Do OD Organisational Development
Putting Theory into Practice

NHS
East Leicestershire and Rutland
Clinical Commissioning Group

# Organisational Development Plan

# 2014-2016

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## Section 1 - Foreword

Since publishing our first Organisational Development (OD) Plan in June 2012[1], there have been a number of significant changes in the NHS following the implementation of the Health and Social Care Act 2012[2] which changed the way the health service in England is organised and the way in which health and social care services are commissioned.

The legislation invited emerging Clinical Commissioning Groups to apply to NHS Commissioning Board (now NHS England) to become established and authorised and I was delighted when East Leicestershire and Rutland Clinical Commissioning Group (CCG) successfully achieved authorisation with no conditions in December 2012 which was the first of four assessment waves.

In the year leading up to authorisation, the CCG had been running in shadow form with delegated authority from the Leicester, Leicestershire and Rutland PCT Cluster[3] and became a statutory body on 1 April 2013 along with 220 other CCGs. On this date, a number of staff transferred to the CCG from across the healthcare system, to coincide with the abolition of PCTs and SHAs, as did a whole raft of roles and responsibilities as defined in the Act and the CCG became the lead commissioner for health for the residents of East Leicestershire and Rutland.

Post authorisation the CCG has had to adapt and develop quickly in response to the ongoing changes and challenges of the new health and social care system. The CCG is clear about what it needs to achieve as commissioners at a time of escalating demands on health and social care services with significant and increasing financial pressures. An ageing population means that year on year the CCG will have more people to provide services to with complex and long term needs. It is essential that the CCG uses its resources more efficiently and cost effectively to be able to provide services that truly meet its patients' needs.

I am very pleased to endorse the publication of our second OD plan which provides an explanation; firstly, of the CCG - who we are and what we are here to do and which includes an overview of the challenges facing the local health economy; secondly, the CCG's key achievements in the first full year post authorisation to 31 March 2014; and finally, all the OD related interventions that are planned to help the organisation achieve its goals over the next two years.

Mr Graham Martin
Chair of the Governing Body
East Leicestershire and Rutland CCG

[1] www.eastleicestershireandrutlandccg.nhs.uk/our-strategies-and-plans
[2] http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
[3] Comprising Leicestershire County and Rutland PCT and Leicester City PCT

## Section 2 – Introduction

The OD plan identifies the key initiatives or interventions that are required to either develop the organisation, its people or its stakeholders in order to make the changes required to develop its workforce and to deliver the CCG's operational plans. The timeframe for this refreshed OD plan follows the two year Operational Plan for 2014-16 and is cognisant of the system changes that are required in the Leicester, Leicestershire and Rutland (LLR) emerging 5 year strategic plan.

### 2.1 Defining OD

The term 'organisational development' has been defined by OD theorists and practitioners in a variety of ways; its multiplicity of definition reflects the complexity of the discipline and is responsible for its lack of understanding.

Simply put, an OD practitioner is to an organisation as a doctor is to a human body. The practitioner "diagnoses" (or discovers) the most important priorities to address in the organisation, suggests a change-management plan, and then guides the organisation through the necessary change. There are different definitions and views on how change should occur.

In 1992, OD was defined as "the process of planned change and improvement of organisations through the application of knowledge of the behavioural sciences".[4] As the primary purpose of OD is to develop the organisation, not to train or develop the staff, it is generally argued that OD is not about training, personal development, team development or a part of HR although it is often mistakenly understood as some or all of these.

However, for the purposes of this plan, **OD is any deliberately planned, organisation-wide effort to increase the CCG's effectiveness and/or efficiency and/or to enable the organisation to achieve its strategic goals and includes staff training and development.**

The CCG's overarching aims remain those that are articulated in the CCG's first OD plan, which are to develop the organisation:

- with shared leadership across constituent practices and localities to ensure GPs are driving system change themselves and provide strong clinical leadership;
- with realistic and credible expectations, clear priorities, with a robust and pragmatic approach to commissioning decisions and management;
- that puts public involvement at its heart; listening to patients and partners and taking action in response;
- capable of meeting the challenges presented by system change and financial constraints;
- with a strong sense of individual and collective confidence amongst staff to enable us to deliver operational aims.

[4] Moorhead, G and Griffin, R.W (1992). Organisational behaviour (third edition). Boston: Houghton Mifflin

To help us to do this, over the next two years, we will further develop as a CCG to work even more closely with our clinicians, patients, members of the public, local authority partners, neighbouring CCGs and stakeholders to deliver our challenging plans and lead system change in primary care.

### 2.2 Related documents

The OD plan is a useful overarching document that captures the key programmes of work and enablers contained in several other CCG documents. Whilst the document can be read in isolation of other CCG publications, related documents are available on the CCG's website[5] in the section headed 'About us' and then 'Our strategies and plans' and should be referred to for additional information and context. The relevant documents are:

- CCG Constitution;
- Two-year operational plan 2014-15 and 2015-16;
- Informing and Involving – our approach to Communications and Engagement Strategy;
- Equality and Diversity Strategy 2012-2015.

National documents and guidance is referenced in footnotes.

### 2.3 Monitoring progress

The OD plan has been written as an internal facing document and is intended to be iterative, flexible and dynamic and will be regularly reviewed and updated to reflect the ever changing nature and emerging developments in the way health and social care is commissioned and delivered.

**An action plan will be developed to operationalise the OD plan** which includes details of when and how the interventions detailed in section 5 will be delivered. This in turn will be RAG (red/amber/green) rated to monitor progress which will be submitted quarterly to the Corporate Management Team (CMT) and annually to the Governing Body.

The plan will next be updated in May 2016.

[5] www.eastleicestershireandrutlandccg.nhs.uk/our-strategies-and-plans

## Section 3 - Who we are and what we do

East Leicestershire and Rutland CCG is a membership organisation which comprises 34 medical (GP) practices in three localities: (i) Melton Mowbray, Rutland and Market Harborough; (ii) Oadby and Wigston; and (iii) Blaby District, Lutterworth and surrounding areas. The CCG has a registered population of approximately 320,000 patients.

### 3.1 CCG functions

The CCG is responsible for exercising its functions which are set out in the Health and Social Care Act 2012 and the CCG's constitution. In summary, the main functions relate to:

a) commissioning health services that meet the needs of: all people registered with member GP practices, and people who are usually resident within the area and are not registered with a member of any CCG;
b) commissioning emergency care for anyone present in the group's area.

The legislation distinguishes between:

- the key statutory duties of CCGs – the 'must dos' that CCGs are legally responsible for delivering, and their
- key statutory powers – i.e. the things that CCGs have the freedom to do, if they wish, to help meet these duties.

CCGs have flexibility within the legislative framework to decide how far to carry out these functions themselves, in groups (e.g. through a lead CCG) or in collaboration with local authorities, and how far to use external commissioning support.

### 3.2 Governing Body

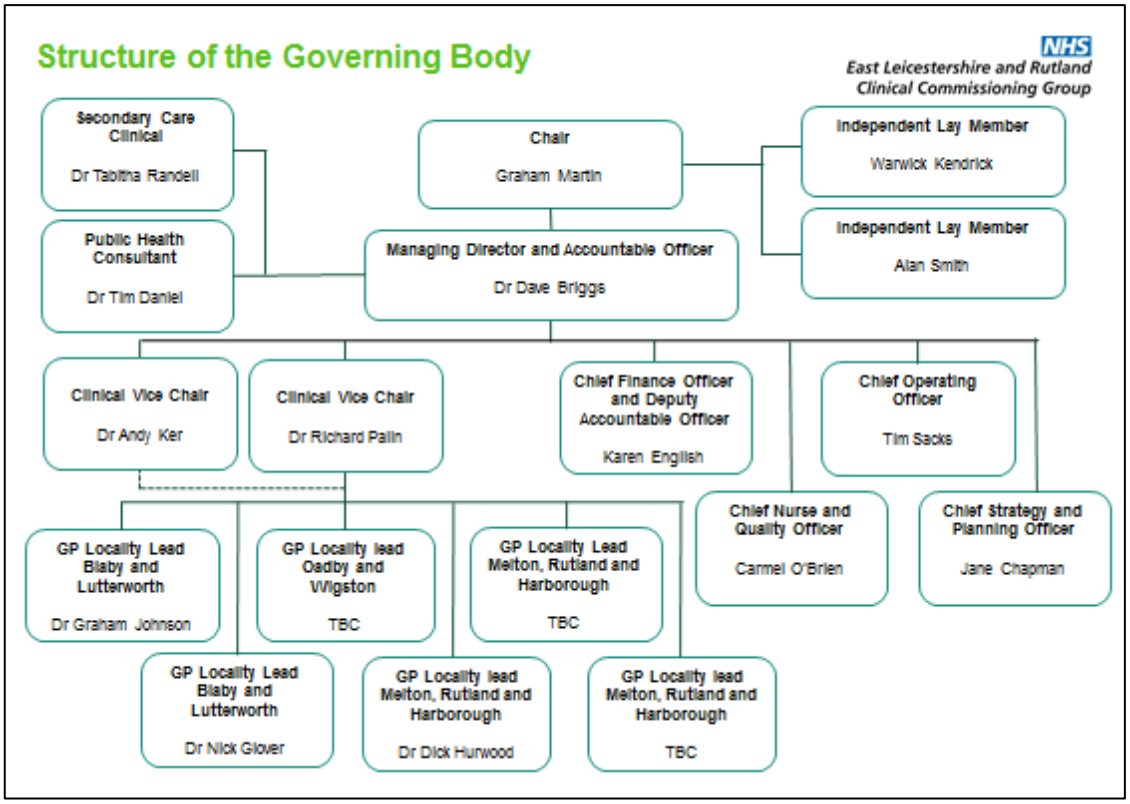
The CCG's Governing Body is responsible for ensuring that the CCG exercises its functions. Following a review of the roles and responsibilities of members of the Governing Body, the clinical capacity has been increased by appointing two additional GPs. From 1 July 2014, the Governing Body will comprise: the Chair and two independent lay members (ILM's); two clinical vice chairs[6] and six locality leads; secondary care clinician and public health consultant; managing director who is the accountable officer and a management team of four chief officers.

Members of the Governing Body are engaged by a variety of methods. The Chair and ILM's are not CCG employees and are appointed for a period of three years to provide an independent degree of scrutiny and challenge and act as 'critical friend' to the Governing Body. The Clinical vice chairs and locality leads are all working GPs who are elected by the membership for up to three years during which time they are appointed as 'office holders' and work for the CCG for two days per week. The secondary care clinician is substantively employed at Nottingham University

[6] Subject to approval of Constitution by NHS England in June 2014

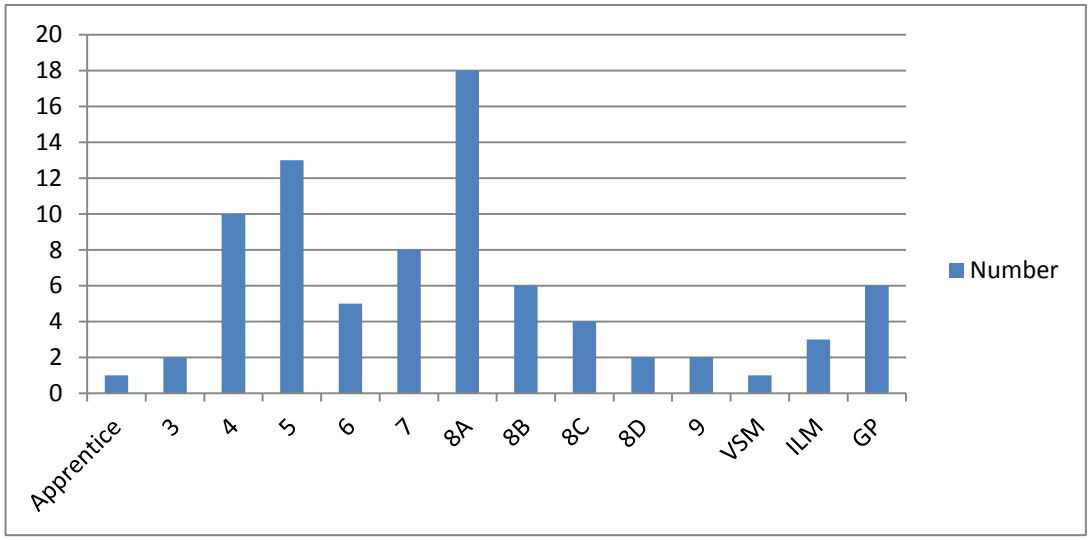
Hospitals and the Public Health Consultant is employed by Leicestershire County Council. The Managing Director and chief officers are all employees of the CCG.

The diagram below shows the structure of the Governing Body effective 1 July 2014.




### 3.3 Workforce

The chart below is based on the number of staff employed at the end of March 2013 and shows the distribution of staff by Agenda for Change pay bands 3 - 9. VSM is Very Senior Manager. ILMs are independent lay members. GPs are practicing doctors who are elected to serve on the Governing Body.



### 3.4 Running costs

NHS England provides CCGs with a nationally defined annual budget or Running Cost Allowance (RCA) based on the registered patient lists for GP practices and moderated at a local authority level to match the latest ONS population projections. The RCA is used to finance all of the CCG's operational costs and includes: office space and facilities management; staff salary costs (including any flexible labour, for example, temporary staff); and all costs associated with clinicians and ILM's appointed to the Governing Body.

All CCGs structures must be affordable and capable of delivering sufficient capacity and capability to support an effective commissioning organisation. The CCG's structure has been designed after consideration of the functions that will be delivered by the CCG, some of which are shared and/or hosted with other CCGs and some are contracted out to a Commissioning Support Unit (CSU).

In 2013-14, CCGs were allocated £25.00 per head of population to cover the running costs of the organisation. In 2014-15 this figure reduced slightly to £24.73 and in 2015-16 it is expected to reduce to £22.07. Within the CCG's RCA for 2013-14 the cost per head for the CSU is £7.36 and for 2014-15 it is £7.41.

### 3.5 Greater East Midlands Commissioning Support Unit (GEM CSU)

CSU's, hosted by NHS England, were established in April 2013 to provide CCGs, NHS England, acute trusts and local government with specialist non-clinical support services in order that clinician commissioners can use their strengths to focus on leading local system change and delivering the best outcomes for patients.

A number of CSUs are now developing strategic alliances amongst themselves or other partners while some have also formed mergers. It is anticipated that CSUs will become autonomous organisations in 2016 and will be fully established, self-sustaining entities in a competitive market. CCGs are expected to test the market in October 2016, to ensure that they are getting best value for money.

GEM CSU is one of the largest Commissioning Support Units in the country and provides a range of services to twenty CCGs with a population of around 5 million people. The CCG currently buys the following services from GEM in a contract that is due for review in October 2014.

| Ref | Service Line |
|---|---|
| 1 | Continuing Health Care |
| 2 | Communications and Engagement |
| 3 | Contract Management, specifically 3a Performance management |
| 4 | Finance |
| 5 | Commissioning intelligence |
| 6 | Clinical procurement |
| 7 | Service redesign |
| 8 | People and change |

### 3.6 Vision, Values and Strategic Aims

The CCG's vision, values and strategic aims have remained unchanged over the last two years and remain at the heart of the CCG.

The CCG's vision is to improve health by meeting our patients' needs with high quality and efficient services, led by clinicians and delivered closer to home.

The CCG's values are shown below and are based on the views of its staff, member practices, clinicians, the public, patients and carers, and partner organisations. The CCG spent time talking and listening to people about the changes it would like to see in local healthcare and where it should be focusing its efforts.


The broad themes that stood out in what people told us were:

- care delivered closer to home including access to services in patients' own homes and other alternatives to hospital admissions;
- closer working with social care to improve care pathways;
- more work on prevention (reducing diseases through screening, advice and health checks);
- better quality and more effective services.

Taking these themes into account, the CCG developed its six strategic aims:

| No. | Strategic aim | What it means |
|---|---|---|
| 1 | Transforming services (and enhance quality of life for people with long-term conditions) | With a particular focus on COPD, diabetes, dementia, mental health and learning disabilities |
| 2 | Improving the quality of care | Focusing on clinical effectiveness, safety and patient experience, with specific goals to deliver excellent community health services and improve the quality of primary care |
| 3 | Reduce inequalities (in access to healthcare) | Targeting areas and population groups with the greatest need |
| 4 | Integrating local services | Between health and social care and voluntary sector and between acute and primary/community care |
| 5 | Listening (to our patients and public) | Our commitment is to listen, and to act on, what our patients and public tell us |
| 6 | Living within our means | The effective use of public money |

### 3.7 Staff Opinion Survey

The NHS National Staff Opinion Survey has been, and will continue to be, an enabler for NHS organisations to listen to and act on the views of their staff. The survey measures a range of aspects of working life and enables organisations to monitor how well they are doing against the pledges made to staff in the NHS Constitution.

The CCG recognises that having motivated and engaged staff is linked to a positive experience which is why it's important to receive and act on feedback in order that we can deliver our vision and strategic aims.

The last national survey took place in autumn 2013. CCGs, Commissioning Support Units and Social Enterprises were given the option to participate and were encouraged to opt in if it was appropriate for them at the time.

In September 2013, the CMT agreed that the CCG would participate in the survey and Quality Health Partners, one of three approved suppliers, were appointed to administer the on-line survey which opened on 28 October 2013 and closed on 3 December 2013. The CCG achieved an impressive 92% response rate. The overall national response rate for all organisations in England was 49% and for participating CCGs it was 75%.

Preliminary results were received on 16 December 2013 and were shared with staff at the CCG time out on 20 December 2013. The full set of reports was provided by Quality Health Partners in March 2014.

Some of the areas where the CCG's results were better than the average for all CCGs/CSUs participating in the survey are:

| Question | CCG | All |
|---|---|---|
| Proportion of staff having some sort of appraisal or review in the last year | 67% | 58% |
| Following appraisal left feeling work valued by organisation | 81% | 73% |
| Having clear planned goals and objective for job | 69% | 60% |
| Immediate manager can be counted on to help with difficult work | 84% | 75% |
| Senior managers involve staff in important decisions | 52% | 42% |
| Communication between senior management and staff is effective | 55% | 42% |
| Care for patients is organisation's top priority | 87% | 66% |

With regard to staff engagement, it is reassuring that 70% of respondents would recommend the organisation as a place to work which is higher than the 53% for all CCGs/CSU's.

The management recommendations included:

- Training levels are low and need to be reviewed in light of priorities;
- Appraisals are a key opportunity to communicate with staff as well as hear and act on their concerns;
- Good communications scores with senior managers – staff: easier to do in a relatively small organisation and key in light of rapid change in CCGs.

In addition, the Corporate Management Team recognised that:

- Whilst the reported incidents of work related stress are consistent with Quality Health Partners' national response rate, it is higher in some areas than others and needs to be further explored and understood;
- The reported incidents of staff reporting to have experienced harassment from managers or colleagues needs to be further explored and discussed as part of the CCG's local action plans.

After reviewing the results at an organisational and team level the CMT initiated a number of actions some of which are detailed in Section 5.

### 3.8 Health of the local population

Some of the health challenges and characteristics of the CCG's local population which help form the CCG's strategic priorities are:

- generally better health than the overall population of England;
- average life expectancy figures are higher than the England average;
- a relatively affluent, rural patch with areas of deprivation;
- a high and rising elderly population;
- a significant number of people affected by ill-health, including GP-diagnosed coronary heart disease, hypertension and diabetes;

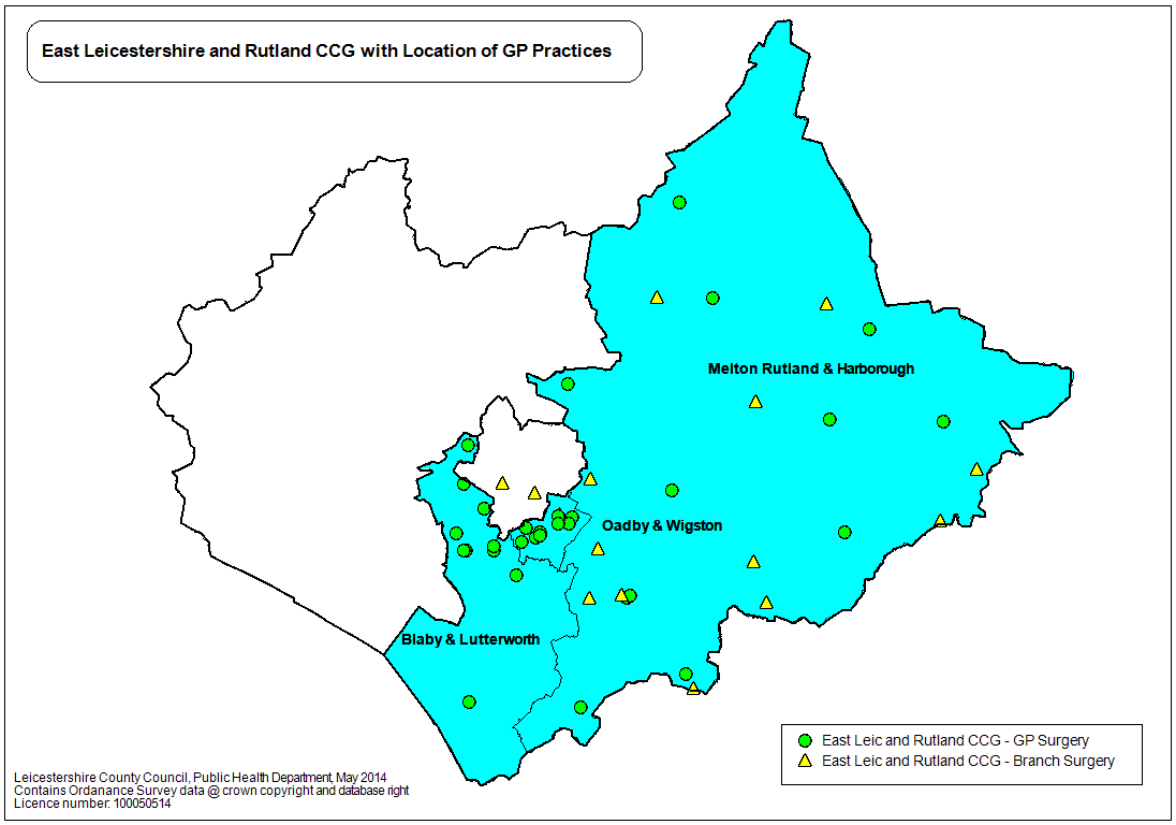
- the major killers across the patch are: cancer; coronary heart disease (CVD) and respiratory disease (COPD) which together account for 72% of all deaths;
- an estimated increase of 103% in dementia sufferers by 2030.

The CCG's commissioning plans are designed to support the strategic aims and to address the health needs of local residents and therefore to deliver the kind of healthcare that local people have told us they want and need.

### 3.9 The local health economy

The CCG commissions health services worth approximately £320 million for people registered with its practices. There are two other CCGs in the Leicester, Leicestershire and Rutland (LLR) health economy: West Leicestershire CCG and Leicester City CCG. The three CCGs have a combined population of approximately 1m people and a total allocation for commissioning healthcare of just over £1 billion.

The diagram below illustrates the location of the CCG's general medical practices and five community hospitals.




The CCG holds contracts ranging from a number of small grants in the voluntary sector to a c£125m contract with the main acute provider, University Hospitals of Leicester NHS Trust (UHL) which provides acute hospital services at its three sites in Leicester and in local community hospitals.

Leicestershire Partnership NHS Trust (LPT) is the main provider of community health, mental health and children services which includes school nurses and health

visitors. LPT manages most of the community-based teams serving the CCG and is a key provider at the five community hospitals.

East Midlands Ambulance Service NHS Trust (EMAS) provides emergency 999 and urgent care crews across Derbyshire, Leicestershire, Rutland, Lincolnshire, Northamptonshire and Nottinghamshire.

NHS England has multi-faceted roles in relation to the new commissioning sector with prime importance being assurance, support and development of CCGs and co-commissioning with CCGs. NHS England's Area Team for Leicestershire and Lincolnshire is fully committed to improving health outcomes for the people of Leicester, Leicestershire, Lincolnshire and Rutland regardless of their circumstances. The area team works in partnership with: local CCGs; local authorities and district councils and local Healthwatch bodies on its patch, in addition to: Public Health England; Health Education England (East Midlands); and the NHS Trust Development Authority, to achieve these outcomes in its area. The area team is also responsible for managing European Cross Border Healthcare nationally and specialised commissioning and networks and senates regionally.

East Leicestershire and Rutland CCG acts as the co-ordinating (lead) commissioner for the following contracts on behalf of the three LLR CCGs:

- Continuing Health Care (via GEM CSU)
- Out-of-county contracts (acute);
- Out-of-county community health services;
- East Midlands Ambulance Service;
- Non-emergency patient transport services – Arriva Transport Solutions;
- Any Qualified Provider (AQP) contracts;
- Leicester, Leicestershire and Rutland voluntary sector arrangements;
- Community based elective care alliance arrangement;
- Home oxygen service contract.

Leicester City CCG coordinates the UHL contract and West Leicestershire CCG coordinates the LPT contract on behalf of the three LLR CCGs in addition to some other contracts.

Embedded in the NHS reforms of 2013 is the requirement for far greater integration and partnership working with a number of different organisations. Over the last year, the CCG has actively engaged with partner organisations to build on existing relationships, and develop new and improved relations with clinicians, patients and carers, public members, staff, partner organisations, including local authorities, and other commissioning agencies. The CCG works with many partner organisations and has established key working relationships with the following:

- NHS England Area Team;
- West Leicestershire CCG and Leicester City CCG;
- Greater East Midlands Commissioning Support Unit;
- Leicestershire County Council and Rutland County Council (particularly with social service commissioners and through Health and Wellbeing Boards);

- The CCG's four district or borough councils which are: Melton Borough Council; Oadby and Wigston Borough Council; Harborough District Council and Blaby District Council;
- Leicestershire and Rutland Safeguarding Children Board and Leicestershire and Rutland Safeguarding Adult Board;
- Voluntary sector providers and charities;
- Healthwatch Leicestershire, Healthwatch Rutland, and other patient and carer representative bodies;
- Leicestershire Police and Leicestershire Fire Services;
- De Montfort University and the University of Leicester.

The CCG is committed to making care more integrated in order to improve health for its population. The CCG has worked with its local authority partners to develop its two-year plans, to ensure health and social care work more closely together and that resources are used effectively. The CCG will do this through the Better Care Fund, strengthening its joint commissioning and working arrangements to deliver integrated care for older people and supporting people with long-term conditions (LTC). This is particularly crucial if the CCG is to meet its financial challenges through the transformation of care systems and improve the quality of healthcare across its providers.

### 3.10 Challenges facing the local health economy

In earlier 2014, the Government identified LLR as one of the eleven most challenged health economies in England and announced additional financial support for external management consultants to work with commissioners and providers to 'develop integrated five-year plans' which deal with the 'particular local challenges they face' and provides the greatest opportunity for financial return.

The LLR health economy suffers from an imbalance between acute services provided at UHL and those delivered in primary care and the community. The over-provision of hospital services in the context of funding constraints, rising demands and future pressures has driven commissioners and hospital leaders to draw up plans to move activity out of the acute sector. The CCG is working with our main providers, local authorities, EMAS, Arriva (patient transport) and the GP out of hours service to escalate the work started in 2013/14 to address the pressures faced within the urgent care system which includes improving the quality of care in the acute sector. An important part of this work will involve strengthening our primary and community provision in order to prevent avoidable admissions and reduce length of stay for patients who could be cared for within their home environment. In addition, in order to further improve planned care services we will continue the redesign that enables planned interventions to take place in alternative settings.

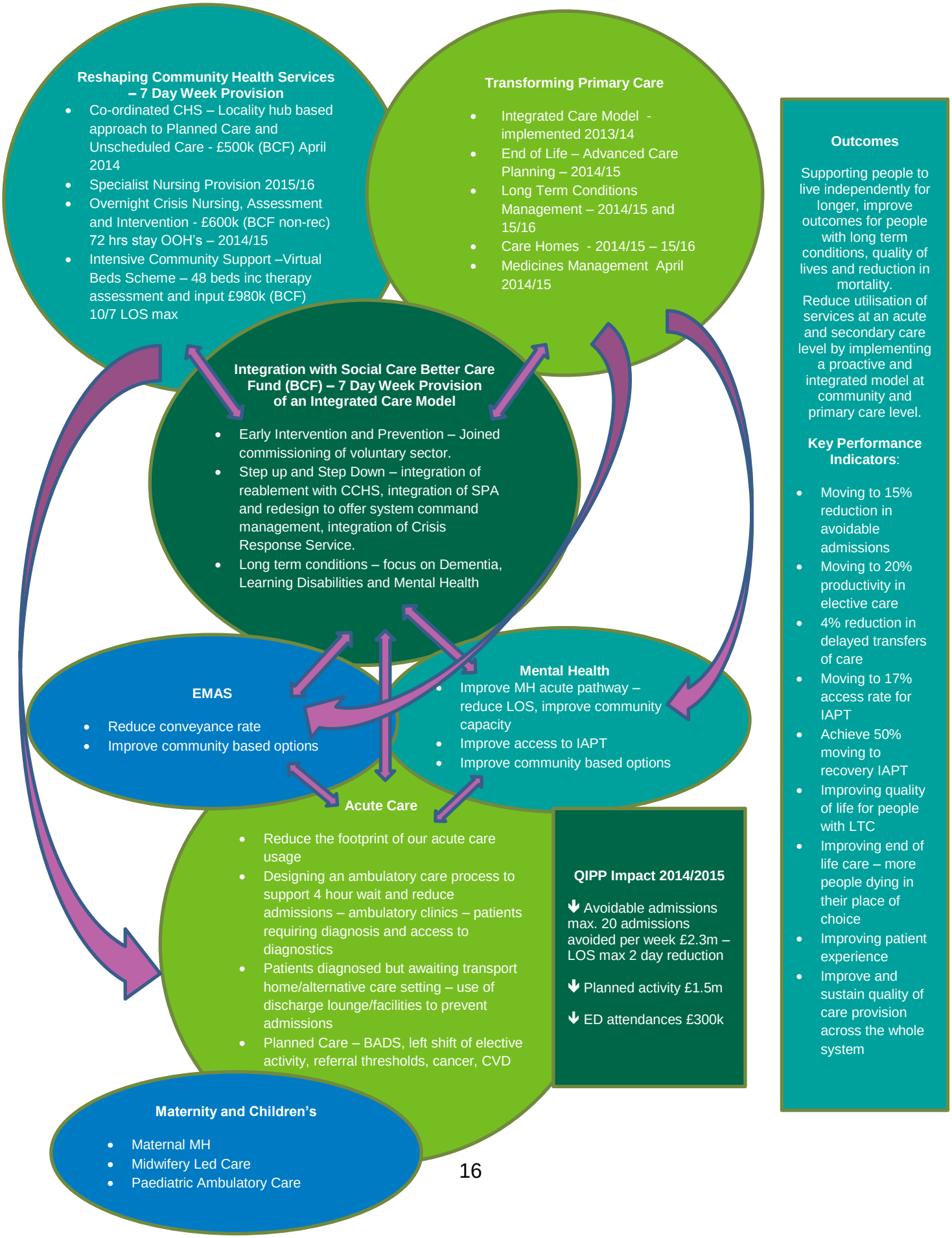
### 3.11 The CCG's priorities for the next two years (2014-16)

The CCG's Operational Plan 2014-16 details the key priorities for the next two years and our intentions to further develop partnership and collaborative working with our local authority partners, neighbouring CCGs and stakeholders in order to deliver the system redesign that is needed to address our local challenges and issues. The key priorities include:

- Continue to focus on the quality of care in our main providers of acute, mental health and community services;
- Reshaping community services to deliver locally based provision that enables patients to remain independent for as long as possible and have a better quality of life;
- Further integration of health and social care provision to transform care that is strong, sustainable and person centred which enables the health and social care system to meet the future demands;
- Service improvements which deliver better quality care and patient experience whilst reducing clinical variation, eliminating waste and delivering better value for money;
- Reducing pressure within our urgent care system to prevent avoidable admissions and reduce length of stay for patients who could be cared for at home;
- Support general practice to come together with new ways of joint working to enable primary care health teams to have more time to proactively manage patients with multiple illnesses, at the end of life, in care homes or at risk of admission;
- Children and their families will continue to be an important priority for the CCG;
- Working with our mental health providers, clinicians and service users to improve our acute mental health pathway.

Finally, the CCG is working in partnership with NHS England to formulate a five year strategy that focuses on some strategic health priorities.

**3.12 Plan on a page** - The diagram below provides an illustrative summary of the CCGs two year operational plan for system redesign for 2014-16



## Section 4 – CCG Assurance Framework

The CCG assurance framework was published in November 2013[7] and has been designed to provide confidence to internal and external stakeholders and the wider public that CCGs are operating effectively to commission safe, high quality and sustainable services within their resources. The framework is a key part of NHS England's commitment to support CCG development nationally and sets out a clear direction of travel, rooted in achieving CCG ambitions for improvements in health outcomes and the quality and safety of care, and focussed on developing healthy, vibrant, clinically led commissioning organisations.

### 4.1 The six domains

Details of the six broad assurance domains' under which assessment of CCGs will be made by NHS England are provided below.

| Domain | Description |
|---|---|
| 1: Are Patients receiving clinically commissioned, high quality services? | The CCG consistently demonstrates a strong clinical and multi- professional focus which brings real added value, with quality at the heart of governance, decision-making and planning arrangements to commission safe, high quality and compassionate care for patients. |
| 2: Are patients and the public actively engaged and involved? | The CCG demonstrates active and meaningful engagement with patients, carers and their communities which is embedded in the way that the CCG works. |
| 3: Are CCG plans delivering better outcomes for patients? | The CCG is delivering improved outcomes within financial resources, supported by clear and credible plans which are in line with national requirements (including excellent outcomes), and local Joint Health and Wellbeing Strategies. |
| 4: Does the CCG have robust governance arrangements? | The CCG has effective and appropriate constitutional, corporate, clinical and information governance arrangements in place, with the capacity and capability to deliver all its duties and responsibilities, including financial control, as well as effectively commission all the services for which it is responsible. |
| 5: Are CCGs working in partnership with others? | The CCG has strong collaborative arrangements in place for commissioning with other CCGs, local authorities and NHS England, as well as appropriate external commissioning support services and wider stakeholders including regulators. |
| 6: Does the CCG have strong robust leadership? | The CCG has in place great leaders who individually and collectively make a real difference. |

### 4.2 Key achievements in 2013-14

[7] NHS England CCG Assurance Framework for organisational health and capability 2013/14

This section provides details of some of the key activities and progress made against the six domains of the assurance framework in the twelve months since authorisation in April 2013. Whilst the domains have been used as a helpful framework to mark some of the CCG's achievements **it is not intended to represent an assessment** of the CCG's performance against the domains**.**

**Domain 1: Are Patients receiving clinically commissioned, high quality services?**

**Compassion in Practice: Nursing, Midwifery and Care staff**[8]
The 6Cs were launched to our practice nurses at the inaugural protected learning time event in June 2013. Local Practice Nurses were informed about the impact of the 6Cs on their work and their responsibilities. The CCG's quality team participated in a number of workshops throughout the launch of the 6Cs to share learning and best practice. The 6Cs have also been incorporated in the CCG's vision and values and staff handbook. All provider contracts have been reviewed to incorporate monitoring of the 6Cs.

**Equality Objectives**
The CCG's equality objectives have been developed to make sure that they are relevant to the CCG's role as a commissioner; focus on patient outcomes; and a proportionate and reasonable approach has been adopted in setting the objectives. This way, the CCG can make sure that the focus of the organisation stays on the areas that will have the greatest impact on improving services for patients.

**Francis Enquiry**[9]
Following the publication of the Francis Report in February 2013 into the failings at Mid Staffordshire NHS Trust, the LLR response was submitted to Governing Body in July 2013 and the CCG's action plan was approved in September 2013. Some of the actions that relate to the organisation and its culture included: updating the CCG's Constitution with the paragraph on whistleblowing as recommended by Sir David Nicholson; all CCG policies are being reviewed to remove any gagging clauses and ensure openness is included; through the vision and values events in December 2013, staff were made aware of their responsibilities in relation to Francis and the vision, values and expected behaviours of the CCG; staff induction and training programmes were reviewed and updated; as one of the Francis actions related to nurses being an integral part of NHS organisations, the CCG's Board Nurse attends all regional nursing forums as required; finally, the CCG has appointed a Practice Nurse Facilitator to work within the CCG to support Practice Nurses in the community.

**GP concerns**
In response to the Francis enquiry, the CCG has strengthened and simplified its systems for GPs to raise concerns with the implementation of the Reporting Poor Quality Care template. This LLR initiative is being rolled out across the patch to GP practices using SystmOne which will be followed in 2014-15 for EMIS Web users.

[8] http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf
[9] http://www.midstaffspublicinquiry.com/

In 2013-14 the CCG experienced the largest increase in the number of reported poor quality care concerns from 13 in Q1 to 55 in Q4.

**Practice visits**
During October to December 2013 all 34 GP practices were visited by clinical and management representatives from the CCG Governing Body. The visits focussed on: a CCG update; practice views, including their 'top three' issues; commissioning intentions - review and suggestions; a review of the practice profile - including positives and any potential issues, including activity / performance and quality. A report on the outcome of practice visits was submitted to Governing Body in March 2014.

**Practice Learning Events**
The 2013-14 programme of internal events for staff in GP practices included for GP Partners, Salaried GPs and GP Trainees: Paediatrics; Dermatology; Medicine for the Elderly and Medicines Management and Prescribing, events for Practice administration staff, managers, HCAs and Nurses (internal) included: Health and Safety Annual Update (joint practice event with Practice Managers and Building Manager); Customer Service Training (with Spire Leicester Hospital); Preparation for CQC inspection (joint practice meeting coordinated by Practice Managers).

**Safeguarding**
The CCG is a member of Leicestershire and Rutland Children and Adult Safeguarding Boards. Local Safeguarding Children Boards (LSCBs) are the mechanism that enables organisations to come together across the area and hold each other to account and to ensure safeguarding children remains high on the agenda across the region. The Safeguarding Adults Board promotes, informs and supports multi-agency safeguarding adults work and is underpinned by Department of Health guidance No Secrets 2000.

**Service Redesign**
The CCG has re-designed some patient pathways and re-commissioned services to improve patient experience and quality of care. Examples include: (i) Transformation of diabetes pathway – implementation of diabetes specialist nurses in primary care; (ii) The development of motor neurone disease pathway for patients to receive specialist nursing care in the community setting; (iii) Increasing the offer for pulmonary rehabilitation for patients with COPD in the community setting and (iv) Extension of the early supported discharge programme for stroke patients to include discharge from community hospitals.

**Winterbourne View**[10]
The National response to Winterbourne View Hospital sets out a programme of action to transform services so that vulnerable people no longer live inappropriately in hospitals and are cared for in line with best practice. The local response to transform care was approved by the Governing Body in April 2013.

**Working with our Providers**
As commissioners of local services we work closely with providers to ensure that

[10] https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response

organisations create positive cultures which will demonstrate improving quality of care for patients. Post Francis, we undertook an exercise to ensure that quality contractual mechanisms provided a strong framework for Commissioners to ensure that providers were responding to and acting on feedback from staff as well as focusing on ways to improve organisational culture. For 2014/15 providers are ready to respond to the national Friends and Family Test question for staff. During 2013-14 local providers have developed a large scale OD programme called 'Listening into Action'[11] which is an outcomes based approach to engaging people behind quality outcomes. It provides a comprehensive and joined-up way to tackle improvements in specific service areas, delivered through the direct engagement of the people who work there. This is complimented by organisational, health economy and regional work plans to embed Compassion in Practice.

**Domain 2: Are patients and the public actively engaged and involved?**

The CCG has held a number of successful engagement events all of which build on our goal to 'Listen, Respond and Deliver'. Some examples are:

**Be Healthy Be Heard Membership Scheme**
The CCG's membership scheme is a key enabler to engagement. The membership is largely demographically representative of the CCG's area and consists of over 4,000 members of the public. Members are given information via monthly email bulletins and a quarterly newsletter to keep them informed of the CCGs commissioning priorities and projects along with information to help members be as healthy as possible. Members sign up to the scheme as a mechanism to feedback into the CCG and have their views heard.

**Developing the CCG's Equality Objectives**
In developing its equality objectives for 2013-15 the CCG analysed and assessed its equality performance by reviewing various sources of information including feedback from engagement activities with patients, carers, community groups and staff over the last 12 months in preparation for reviewing its commissioning intentions which have formed the basis of the CCG's 2014-16 Operating Plan.

**Informing and Involving Strategy**
The CCG's Informing and Involving Strategy was approved by the Governing Body in July 2013 and refreshed in September 2013. The refreshed strategy outlines our approach to communications and engagement and sets challenging objectives for the CCG to ensure patients and the public, stakeholders, clinicians and staff are fully and effectively involved in commissioning decisions.

**Patient Participation Groups and Patient Reference Groups**
The majority of the CCG's GP practices now have a Patient Participation Group (PPG) or Patient Reference Group (PRG). The CCG has invested time in helping schemes to develop and hosts a quarterly PPG/PRG Chairs' Network meeting to facilitate sharing of best practice and knowledge. To date the network and individual patients and groups have contributed to development of our vision and values, our work to understand patient experience of local services and our

[11] http://www.listeningintoaction.co.uk/LiA-info/

commissioning intentions. Under the Involving and Informing Strategy, we will continue to work with the patients involved in these groups to ensure their views are represented in our decision making.

**Patient and Public Engagement Group**
The CCG has established the group to help strengthen and improve the way it involves local people in its planning and decision making and met for the first time in February 2014.

**Patient Experience**
The patient experience work plan was approved at the Governing Body in November 2013 and the patient experience project was approved at Governing Body in February 2014. In October 2013, the CCG introduced an initiative to take patient stories to the public meeting of the Governing Body. Subsequent stories have been discussed at December 2013 and March 2014 meetings of the Governing Body.

**Review of Urgent Care Services**
As part of a pre-consultation engagement exercise over 5,000 stakeholders, patients and members of the public were asked to consider the proposed options for the future of urgent care services in East Leicestershire and Rutland and tell the CCG if they thought they were reasonable and clear. This was followed by a public consultation process which took place from 24 February 2014 to 18 April 2014. During this time, 31 face to face engagement opportunities took place for patients and the public to feedback their views to the urgent care review project board members. Engagement methods included: eight consultation drop-in sessions and 23 visits with the CCG's listening booth to community groups and locations highly frequented by members of the public. The visits were supported by members of Healthwatch.

**We are Listening**
We are listening is a new initiative launched in February 2014. Staff from ELR CCG joined forces with volunteers from Healthwatch Rutland to visit towns and villages across Rutland to ensure the voices of Rutland influence health and social care. This partnership project between the CCG and Healthwatch Rutland is supported by Rutland County Council and First Contact Rutland. This three-month pilot project ran until April 2014, with the hope that the initiative will become a long-term joint commitment.

The initiative utilises a Listening Booth, a portable kiosk, to speak to the public, patients and carers outside of healthcare locations to find out how people feel about healthcare, their recent experiences, what patients would like to see in their local area and what matters most to people about their healthcare.

**Domain 3: Are CCG plans delivering better outcomes for patients?**

- We have increased the COPD prevalence which means that we are identifying

patients with COPD earlier – earlier identification enables better condition management in primary care – however we still have some way to go to increase prevalence. Achieved 80% of stroke patients spending 90% of their time on a stroke specific unit.

- In May 2013 the CCG ratified the financial Prescribing and medicines optimisation strategy which sets the vision and way forward for prescribing and medicines management over two years against six key goals.

- In 2013-14 the CCG created and delivered a plan aligned to its strategic vision with specific recurrent and non-recurrent investments created to support operational plans in conjunction with the Strategy Team.

- Despite being nationally underfunded per head of population, the CCG achieved a balanced financial position at the end of 2013-14.

- The CCG has submitted a balanced operating plan for 2014-16 which will deliver a 1% surplus control total in both years whilst still meeting organisational objectives and aims.

- The annual Value for Money (VFM) assessment was completed in March 2014 by the CCG's external auditors. Areas of assessment included: Leadership; Commissioning Plans; Financial Planning and Management; Data Quality and External Relationships, the CCG is anticipating positive feedback from this assessment.

**Domain 4: Does the CCG have robust governance arrangements?**

- The CCG's Constitution was ratified by the Governing Body in May 2013 and approved by NHS England in July 2013. The revised constitution included updates to the Scheme of Reservation and Delegation, prime financial policies and operational schemes of delegation. The constitution describes the governing principles, rules and procedures that the CCG will establish to ensure probity and accountability in the day to day running of the group to ensure that decisions are taken in an open and transparent way and that the interests of patients and the public remain central to the goals of the group.

- Quarterly assurance and check point meetings with NHS England to demonstrate the CCG is meeting the requirements of the six domains for assurance/authorisation.

- The 360 degree Stakeholder survey (part of the assurance process) for 2013-14 is complete and will be used as part of NHS England assurance process in June 2014.

- The CCG's Equality and Diversity Strategy 2012 – 2015 was approved by the Governing Body in June 2012 and sets out the CCG's approach to promoting equality and diversity and how it will meet its Public Sector Equality Duty

(PSED). The CCG has met the specific duties as it: (a) agreed its equality objectives for 2013-15 in October 2013 and (b) published information to demonstrate its compliance with the Equality Duty in January 2014.

- The CCG's Committee structures and committee terms of reference have been reviewed as required. The Governing Body receives reports from each of its sub-committees on a regular basis.

- The CCGs Risk Management Strategy and Policy was approved at Governing Body in April 2013 and introduced a two tier risk management structure. The first is the Corporate Risk Register or Board Assurance Framework and secondly, operational level risk registers at department level.

- The CCG regularly publishes information on its website as part of its Publications Scheme as required under the Freedom of Information Act 2000.

- The CCG regularly reviews the organisational capacity/capability against risks within the Corporate Risk Register and Governing Body Assurance Framework.

- The Governing Body receives assurance and is regularly updated of any local implications and actions which arise from national reviews.

- The CCG's on-going programme of development sessions for the Governing Body included:

| Month | Topic |
|---|---|
| April 2013 | Safeguarding in Prevent - a strategy to tackle the influences of violent extremism and support those vulnerable individuals who are drawn to it |
| September 2013 | Governing Body roles and responsibilities |
| December 2013 | Organisational Development Plan and Development for the Governing Body |
| January 2014 | Governing Body roles and responsibilities and the CCGs leadership model |

**Domain 5: Are CCG working in partnership with others?**

**Stakeholder Survey**

The annual 360$^{o}$ stakeholder survey was conducted by Ipsos Mori on behalf of NHS England during March – April 2014 and allows stakeholders to provide feedback on their working relationships with CCGs. The survey is a key part of ensuring these strong relationships are in place local system and provides CCGs with on-going information, advice and knowledge to help them make the best possible commissioning decisions.

In the 2013 survey, 64 stakeholders were identified to participate in the survey and there were 40 respondents. The survey identified several areas where the CCG scored better than other CCGs, for example, to what extent to you agree that the CCG has acted on suggestions where 63% of ELRs respondents said

they strongly or tend to agree in comparison to other CCGs nationally where the score was 51%. The survey also identified several areas where the stakeholder feedback ranked the CCG the same as other CCGs. There were also some areas where the CCG did not score as well as other CCGs and in some cases where stakeholders reported a lower score than in last year's survey. These areas have been incorporated in Section 5.

**Collaborative Commissioning**
The CCG reviewed its arrangements and established a Memorandum of Agreement for collaborative working which included creating the Performance Collaborative and Commissioning Collaborative Boards. As part of these arrangements, the CCG is lead commissioner for a number of contracts and providers (section 3.9). Whilst some good progress has been made in relation to collaborative working across LLR, this remains a critical factor to the success of system and service redesign.

**Health and Wellbeing Boards**
The CCG is a member of both the Leicestershire County Council and Rutland County Council Health and Wellbeing Boards (HWB). The Health and Social Care Act 2012 establishes HWB as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. HWB members will collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future.

The CCG's priorities are informed by the Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Strategy of our two County Councils. The CCGs works with its Public Health colleagues to better understand local needs and issues of our diverse population.

**Healthwatch**
A representative from Healthwatch Leicestershire and Healthwatch Rutland are in attendance at public meetings of the CCGs Governing Body. Healthwatch is the independent consumer champion operating at both national and local level created to gather and represent the views of the public and people who use services.

**Domain 6: Does the CCG have strong robust leadership?**

- The CCG is a clinically lead organisation with an Accountable Officer and Managing Director who was until joining the CCG a full-time GP. In addition, membership of the Governing Body includes several GPs, a secondary care clinician, public health consultant and executive Nurse.
- The CCG's Board Development programme in January 2014 focussed on a review of roles, responsibilities and behaviours of members of the Governing Body. In March 2014, the Governing Body proposed that clinical leadership and capacity be reviewed and two additional GPs be appointed to the

Governing Body. A proposal was put forward to the CCG's Member Practices for approval which will result in the appointment of two clinical vice chairs without responsibility for a locality.

- The Chief Officers, Head of Corporate Governance and Legal Affairs and Head of Communication and Engagement completed and received feedback using a 360 appraisal tool.

- The CCG is a member of the East Midlands Leadership Academy. During the year, 14 delegates attended 31 training days. Programmes attended include: Board Effectiveness; Compassionate Leadership and a variety of financial skills development workshops.

- Locality leads engaging with member practices.

**Staff satisfaction**

Staff satisfaction is an important workforce measure of how content or satisfied employees are with their jobs. During 2013 the CCG did a number of things in response to the 2012 staff opinion survey's findings and to further build the level of staff satisfaction. Some examples are: to hold regular staff briefings and the introduction of 'Ask the boss' or 'Dear Dave'. The CCG launched an internal staff newsletter and has hosted a number of charity events and marked key celebrations during the year.

The following relevant indicators are taken from the 2013 survey results:

| Question | CCG | All |
|---|---|---|
| Senior managers involve staff in important decisions | 52% | 42% |
| Communication between senior management and staff is effective | 55% | 42% |
| Staff would recommend organisation as a place of work | 70% | 53% |

### 4.3 Other achievements

The table below captures some of the other key achievements and successes in the CCG's first year since authorisation from April 2013 to March 2014

| Quarter | Achievement | Detail |
|---|---|---|
| April to June 2013 | CCG Structure | • CCG management structure in place and virtually populated by 1 April 2013 |
| | Protected Learning Time Event | • First ever GP training event of this scale in our area. More than 400 GPs. Practice nurses, health care assistants and practice staff. Start of a successful programme of events aimed at making a difference for our patients |

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| Oct – Dec 2013 | Finance Team Re-structure | • The CCG restructured the finance team in order to provide better financial support to the CCG directorates and to offer career progression and development opportunities for the finance team |
| | Bullying and harassment training | • Fifty six members of staff attended one of 6 training sessions. As a result fifty two delegates said that they would feel more confident to report any incidents of bullying and harassment should they experience it |
| | Vision and Values Events | • Sixty members of staff attended one of four visions and values events. As a result, 90% of attendees understand the organisations vision, values and strategic aims and how their role and the roles of others contribute better |
| | Staff Survey | • Achieved 92% response rate |
| Jan to March 2014 | Team events | • There has been a number of team development sessions which have focused on improving teams work and communications, examples include the Nursing and Quality team in February and the Medicines Management team in March |
| | Media Training | • For all members of the Governing Body including GPs |
| | The Better Payment Practice Code | • The Code requires CCGs to pay all valid invoices by the due date, within 30 days of receipt, or within agreed contractual terms. In February 2014, the CCG became an approved signatory of the Prompt Payment Code, an initiative devised by Government and the Institute of Credit Management. Approved signatories agree to pay suppliers on time; give guidance to resolve disputes quickly and encourage others to sign up to the code. |

## Section 5 - OD Plan

The plan details the products and/or interventions that are required against a number of areas which have been grouped into five sections: (i) Governance and Assurance; (ii) Leadership Development; (ii) Organisational Effectiveness; (iv) Primary Care Development; and (v) System Change.

| Ref | Product and/or intervention | Planned development |
|---|---|---|
| 1. | Governance & Assurance | **CCG Assurance**<br>• On-going quarterly assurance conversations (checkpoints) with NHS England Area Team.<br>• Publish Annual Report and Accounts and host Annual General Meeting.<br><br>**Changes to Leadership Model**<br>• Proposal approved by Governing Body April 2014.<br>• Following expressions of interest and interviews, two appointments made wef 01/07/14 pending approval of changes to constitution by NHS England in June 2014.<br><br>**Election/re-election of GP Locality Leads**<br>• Initiate a process to elect/recruit GPs to fill vacant locality lead posts on the Governing Body.<br>• Initiate an election process for locality leads coming to the end of their initial term of office.<br><br>**Collaborative working**<br>• Review arrangements for collaborative working across LLR (approved by Governing Body May 2013).<br><br>**Equality Objectives**<br>To meet the Public Sector Equality Duty contained in the Equality Act the CCG is required to: (a) publish information to demonstrate their compliance with the Equality Duty at least annually; and (b) set equality objectives at least every four years. |

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| | | The CCGs Equality Objectives for 2013 – 2015 are:<br><br>1. Addressing needs of older people and access to services<br>Year 1 – undertake baseline to identify what access looks like at present and identify gaps. Aligning this to the duty to have regard to reducing health inequalities, improving access and health outcomes.<br>Year 2 – review the results of the baseline and identify areas to address / change. Develop plans for improving access for older people as identified through the baseline.<br><br>2. Targeting provision and access to seldom heard groups – travelling families, BME, LGBT, rural deprivation<br>Year 1 – define what is meant by "seldom heard groups / communities" in relation to East Leicestershire and Rutland population in comparison to Leicester, Leicestershire and Rutland. Review how the CCG is currently engaging with these groups and how these mechanisms can be strengthened. Identify and map existing mechanisms of engagement through which the CCG accesses / or can access these groups / communities to gather intelligence. Consider how the CCG engages with the local authorities in strengthening engagement with these groups / communities.<br>Year 2 – using the information / intelligence gathered in year 1, identify how the CCG is going to target / prioritise provision.<br><br>3. Access to early intervention and prevention of Mental Health issues<br>Year 1 – evaluate and understand local mental health issues in relation to young people and other groups. Review access to early intervention and identify what is currently available in order to prioritise and improve health outcomes across East Leicestershire and Rutland.<br>Year 2 – baseline undertaken will determine actions for year 2. For example this could be work with young people to identify mechanisms for improving access to mental health services. Year 2 will be about using the information to improve outcomes for patient and prioritise mental health services.<br><br>The Corporate Management Team are responsible for developing a detailed plan underpinning each of the objectives and the actions and milestones to be achieved over the next two years. Progress against the equality objectives will be reviewed in line with the CCG's two year operational plan. The Governing Body will receive a progress update against the equality objectives on a quarterly basis with the first report to be received in July 2014. |

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| | | **Actions in response to National Reports**<br><br>**1. Francis**<br>• Complete review of organisational policies to remove any gagging clauses and ensure openness is included.<br>• Once complete, each member of staff will receive a copy of the CCG's Staff Handbook, which will include reference to the vision, values, NHS Constitution and duty of candour.<br>• Develop and deliver frequent staff induction programme for new starters to the CCG.<br><br>2. **Winterbourne**<br>• The CCG will be required to ensure that there is strategic oversight of LD arrangements embedded in the 5 year strategy, operational plans and team structures.<br><br>**Governing Body (Board) Development**<br>• Externally facilitated Board development will be procured at regular intervals throughout the period.<br><br>**Sustainability Strategy**<br>• The Sustainable Development Strategy for the Health, Public Health and Social Care System 2014-2020[12] was published in January 2014 and describes the vision for a sustainable health and care system by reducing carbon emissions, protecting natural resources, preparing communities for extreme weather events and promoting healthy lifestyles and environments. The CCG is in the process of updating its Sustainability Strategy and sustainable development plan to reflect the above publication with the aim to reduce the negative impact on the environment by managing energy use and reducing waste by switching to other sources of energy, improving recycling facilities and using fewer disposable items. The CCG will measure its success with regular reporting and evaluate progress as well as joining up with local Health and Wellbeing Boards. |
| 2. | Leadership Development | **Stakeholder Survey**<br>• The 2013 survey identified two key areas for development regarding the CCGs ability to effect real change through its commissioning decisions and confidence in the CCGs clinical and non-clinical leadership. Both of these areas will be addressed in 2014-15. |

[12] www.sduhealth.org.uk/sds

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| | | **Clinical leadership development needs**<br>• The following skills have been identified as areas of development for some clinicians on the Governing Body and will be addressed in 2014-15; leadership training – theory and practice; chairing meetings; introduction to project management; introduction to NHS finance and procurement and access to a coach.<br><br>**East Midlands Leadership Academy**<br>• The CCG will maximise its membership subscription with the Leadership Academy.<br><br>**Leicestershire Couty Council Leadership Development Programme**<br>• The Council invited the CCG to nominate managers to join its 'Leading for High Performance' development programme in recognition of the value it sees of joint leadership development given the integration agenda we are working on collectively.<br>• Eight delegates will attend the programme which will include a launch session, two 1-day programmes (Ambition during austerity and Wicked problems and the role of leadership) and a final session (Taking action).<br>• The programme will provide an opportunity to have critical conversations between your peers across the council alongside thought provoking development and activities and includes sessions on: emotional intelligence; resilience; and leading and maintaining high performance during sustained change. |
| 3. | Organisational effectiveness | **Appraisal process**<br>• The CCG has launched a new appraisal process which uses the NHS Healthcare Leadership Model and is based on self-review. The new process will ensure that all members of staff have personal objectives which are SMART and are aligned to the strategic aims of the organisation.<br>• Training will be delivered to all staff to embed the new process.<br><br>**Capacity and capability review**<br>• Conduct review of capacity and capability across CCG to identify any gaps in the skills required to deliver the required system change to the local health economy. |

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| | | **Mandatory and Statutory Training**<br>• All employees are required to evidence that their mandatory (required by CMT) and statutory (required by law) training is complete and in date. This involves a number of modules that are either completed on line or classroom based.<br>• Statutory modules include: Equality and Diversity: General Awareness; Fire Safety Awareness; Health and Safety Awareness; Introduction to Information Governance; Information Governance: The Refresher Module; Manual Handling Awareness; Mixed Messages / Conflict Resolution; Safeguarding Adults – Part A; and Safeguarding Children and Young People Level 1.<br>• Mandatory training modules include: Equality, Diversity and Human Rights Training; Fire Safety; Information Governance and Information Security; and Display Screen Equipment.<br>• The CCG will undertake a review to determine whether there is an alternative and more effective way to deliver mandatory training.<br><br>**Running costs**<br>• Given that the running cost allocation is expected to reduce by 10% in 2015-16, the CCG will need to review its infrastructure to ensure that it remains affordable. This equates to an annual saving of £786k in 2015-16.<br>• Test the market for services provided by GEM CSU to ensure that the CCG is getting best value for money (Oct 2016).<br><br>**Staff Opinion Survey**<br>• CMT reviewed and agreed corporate priorities.<br>• Cascade results and launch 'Team Challenge' 1 May – 30 June. Three elements: (i) discuss the results and agree local actions to address areas of concern; (ii) progress team outputs from CCG time out on 20 December 2013 to 'STOP' and 'Do differently' some activities; and (iii) ensure that all team members have completed and are in date for all statutory and mandatory training.<br>• Establish health and wellbeing task and finish group.<br>• Team challenge feedback event in early July 2014.<br>• Participate in future surveys (October 2014 and 2015). |

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| | | **Talent Management / Succession planning**<br>• Identify CCG critical roles and use Talent Management information from new appraisal process to produce Succession Plan and identify risk areas/plans to address.<br><br>**Training Needs Analysis**<br>• Complete TNA and produce CCG Training Plan with pooled training budget.<br><br>**Vision and values**<br>• Incorporate into CCG induction programme.<br>• Progress review of CCG values. |
| 4. | Primary Care Development | **Help reduce unplanned admissions (from two year plan)**<br>• Develop a model of integrated and coordinated community based services.<br>• Use changes to GMS contract for 2014/15 to complement changes in primary care.<br>• Operationalise the integrated care service developed between CCG and its two local authority partners.<br>• Develop model of locality based care co-ordinators to expand integrated care service and reshape community services.<br><br>**NHS England's Call to Action (from two year plan)**<br>• Develop a programme of support, advice and education to help GP practices to work closely together to deliver NHS England's 'call to action' for seven day working and proactive management of patients<br><br>**Disease Management (from two year plan)**<br><br>CVD<br>• Facilitate training and education in primary care to identify patients at risk of heart failure along with increased diagnostic access to Echo via the re-procurement of the existing service to improve speed of diagnosis.<br>• Pilot one stop heart failure clinic in the community and review role of specialist heart failure nurse with the possibility of expanding their current remit to include non-left ventricle systolic dysfunction. |

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| | | Cancer<br>• Implement initiative to support the early diagnosis of cancer.<br>• Extend GP access to diagnostics for suspected cancer diagnosis.<br>• Review and implement cancer risk management tools to extend the two week wait referral.<br>• Promote non-obstetric ultrasound of neck lumps with GPs and explore and scope the feasibility of extending direct access diagnostics to: flexible-sigmoidoscopy / colonoscopy to support the diagnosis of bowel cancer; and CT colonography (less invasive than a conventional colonoscopy) to support the diagnosis of bowel cancer in frail elderly patients.<br>• Promote the use of cancer risk management tools, (which work out the risk of a patient having a current but as yet undiagnosed cancer taking account of their risk factors and current symptoms) such as QCancer with GPs.<br><br>Respiratory Disease<br>• Continue to support general practices to continue the improvement programme of managing patients closer to home: Case finding; Spiro metric competency assessment and Inhaler technique education and training to primary healthcare professionals.<br>• For 2015/2016 the CCG will continue to work in partnership with its two local authorities, to drive forward integrated working.<br><br>Dementia[13]<br>• The CCG has been working with care homes to provide the specialist dementia support in-reach service. The care pathway is aligned to the memory assessment pathway and the community care memory assessment clinics and local authority dementia advisor support services. This will continue for 2014/2015.<br>• Continue to develop primary medical care to develop the care of dementia with general medical practice as well as work closely with community and secondary care to ensure dementia has a key focus on care delivery.<br><br>End of Life<br>• The CCG will work in partnership with Macmillan Cancer Support. A specialist palliative care nurse will work alongside GPs and practice nurses with close liaison with community nursing teams and secondary care to develop advanced care plans following the opening dialogue between patients and carers.<br>• GPs will receive mentorship support from a GP with a special interest in palliative care who will provide clinical |

[13] LLR Joint Dementia Commissioning Strategy (2011-2104)

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| | | leadership by promoting excellence in end of life care for all patients and improving lines of communication between all providers.<br>• The focus of the primary care programme will be: increase practice palliative care registers; the development of an advanced care plan; information sharing with out of hours and after death audit.<br>• Training, education and specialist palliative care support will be sourced through Macmillan Cancer Support services and LOROS.<br><br>**Primary Care (from two year plan)**<br>• Help general practice to come together with new systems of joint working to enable primary healthcare teams to have more time to proactively manage patients with multiple illnesses, at the end of their lives, in care homes or at risk of admission.<br>• Proactive care planning for all patients at the end of their lives.<br>• Proactively work with care homes to improve patient care and reduce unnecessary unplanned admissions.<br>• Combine care for patients with multiple long-term conditions through advanced planning and multi-disciplinary teams (MDT) working to reduce workload and patient visits to practice.<br>• Use of the medicines management team to work on a review of patients relying on multiple medications, medicines reconciliation (i.e. the process of identifying the most accurate list of all medications that a patient is taking), and proactive patient management, as well as improving the quality of prescribing.<br>• Focus on the systems and processes of our healthcare providers to improve the transition towards a primary care.<br><br>**Locality Meetings**<br>• Continue to develop and facilitate the locality structure (for the CCG's three localities) which provide a forum for member practices to feed into the CCG, feedback to their practices and discuss key issues and concerns.<br>• Monthly locality meetings to promote two-way discussion on all business and a mechanism for GPs to be updated on CCG matters to inform commissioning and planning processes; share learning from adverse events e.g. safeguarding issues etc; and monitoring of performance and quality through the sharing of benchmarked data and information.<br><br>**Practice Learning Time**<br>The following programme of events has been agreed: |

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| | | Q1 - Cardiac disease including heart failure and arrhythmias/respiratory disease including COPD and lung cancer;<br>Q2 - Hepatobilary disease/nephrology including CKD and acute kidney injury;<br>Q3 - Women's health Including antenatal care in patients with chronic disease, the new cervical screening programme and gynaecological cancers;<br>Q4 - End of life scenarios (case-based programme including non-cancer EoL scenarios for liver, renal, cardiac and respiratory conditions and cancer itself).<br><br>• In-house PLT events have yet to be decided with the focus for Clinicians likely to be on the new enhanced service for unplanned admissions, clinical leadership and change management and implementation of streamlined processes.<br><br>• Non-clinical staff / HCAs will be involved in a review of their skill-set with a view to up-skilling individuals to provide higher level services in addition to their currently contracted duties (e.g. training for practice receptionists in phlebotomy, undertaking ECGs etc).<br><br>• The external events for PMs, HCAs, PNs and admin staff are to be confirmed<br><br>**Practice Visits**<br>• Continued commitment to deliver programme of annual clinical visits to practices to inform our future commissioning intentions and to assure the CCG that practices are following best practice guidelines.<br><br>**Primary Care OD Support**<br>• Develop a programme of work to support GP practices progress their OD agendas to embrace and deliver the changes required in primary care.<br>• Two initial scoping meetings held prior to launch at PLT in June 2014. |
| 5. | System Change | **Community Care**<br>• Coordinating Community Health Services - further invest (BCF) in locality based approach to coordinate |

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| | | planned and unscheduled care, i.e. Intensive Community Support (ICS) and Integrated Crisis Response Service (ICRS).<br>• Nursing provision - conduct review of specialist nursing provision in community settings to ensure targeted use of specialist skills and optimum alignment with locality based coordinated CHS model.<br>• Step up and step down programme initiatives for 2014-15 include: Integrated Crisis Response Service; Night nursing assessment service; Develop intensive community support service and Discharge pathways and patient transfer minimum data set.<br>• Step up step down programme initiatives for 2015-16 include: improving support to care homes; older people's mental health and dementia.<br>• Expand the integrated care platform to reduce the reliance and demand on bed-based care services to wherever feasible, delivering coordinated, integrated services on a locality hub basis in order to move towards more community based provision.<br><br>**Mental Health**<br>• Review and redesign of our mental health acute system – this will include working with our partners and provider jointly to develop a model that improves the way we support people in a mental health crisis.<br>• Take a step-up and step-down approach to system-wide redesign - this will focus on the redesign of the mental health crisis service, adult community, emergency and inpatient mental healthcare services.<br><br>**QIPP**<br>Identify OD interventions required by Programme Leads to support five work streams:<br>• Changes to emergency attendances and emergency admissions;<br>• Changes to planned care, elective and outpatient thresholds;<br>• Transform primary care;<br>• Step up, step down programme;<br>• Transform mental health and learning disability.<br><br>**Partnership Working** |

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| | | • NHS England Area Team – understand the role and scope of clinical networks and senates.<br><br>**Workforce Development Team**<br>• Build links with local workforce development team and Health Education England.<br>• Understand the role of the LETB/C and how it can support LLR in addressing some of the workforce changes required to transform services and shift care from acute to community setting.<br>• Profiling the workforce to identify capacity/capability gaps in community nursing. |