology

    The full year impact of these pathways will be commissioned from April 2019, with any outstanding implementation plans having agreed delivery trajectories.

26) For 2019/20 the CCG expects to also commission revised pathways for:

    a) Joint Injections
    b) Back Pain
    c) First contact practitioners
    d) Rheumatology
    e) Gynaecology

27) The CCG will be working with providers to link the RightCare benchmarking with the Get It Right First Time (GIRFT) analysis to focus on areas where the system can gain the largest efficiencies

Better Care Fund

28) The CCG will continue to work with Dudley Metropolitan Borough Council to support the aims of the Better Care Fund.

29) The Council and CCG have jointly evaluated the schemes funded from the Improved Better Care Fund (iBCF) to determine those schemes that have made the most significant contribution to the reduction in delayed transfers of care and increased admission avoidance.

30) These schemes have had considerable service user benefit in maintaining independence and encouraging reablement. The CCG will work with Dudley MBC to ensure recurrent funding for these services as a platform for future joint working.

Gain and Loss Shares

31) As part of agreeing contracts, the CCG has started discussions on areas where there is the potential for gain and loss shares across a service pathway and a population level. Early work has been developed jointly with NHS England and NHS Improvement as part of the establishment process for the MCP, and the CCG is looking at the wider applicability with other Providers.

Service Pathway Changes

32) Building on pathway redesigns in 2018/19, the CCG will commission the following service changes from April 2019

a) Inpatient Rehabilitation – in order to maximize the potential for patient rehabilitation, the CCG will commission rehab services in the community wherever possible. During 2018/19 the CCG has implemented a prior approval mechanism to offer patients community rehabilitation services as a first choice option. This will be incorporated into contracts from April 2019 and the CCG will not pay for inpatient rehabilitation where the patient has not been offered a community alternative

b) Pain management – In reviewing the MSK pathway the CCG has reviewed the increase in joint injections and the place of treatment. Many joint injections which should be delivered in primary care (where needed at all) are currently being delivered in secondary care. Following clinical review, the CCG will only commission joint injections from the following clinicians. Any patient who is assessed in secondary care (including triage/first contact practitioner services) must be referred back to primary care where the GP is the identified clinician. Any patient not referred back to primary care who receives their injection in secondary care will only be paid for at the primary care rate

Site	By Who	Includes	Exceptions / Considerations
Primary Care Only			
Shoulder	GP	a) sub-acromial b) gleno-humeral	N/A
Elbow	GP	a) 'tennis' elbow	• Conditions related to rheumatoid arthritis
Wrist	GP	a) carpal tunnel	• Possible opportunity to develop a service • Nerve conduction studies to be considered • Numbers are relatively low • Procedures of Limited Clinical Priority (PLCP)
Knee	GP		N/A
GP & Consultant /Specialist			
Hand/Fingers	GP	a) trigger finger / thumb Rheumatology /	

	Consultant / Specialist	Orthopaedics	• Could be done in a community setting
Hip	GP	a) trochanteric bursitis b) hip injection (guided)	
	Consultant / Specialist		• x-ray required only as a diagnostic test
Foot	GP Consultant / Specialist	a) plantar fasciitis	N/A
Consultant /Specialist Only			
Back	Consultant / Specialist		• x-ray required • Prior Approval only
Neck	Consultant / Specialist		• x-ray required
Ankle	Consultant / Specialist		N/A

c) Guided joint injections – the CCG will develop a guided joint injection service through the introduction of a GP with specialist interest. All future joint injections clinically appropriate for this service will only be paid at the primary care rate.

d) Back pain – the CCG will implement the national back pain pathway from April, harmonizing Policy with the rest of the Black Country CCGs.

e) Outpatients – the CCG intends to extend the use of peer review in primary care and advice and guidance. This is expected to extend the range of conditions treated in primary care, reducing waiting times for patients requiring to see a specialist in secondary care.

f) Minor injuries and illnesses – following the implementation of the Urgent Treatment Centre at Russell's Hall Hospital the CCG expects 6% of current A&E activity to transfer to the UTC from the Emergency Department. The CCG is open to a risk gain share proposal from the 2 providers in this area

g) Ambulance Turnaround Delays at Russell's Hall Hospital – following the development of a dedicated ambulance triage area at the hospital, the CCG expects a significant reduction in ambulance delays, with no delays over 45 minutes. A risk and gain share will be developed to support this reduction

h) Care Home Teams – the CCG will work with Dudley MBC to develop an integrated support team to Nursing and Residential homes to include rapid response, palliative

care teams, social care support and trusted assessors to reduce emergency hospital admissions and facilitate early discharge when residents are admitted. The CCG is planning to reduce emergency admissions by 20%

System Resilience Funding

33) In order to support planning for the winter period, the CCG will mainstream funding received through system resilience monies. The use of the resource will be discussed at the Urgent Care Operational Group and decisions ratified at the A&E Delivery Board.

34) An agreed schedule of the use of the system resilience funding will be attached to the contract. Any changes agreed by the A&E Delivery Board during the life of the contract will be implemented by agreement without notice period to support urgent care delivery.

Quality, Innovation, Productivity and Prevention Schemes (QIPP) 2019/20

35) As part of the budget setting process for 2019/20 the CCG will be required to deliver efficiency savings. As part of the development of the MCP, the QIPP target will be divided between the 2 organizations, but will start the contract cycle as part of CCG contracts.

36) The CCG will seek to align QIPP priorities with Trust Cost Improvement Plans (CIP) to maximize system efficiencies. It is proposed that the Clinical Strategy Board is utilized to identify joint pathway designs and oversee their implementation

37) The development of the 2019/20 QIPP programme has started, but will not be finalized in time for the publication of commissioning intentions. The CCG will work with patients and providers to develop appropriate schemes between September and December

38) Based on current service discussions the following areas will be included for discussion as part of the QIPP process

a) Reducing current demand growth assumptions to 2018/19 outturn levels – a key priority for the CCG is to transfer capacity and resource to non-Hospital services, in line with development of the MCP. The CCG has put in place a number of demand management schemes over the last 12 months and expects these services to reduce growth in demand to match expected demographic growth. Therefore the key planning assumption for 2019/20 is that secondary care expenditure will not increase in line with the growth of the CCG allocation and that this money will be ringfenced for the development of the MCP. This assumption will be reviewed in line with the national planning guidance when issued.

b) In order to support the development of community based access, the CCG will be supporting the development of the GP communications centre to integrate current Single Points of Access and allow capacity management of community services. This

will support, but is not limited to, access to specialist opinion, GP referral to specialist community teams without diversion to A&E and a single point of access to community capacity for 111 and Ambulance Services

c) The list of Procedures of Limited Clinical Priority will be reviewed in line with the national consultation led by NHS England. The opportunity will also be taken to harmonies, where required, with the rest of the STP footprint

d) Patients are increasingly developing personalized care plans for their care, in partnership with their clinicians. This increased patient empowerment is supported by the CCG and to support their development, the CCG will expect providers to deliver care in accordance with these care plans.

e) The CCG will be reviewing the criteria for the provision of hearing aids.

f) The CCG wishes to develop a diagnostics formulary to review the current use of direct access diagnostics and pre-referral diagnostics. Evidence from both primary and secondary care is that inappropriate diagnostics are being requested and performed.

g) The CCG wishes to review the pathway for pneumonia and Chronic Kidney disease given the significant increase in activity during 2018/19.

h) As part of the urgent care review the CCG will review the criteria for access to the ward attender capacity at Russell's Hall Hospital and the pathway for GP initiated admissions.

i) The CCG will lead a review of ambulance conveyances to Russell's Hall Hospital. Based on current attendances a high number of conveyed patients are being discharged with no treatment undertaken at the hospital. The review will look at alternative pathways for these patient groups and the CCG will work with the Integrated Urgent Care commissioners at Sandwell and West Birmingham CCG to establish targets for reduced conveyance.

j) The CCG will review the pathway for osteoporosis.

k) Current GP with Specialist Interest services will be reviewed to ensure clinical and financial appropriateness. A model will be developed for a successful delivery model.

l) The CCG will work with providers to introduce direct access to surgery for GPs with a specialist interest. This will build on the successful model in ENT.

m) The CCG will build on the development of the frailty strategy to support people to be maintained in their own homes.

n) The CCG will review the epilepsy pathway.

o) The CCG will work with STP partners to develop a community service for patients with personality disorders. It is expected this will reduce the requirement for bed based care for this client group.

p) The CCG will review the potential for utilizing digital image review to reduce the need for patients to be referred to outpatients

q) The CCG will review the community Gynaecology service supported by specialist input. This will be developed as an integrated pathway with the sexual health service.

r) In order to support the MCP development of Integrated Teams, the CCG will review the District Nursing and Case Management Services. In order to support the development of integrated community teams the review will consider the interface with tissue viability, leg ulcer, community IV, continence and Practice Nursing teams to move towards the creation of a Home Care Nursing Service. Other services may be included as the review progresses to maximize the potential of the Integrated Teams.

s) The CCG will seek to develop a community urology service focussed on lower urinary tract symptoms and over active bladder conditions.

t) The CCG will review the current social prescribing services with local partners to develop a Dudley wide strategy for social prescribing.

u) Advice and Guidance services to be benchmarked to develop a consistent model as a support to Primary Care.

v) The CCG wishes to accelerate the implementation of the end of life strategy. A key component is to support individuals to die in their place of choice and the CCG will commission services to enable the appropriate service capacity to be available.

w) Individual Patient Placements - The MCP's Whole Population Budget will include resources for the placement of individual patients with complex mental health needs. We wish to explore, in conjunction with Dudley and Walsall Mental Health Partnership NHS Trust, the potential for putting this arrangement in place from 1 April 2019, in the lead in to the mobilisation of the MCP contract. This will be designed to incentivize the provider to manage the resources associated with these patients, avoid unnecessary external placements and facilitate discharge to local services should placement be necessary.

x) The CCG will engage with partners to support the reduction of loneliness and isolation. There is evidence that this is a significant factor in the health and wellbeing of the 18-25 year old group. The CCG will review capacity in existing services and identify service gaps in NHS, social prescribing and wider sector provision.

y) The CCG will work with providers and the Commissioning Support Unit to review information requirements in the contracts to ensure that the patient pathway can be identified across organisations to give a more holistic view of services.

z) The CCG will work with the Local Authority and third sector to review home care support to support independence

These commissioning intentions, taken as a whole, continue the strategic direction of a Long term strategy for care across Dudley. Working with partner organizations to focus on outcome driven services has seen significant improvement in population health and the priorities for future years will further enhance care provision across the Borough. Many of the areas described have already been the subject of extensive consultation and implementation planning. Where appropriate full consultation will take place on new developments to ensure the best possible services are developed.