NHS
Castle Point and Rochford
Clinical Commissioning Group

Commissioning Operational Plan 2014-2016

NHS Castle Point and Rochford Clinical Commissioning Group

V4.3

Feb 2014
Review Date:

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Name	Title	Organisation	Signature
Dr Sunil Gupta	Accountable Officer	NHS Castle Point and Rochford CCG	
Tom Abell	Accountable Officer	NHS Basildon and Brentwood CCG	
Claire Panniker	Chief Executive	Basildon and Thurrock Hospitals NHS Foundation Trust	
David Marchant	Chief Executive	Castle Point Borough Council	
Dr Anthony Marsh	Chief Executive	East of England Ambulance Trust	
Helen Taylor	Director of Integrated Commissioning & Vulnerable People	Essex County Council	
Cllr David Finch	Chairman, Essex Health and Well-being Board	Essex County Council	
Ian Stidston	Director of Commissioning	NHS England Area Team - Essex	
Sally Morris	Chief Executive	South Essex Partnership NHS Foundation Trust	
Dr Paul Husselbee	Accountable Officer	NHS Southend CCG	
Jacqueline Totterdell	Chief Operating Officer	Southend University Hospital NHS Foundation Trust	
Amar Dave	Chief Executive	Rochford District Council	
Dr Nimal Raj	Accountable Officer	NHS Thurrock CCG	

FOREWORD

Foreword by Dr Sunil Gupta, Accountable Officer, NHS Castle Point and Rochford CCG

The NHS is facing the great challenge of improving the quality of care provided to patients in an environment of flat cash. This plan outlines how Castle Point and Rochford CCG plans to rise to this challenge. Our vision is to enable the people of Castle Point and Rochford to live longer, healthier and happier lives by commissioning high quality, cost-effective, caring and compassionate services in partnership with our fellow health and social care commissioners. There are several components to this plan. We plan to help Patients and the Public have greater control and responsibilities for maintaining and improving their own health. We will support GPs to work more closely together and with community services to better manage long term conditions, support the frail elderly and reduce A&E attendances and admissions into hospitals and nursing homes. We will also work with other organisations in Essex to help the hospitals in Essex to work more closely together to provide centres of excellence. We welcome your comments, ideas and suggestions on how we can all jointly help to achieve these plans.

Sunil Gupta.

NHS CASTLE POINT AND ROCHFORD CCG VISION

Vision

Enable the people of Castle Point and Rochford to live longer, healthier and happier lives by commissioning safe, high quality, cost-effective, caring and compassionate services in partnership with our fellow health and social care commissioners. The Patients and Public will have greater control and responsibilities for maintaining and improving their own health. GPs will work more closely together and with community services to better manage long term conditions, support the frail elderly and reduce A&E attendances and admissions into hospitals and nursing homes. Hospitals in Essex will work more closely together to provide centres of excellence.

In pursuit of this vision over the next 5 years, the CCG will:

- Eliminate unnecessary waste in partnership with Southend CCG from our South East Essex system to maximise reinvestment, at the same time improving the quality of services, and to improve the health and quality of life for our population.
- Continue to deliver on both national and local commitments and targets as per NHS Constitution.
- Lead the local health community to ensure that patient insight shapes services, ensuring the best value for the best services.
- Face the challenges that are common across the NHS – the economic downturn, more people with long term conditions and an ageing population.
- As groups of GPs, the CCG will engage and work collaboratively with all stakeholders in redesigning patient pathways to improve efficiency, whilst maintaining standards of care, in such areas.
- Use the Public Health Data available, and by analysing performance reports for both secondary and primary care, will prioritise programmes with the greatest opportunity to deliver benefit in meeting the goals.
- Continue to deliver efficiency savings through clinical leadership and Peer Review process as the preferred approach to referral management.
- Work collaboratively with the neighbouring CCGs in South Essex on the comprehensive review and redesign of MSK (area of greatest expenditure).
- Work with the Essex County Council and neighbouring CCGs through Better Care Fund on the transformation of Community Services ensuring that the services commissioned ultimately meet the needs of our most vulnerable patients.
- Close working relationships will continue to be forged with local district and borough councils, in delivering the Health and Wellness agenda and health services in relation to older people.
- Focus on outlying our health indicators, which is deaths from CVD and cancer, which Public Health data attributes to the high elderly population. We will focus on raising awareness and initiatives aimed at early detection
- Focus on reducing variation in health care services evident across the member practices.
- Assist all member practices in becoming more efficient and cost effective by helping them through their CQC application processes, supporting their aspiration for developing GP Federations.

SYSTEM-WIDE PLAN ON A PAGE

The South Essex health economy is a system comprised of partners from Basildon and Brentwood, Castle Point and Rochford, Southend and Thurrock who have come together to agree, refine and implement the following vision

To make affordable high value health services available to all to improve the health and well-being of our population

System Objective One
Using a focus on personalised care and evidenced based innovative measures to empower individuals to manage their LTC more effectively, improving outcomes and reducing health inequalities

Delivered through intervention Self Management and Patient Education Programmes

- Focus on training primary care clinicians
- We will review and implement innovative technological solutions to support self management

System Objective Two
Improve patient experience for both physical and mental health services, using innovative methods to obtain real time patient feedback

Delivered through review of the following areas

- Stroke (Centralisation)
- Cancer (Centralisation)
- Maternity (Capacity Review)
- Vascular (Centralisation)
- Renal (Centralisation)

System Objective Three
As a Health Economy drive forward transformation of specialist services, supporting centres of expertise

Delivered through robust contract management

- Ensure adherence to WHO checklists / safety measures in Acute and Primary Care
- To commission safe services to ensure patient safety is paramount

System Objective Four
Improve patient safety to reduce harm and increase patient confidence in local health services

System Objective Five
Shifting 5% of resources from secondary to primary and community services

System Objective Six
Integrating Health Social Care through partnership working

System Objective Seven
Strengthened collaborative commissioning and contracting

Delivered through partnership working and contract negotiation

- Reducing acute emergency activity through integrated pathways, whole system working and proactive management of high risk patients
- Reducing planned care activity through redesign of pathways
- Transform primary and community care services delivered into Residential and Nursing homes
- Delivering the agreed outcomes for the Better Care Fund
- Community Contestability
- Integrated Nursing Model
- Mobilisation of Community Resources e.g. voluntary sector services
- Implement Dementia Network work programme
- All patients attending A&E to be reviewed by a consultant prior to admission
- GP and SPOR in A&E (front door model)

Overseen through the following governance arrangements

- ECC, CPR CCG & B&B CCG system leadership group overseeing implementation of the improvement interventions.
- Business Management Group of the H&W Board.
- System wide Urgent Care Group.
- Individual organisations leading on specific project

Measured using the following success criteria

- All organisations within the health economy report a financial surplus in 18/19
- Delivery of the system objectives
- No provider under enhanced regulatory scrutiny due to performance concerns
- With the expected change in resource profile

System values and principles

- No-one tries harder for patients and the community
- We will maximise value by seeking the best outcomes for every pound invested
- We work cohesively with our colleagues to build tolerance, understanding and co-operation

STAKEHOLDER ENGAGEMENT

NHS Castle Point and Rochford CCG has worked alongside local stakeholders in the development of our Strategic and Operational Plans for the next five years. This work includes:

Stakeholder	Engagement
Health and Wellbeing Board	Presentations of CCG vision for comments
Health and Wellbeing Board	Sign off of draft Operational Plan on the 12th February 2014
All Essex	BCF Fund event held with all local stakeholders - January 2014
SEPT	Board to Board meeting and QIPP Planning session – January 2014
Southend CCG	Board to Board meeting and QIPP Planning session – January 2014
Healthwatch	Essex Healthwatch representation on CCG Commissioning Reference Group
B&B CCG	Collaboration (aided by co-location) of Strategic and BCF Planning development
SUHFT	CAO direct engagement with SUHFT Chief executive and Essex system meeting in January
Patient and Public engagement	2 Call to Action Events in October across the both locality seeking patient feedback on services
Patient and Public engagement	Ongoing engagement via monthly Commissioning Reference Group (Patient Involvement Forum)

FINANCIAL SUMMARY

Supplementary Information to follow

1.1 IMPROVING OUTCOMES – 7 OUTCOME MEASURES

NHS Castle Point and Rochford CCG is committed to improving the health and wellbeing of our local population and will demonstrate the improvements made over the next two years, through the progress measured against the national NHS Outcomes Framework indicators included throughout this plan and the actions that the CCG plan to undertake to achieve these improvements in outcomes locally.

The CCG's performance against the five domains noted below and the seven national outcome ambitions has historically been better than the national average. However, the CCG continues to strive for the best outcomes for our population and further improvement in these areas. The focus for greater improvement has been set around the areas of greatest concern identified through the Joint Strategic Health Needs Assessment and this is highlighted in section 1.3 of this plan.

	7 national improving outcome ambitions:	Baseline	2014/15 Standard	Action Required	Lead	Deadline
1	Securing additional years of life for our local population with treatable conditions	1554	1553.6 (2014/15) 1553.2 (2015/16) 1552.8 (2016/17) 1552.4 (2017/18) 1552.0 (2018/19)	To improve the confidence and capability of GPs and Practice staff to recognise, assess, support and refer people with mental health problems. To improve primary care and preventative mental health services to facilitate support earlier and in the least restrictive environment.	MT	Mar 2016
2	Improving the health related quality of life for people with one or more long-term condition, including mental health conditions (2012/13 baseline 73.1 (Eng. Avg) and 74.4 (Essex avg.)	74.7 (CCG)	74.90 (2014/15) 75.10 (2015/16) 75.30 (2016/17) 75.50 (2017/18) 75.70 (2018/19)	Improving the case management of people who have been detained under the MH Act. Improving the case management of people who repeatedly attend A & E. Improve quality of reviews for people in residential and nursing care. Implement the use of personal health budgets to promote independence and individualised recovery focus service delivery. Facilitate the development of a Recovery College and Peer Support services.	MT MT MT MT JI	Apr 2015 Apr 2015 Apr 2015 Apr 2015 Apr 2015

	7 national improving outcome ambitions:	Baseline	2014/15 Standard	Action Required	Lead	Deadline
3	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	1636.1	1627.3 (2014/15) 1618.5 (2015/16) 1609.7 (2016/17) 1600.9 (2017/18) 1592.1 (2018/19)	Build on 2013/14 review of integrated community teams through establishing a dedicated service specification for SEPT to include all objectives set in BCF model. 100% GPs to have a named palliative care and community nurse, supporting practice level MDTs. In an effort to deliver integrated Teams across the locality the CCG will ensure that there is a health and social care provider in place that will support identification of patients at risk and ensure that appropriate care packages are in place to avoid unnecessary time spent in hospital: • BCF programme roll out to agree service specifications around integrated prime provider, funded by BCF. ○ Review risk stratification model and software to support. • Conclusion of Community Contestability and recommendations implemented. • Include at practice visits checks to ensure that high risk patients are being discussed at monthly MDT meetings. • 100% practices to have risk registers in place for high risk patients. • Finalise design of ambulatory care unit and associated pathways. • Commission community based intermediate care beds. • Recommission community geriatrician service to support proactive case management of patients in the community. • Commission dedicated Cancer Assessment Unit. • Implementation of Falls Prevention Strategy in partnership with ECC and B&B CCG. • A Continence Management Strategy to be developed and rolled out across Essex. • Redesign Diabetes Service to deliver and integrated service across acute, community and primary care to deliver improved services. • Develop a business case for improved carers support and commission jointly with ECC for implementation 2014/15. • To ensure all system specialist palliative care providers (including	EH KMK KMK KMK EH KMK KMK KMK EH EH EH EH (LP) EH (LP) EH (JM) EH KMK	Oct 2014 July 2014 March 14 June 14 July 14 Jun 14 July 14 March 15 Sept 14 Sept 14 June 14 April 14 TBC August 14

				voluntary sector) are fully integrated through one core MDT with strong clinical leadership. • By April all specialist palliative care providers will be using single electronic patient records (SystemOne). • Providing additional resource and support to practices in relation to managing patients in care homes.	KMK KMK	March 2014 April 2014
4	Increasing the proportion of older people living independently at home following discharge from hospital.			The CCG will enable locally integrated planning and commissioning (using BCF) across the following themes to deliver this ambition: Provide information and advice to minimise Social inclusion including prevention and early intervention • Deliver Dementia workstreams pathways as agreed through Dementia Network • With ECC Implement Falls Prevention Strategy • With ECC implement Incontinence Management Strategy • With ECC maximise support for Carers • Implement Urgent Care Pathways linked to admission avoidance including crisis response • With ECC ensure support for professional carers to raise standards in care homes, linking with providers of community services • End of Life Care - CCG will develop more integrated approaches and establish common areas to join up and improve End of Life care and support.	LP JM VM EH TD KMK	May 2014 Jan 2015 Sept 2014 Oct 2014 Dec 2014 Aug 2014
5	Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.	134.6	132.0 (2014/15) 129.5 (2015/16) 126.9 (2016/17) 124.4 (2017/18) 121.8 (2018/19)	Improve the care planning and management process to help people recover from a crisis and get home as quickly as possible. Improve the discharge planning to ensure people go home as soon as they're ready minimising the distress caused by delayed discharges.	KMK KMK	Feb 2015 Feb 2015

	7 national improving outcome ambitions:	Baseline	2014/15 Standard	Action Required	Lead	Deadline
6	Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community	5.7	5.57 (2014/15) 5.44 (2015/16) 5.31 (2016/17) 5.18 (2017/18) 5.05 (2018/19)	Commission responsive crisis care to ensure quick access to services when needed, by the right skilled teams in a safe and least restrictive environment, with good integrated pathways to reduce risk of relapse and support reablement. Explore development of alternatives to inpatient services. Work closely with Public Health to ensure: • People aged 40 – 74yrs on SMI registers access NHS annual health checks. • People on SMI registers access "Making Every Contact Count" Initiative • People on SMI registers have access to screening programmes • Inclusion in targeted lifestyle support programmes of people with mental health problems. Increase mental health training for community services.	KMK	March 2015

	7 national improving outcome ambitions:	Baseline	2014/15 Standard	Action Required	Lead	Deadline
7	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.			• Work with Acute providers to operate in a culture of openness, learning from SIs and transforming services dependent on patient feedback: o RCA undertaken o Quality visits / audits scheduled for 2014/15 o Working with provider to ensure mechanism in place to minimise the risk of preventable harm. o Safety thermometer compliance. o Mandatory training and investment in staff competencies via the appraisal process o Development of quality dashboard and quality outcomes framework.	TD	

1.1 IMPROVING OUTCOMES – 5 DOMAINS

The five NHS Outcome Framework Domains are outlined below and the subsequent delivery plan identifies how the CCG plans to achieve measurable improvements in performance against these areas during 2015/15 and over the next five years.

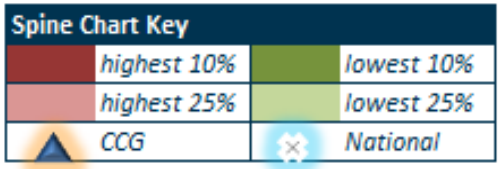
Although the CCG is historically performing significantly better than the national average in a number of areas, any area where performance is below the national average a standard has been set to ensure that performance improves to this level. In areas where the CCG is already performing better than the national average, performance has been stretched to achieve ongoing improvements in outcomes for our population with particular focus on the key health concerns for our population, as set out in section 1.3 below.

The CCG is committed to monitoring and improving the quality of services that are commissioned by moving from a traditional mode of performance monitoring to improving patient services by listening to and commissioning for the patients that access these services. This will be achieved by ensuring that our providers collect the views of service users through patient surveys, transactional websites to facilitate patient feedback and full roll-out of the Friends and Family test incentivised through CQUIN's. Quality outcomes will be developed with providers to focus not solely on activity but also, how well patients stay after treatments are accessed. The collection of soft data collection through a variety of methodologies will allow the CCG to proactively respond to complaints and concerns expressed by patients, the public and NHS staff. The CCG has recently reviewed its whistleblowing and complaints policies to ensure that there exist systems to capture any early warning signs of a failing service. The CCG is committed to listening to all concerns raised and ensuring that bespoke replies are delivered to all those raising concerns.

Domain 1	Preventing people from dying prematurely;
Domain 2	Enhancing quality of life for people with long-term conditions;
Domain 3	Helping people to recover from episodes of ill health or following injury;
Domain 4	Ensuring that people have a positive experience of care; and
Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm.

Domain 1: Preventing People from Dying Prematurely

The following indicators benchmark current CCG premature mortality from the major causes of death. The indicators consist of directly age and sex standardised mortality rate (DSR) per 100,000.



Period	National	Median	75th Percentile	CCG	% Var (Nat.)	CCG Percentile	Spine Chart (Diff from Median) (Limited to +/-100%)
Under 75 Mortality from Cardio Vascualr Disease							
CCGOUT303 2012	66.90	*66.35*	*77.46*	46.43	▼ 30.6%	4.2	

CCG rate is significantly lower than national average. The CCG is aiming to reduce the rate further through the actions outlined in the following delivery plan.

Under 75 Mortality from respiratory disease							
CCGOUT304 2012	28.25	*27.01*	*33.62*	21.60	▼ 23.5%	26.6	

CCG rate is lower than national average. The CCG is aiming to reduce the rate further through the actions outlined in the following delivery plan.

Emergency admissions for alcohol released liver disease							
CCGOUT305 2012/13	25.73	*23.40*	*33.20*	7.90	▼ 69.3%	0.9	

CCG rate is significantly lower than national average. The CCG is aiming to reduce the rate further through the actions outlined in the following delivery plan.

Under 75 Mortality from cancer							
CCGOUT306 2012	123.83	*122.13*	*135.01*	115.70	▼ 6.6%	31.9	

CCG rate is lower than national average. The CCG is aiming to reduce the rate further through the actions outlined in the following delivery plan.

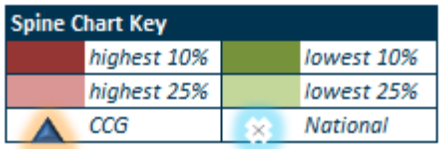
Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 1	Preventing people from dying prematurely;	Reducing<75 mortality rate from respiratory	15.96	27.44	15.95	Co-ordinated network review to be undertaken on respiratory pathways, looking at gender specific variation in respiratory mortality.	KMK/ LP/ST	Feb 2015
		Reducing<75 mortality rate from liver (2012)	12.90	15.40	12.89	Fully integrated MDT service model for management of liver disease to be established, including raising awareness and early detection, with local liver specialist leadership to be identified to reduce mortality rates.	KMK/ EH/ SG	March 2016
		Reducing<75 mortality rate from cardiovascular	46.43	65.47	46.42	• Maximise the opportunity to utilise GPWSI, working through the CVD Network (including Public Health) to deliver new care pathways that enhance management of CVD in primary care and acute services. This will include GP education, diagnostics in primary care, patient awareness. • Support health promotion locally through initiatives around weight management, walking buses, establishing a credit bases system for patients with LTCs to incentivise healthy choices.	KMK/ JM/BK TD/AM/ DS	December 2014 June 2015
		Reducing<75 mortality rate from cancer disease	115.70	123.26	114.75	• Engage directly with member practices in relation to their responsibilities around early detection. • Roll out education programme across CP&R locality. • Supporting cancer specialisation through implementation of the strategic clinical network. • Ensure that our Governing Body is sighted on screening performance and takes responsibility for maximising uptake to national screening programmes e.g. bowel cancer screening.	KMK/ LP/MM	Oct 2014 Oct 2014 Feb 2015 Mar 2015
		Excess under 60 mortality in adults with learning disabilities – *measurement under development*	tbc	tbc		• Ensuring all patients with LD have the opportunity to access comprehensive physical health assessments within the primary care environment.	TD/AM/ ST	March 2015

Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 1	Preventing people from dying prematurely;	Life expectancy at 75	CP M: 11.2 CP F: 13.3 R: M 11.6 R: F 14.0	M:11.4 F: 13.2	M: 11.3 F: 13.1	• Through public health leadership on our Governing Body, prioritise and support public health initiatives that improve life expectancy at 75.	KMK/ DS	March 2015
		Excess under 75 mortality rate in adults with serious mental illness	tbc	436.2		Through South Essex Mental Health commissioning Board and the Strategic Clinical Network work collaboratively to deliver South Essex Mental Health strategy including reducing mortality rates and initiatives such as: • 100% of mental health patients to have an annual health check. • Identification of high risk patients in primary care settings, reviewing prescription items. • Working with lead providers to reduce suicide rates. • Ensure through contract that there are robust arrangements in place to maximise opportunities for patients to access employment post mental health acute episode. • Improving access to IAPT services to 15% (see IAPT below) • Through contract ensure early psychosis have high quality intervention / crisis plan.	 TD SW KMK MT/DS JI MT	 March 2015 March 2015 March 2015 Feb 2014 March 2015 March 2015

Area	Aim	Indicator	2012/13 Baseline	National Avg.	Standard	Action Required	Lead	Deadline
Domain 1	Preventing people from dying prematurely;	Potential years of life lost from causes considered amenable to healthcare: adults, children and young people	1553.9	2060.8	1553.6 (14/15) 1553.2 (15/16) 1552.8 (16/17) 1552.4 (17/18) 1552.0 (18/19)	• Supporting young people with LTCs by identifying a lead clinician, as a point of contact. • Robust self management plans developed with the patient and their family/carer. • Access to high quality information and support, embracing mobile phone technology, looking at Apps to support self management. Provide schools within CP&R with a named GP link with a view to creating opportunities to provide advice, support and education. To include education sessions for parents around LTCs. Review CHIMAT data to identify key areas of focus across the locality. Work with Local Authorities to ensure special educational needs are in place from Sept 2014. Ensure that appropriate measures are in place to identify better health outcomes for children and young people.	KMK/ KS/CM CM CM	Oct 2014 Oct 2014 Sept 2014 Sept 2014 Sept 2014
		Survival from cancers (adults): ➢ One year survival (all cancers) ➢ Five year survival (all cancers) ➢ One year survival from breast, lung and bowel cancer combined ➢ Five year survival from breast, lung and bowel cancer combined	B 1yr: 94.7% B 5yr 81.9% L 1yr 28.4% L 5yr 6.6% CR 1yr 70.0% CR 5yr 52.9% **(DATA FOR ESSEX NETWORK)**	B 1yr:94.7% B 5yr 83.3% L 1yr 28.4% L 5yr 8.0% CR 1yr 69.4% CR 5yr 51.9%	B 1yr:96% B 5yr 85% L 1yr 30% L 5yr 9% CR 1yr 71% CR 5yr 53%	• Supporting the initiatives to raise awareness campaigns locally. Ensuring we are utilising the CCG's communication strategy to raise awareness. • Programme of practice visits led by public health to inform and support GPs on early detection initiatives. • See early detection actions above. • Support primary care clinicians following national initiatives aimed at raising awareness that wold impact upon primary care e.g supporting the cascade of information to clinicians through desktop guides.	KMK/ LP/MM KP KMK	March 2015 December 2014 June 2014 and ongoing

Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 1	Preventing people from dying prematurely;	Reducing deaths in babies and young children	4.8	4.2	4.2	• Review maternity model across south Essex, ensuring appropriate capacity and high level of care. • Through contract ensure robust arrangements in place to negate harm • Unique dedicated acute streamline pathways, ensuring appropriate intervention at the earliest point • Reviewing paed teams as part of Community Contestability	TD/HF/KS VG TD/HF/KS EH/JM	March 2016 Feb 2014 March 2016 Feb 2014
		Five year survival rate from all cancers in children				• Based on guidance from strategic clinical network for cancer, ensure the improving outcomes guidance for children and young people is fully implemented locally, with streamlined access to specialist centres, supported by robust local MDT arrangements. • Any recommendations arising from peer review of C&YP Cancer Services will be implemented by the CCG.	KMK/ CM/ MM KMK/CM/ MM	April 2014 TBC

Domain 2: Enhancing the quality of life for people with long term conditions

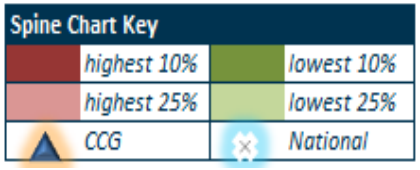


Period		National	Median	75th Percentile	CCG	% Var (Nat.)	CCG Percentile	Spine Chart (Diff from Median) (Limited to +/-100%)
Unplanned hospitalisation for chronic ambulatory care sensitive conditions								
CCGOUT402	2012/13	826.52	*82180*	*989.00*	762.40	▼ 7.8%	39.0	
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s								
CCGOUT403	2012/13	338.64	*327.80*	*40165*	258.30	▼ 23.7%	26.1	
% of patients with LTCs who feel supported to manage their condition								
CCGOUT401	2010	72.83	*73.13*	*75.41*	73.78	▲ 1.3%	59.0	
Level of Ambition Atlas #201 | Health-related quality of life for people with Long Term Conditions (OF 2) (crude rate) - CCG Level								
LOA201	2012/13	73.12	*73.41*	*75.29*	74.74	▲ 2.2%	69.5	

Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 2	Enhancing quality of life for people with long-term conditions;	Improved scores for being treated with dignity in national inpatient survey (2007/08)	75	78	78	• Contractually monitor performance around the Friends and Family Test results, requesting recovery plans if required.	TD/ AM/ KS	March 2015
		Reduce hospitalisation for unplanned chronic ambulatory care sensitive conditions (2012/13)	762.4	808.3	760	See Long Terms Conditions management above. • Review urgent care pathways and ensure MAU (key clinical facility for management of ACS conditions) is supported by a dedicated consultant physician. • Work towards integrating the Dementia Intensive Support team into Community Services to reduce admission to acute hospital for people with dementia.	EH/LP/ IL	Sept 2014
		Enhancing quality of life for people with LTCs – measured through GP patient survey (2012/13)	0.73	0.74	0.75	• Ensure self management programme rolled out in CP&R locality. • Utilising new provider arrangements in primary care to support consistency in management of Chronic diseases e.g GP Federation. • Use of technology to support self management and monitoring of patients with LTCs. • Ensure appropriate information available to patients to support self care management. • Roll out of personal health budgets across our locality.	LP LP LP VM MG	Aug 2014 June 2014 Nov 2014 Sept 2014 **TBC**

Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 2	Enhancing quality of life for people with long-term conditions;	Reducing time spent in hospital by people with LTCs – Chronic ambulatory care - Length of Stay (2012/13)	205.5	228.3	204	• Reablement assessment to be included within the acute model. • Though Community Contestability improve facilitation of SPOR to support early discharge. • Increase access to IV therapy, rapid response nurses, physiotherapy, respiratory and COPD nurses.	MG LP EH	March 2014 Jan 2014 Aug 2014
		Reducing time spent in hospital by people with LTCs – asthma, diabetes and epilepsy - Length of Stay (q4 2012/13)	67.7	77.0	66	As above.	EH	
		Unplanned hospitalisation for asthma, diabetes and epilepsy under 19s (2012/13)	337.9	258.3	258	Implementation of further High Impact Pathways.	SMC	
		Proportion of people feeling supported to manage their condition (2012/13)	70.78	69.57	72	As above • Expanding our health coaching training programme. • Developing train the trainers to educate and support primary care clinicians.	TD/ AM/ BK ST/MK	May 2014 May 2014
		Health related quality of life for carers. (2012/13)	0.81	0.80	0.82	• Roll out of partnership initiatives • Practices to include carers on practice registers to ensure appropriate health checks undertaken • **Establish outcome measures to improve support to carers (see section xx)**	KMK	March 2015
		A measure of the effectiveness of post diagnosis care in sustaining independence and improving quality of life for people with dementia.				• Patients with Dementia are supported in primary care by the Community Dementia Nurses, thus enabling PWD to live longer in the community. Pathways have been developed to ensure all newly diagnosed patients with Dementia are reviewed appropriated and on the QOF registers	IL	
Domain 2	Enhancing quality of life for people with long-term conditions;	Estimated diagnosis rate for people with dementia (2012/13)	63%	48.7%	83%	Currently unable to view QOF data for 12/13. However, the standard for based on 58% should be 12/13 = 1029 13/14 1233 The current MH registers predicted outturn will be 1342, over performing against the existing standard. The MH Commissioning Team will over the coming 6mths validate the QOF with the MH registers	KMK/IL	July 2014

Domain 3: Helping people to recover from episodes of ill health or following injury



Period		National	Median	75th Percentile	CCG	% Var (Nat.)	CCG Percentile	Spine Chart (Diff from Median) (Limited to +/-100%)
Emergency admissions for children with lower respiratory tract infections (OF 3.2) (indirectly standardised) - Upper Tier LA level								
LOA305	2012/13	373.61	*366.22*	*473.94*	268.98	▼ 28.0%	22.8	
Patient Reported Outcomes for elective procedures : Hip replacement								
CCGOUT503	2011/12	0.41	*0.41*	*0.43*	0.41	▼ 1.1%	38.3	
Patient Reported Outcomes for elective procedures : Knee replacement								
CCGOUT504	2011/12	0.30	*0.30*	*0.31*	0.31	▲ 3.0%	56.3	
Patient Reported Outcomes for elective procedures :Groin hernia								
CCGOUT505	2011/12	0.09	*0.09*	*0.10*	0.09	▲ 3.7%	41.0	

Stroke Standards – To be updated for final submission

Performance Indicator	CCG / Trust	Outturn 10/11	Outturn 11/12 YTD	2012/13 Target / Threshold	YTD/ 12/13 FOT	2013/14 Target / Threshold		APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	Q1	Q2	Q3	YTD/ 13/14 FOT	TREND
Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit (SHA Metric 4)	CPR					At least	80%		100%	90.5%	91.3%	100.0%	82.6%	81.8%	100.0%	92.0%		95.5%	91.3%	92.0%	92.7%	
Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit (SHA Metric 4)	SUHFT		90.1%	80%	91.10%	At least	80%	94.3%	98.0%	93.0%	94.9%	96.6%	88.60%	88.90%	98.10%	94.10%		95.1%	93.80%	93.70%	93.9%	
	BTUH		76.3%	80%	87.4%	At least	80%	96.6%	71.1%	85.7%	88.6%	88.2%	73.00%	91.30%	89.10%	85.40%		82.6%	84.00%	88.60%	85.2%	
Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours (SHA Metric 5a)	CPR					At least	60%	100%	100%	100%	100%	100%	100.0%	75.00%	50.00%	0.00%		100%	100.0%	57.10%	78.6%	
Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours (SHA Metric 5a)	SUHFT		17.1!%	60%	71.1%	At least	60%	60.00%	100%	100%	60%	75%	100%	83.30%	50.00%	0.00%		86.70%	76.90%	46.20%	71.40%	
	BTUH		55.1%	60%	66.1%	At least	60%	66.7%	63.2%	69.2%	72.2%	81.8%	53.80%	61.50%	59.10%	52.60%		66.0%	69.00%	57.40%	63.2%	
Suspected stroke: % access to a brain scan within 60 minutes - all patients (ASI 4a)	CPR					At least	50%	0%	62.50%	52.40%	52.40%	59.10%	43.50%	30.0%	70.40%	25.00%		57.80%	51.50%	43.70%	49.70%	
Suspected stroke: % access to a brain scan within 60 minutes - all patients (SHA Metric 6a)	SUHFT		44.7%	50%	62.6%	At least	50%	40.50%	55.80%	45.60%	49.10%	48.30%	44.20%	41.50%	64.80%	51.00%		47.90%	47.40%	52.50%	48.90%	
	BTUH		31.4%	50%	76.9%	At least	50%	63.6%	47.4%	65.6%	62.5%	57.1%	76.90%	70.00%	76.90%	87.80%		58.1%	94.20%	77.50%	66.7%	
% stroke patients receiving thrombolysis within 3 hours of onset (SHA Metric 7a)	CPR			12%		At Least	12%	0%	31.8%	11.8%	9.5%	18.20%	16.70%	4.5%	20.80%	8.30%		22.5%	14.80%	11.40%	14.8%	
% stroke patients receiving thrombolysis within 3 hours of onset (SHA Metric 7a)	SUHFT		10.6%	12%	18.0%	At Least	12%	15.2%	26.5%	16.7%	11.3%	12.7%	10.80%	15.10%	16.00%	10.40%		20.0%	11.70%	14.60%	15.0%	
	BTUH		4.2%	12%	8.3%	At Least	12%	7.7%	7.0%	15.6%	12.2%	12.5%	9.10%	9.30%	7.10%	11.10%		9.9%	16.40%	9.20%	12.1%	
% Low risk TIA patients seen and scanned within 7 days of onset (SHA Metric 8a)	CPR			65%		At Least	65%	~	50.0%	68.8%	72.70%	61.50%	64.70%	62.5%	75.00%	40.0%		63.6%	67.30%	58.80%	63.9%	
% Low risk TIA patients seen and scanned within 7 days of onset (SHA Metric 8a)	SUHFT		44.4%	65%	52.3%	At Least	65%	52.2%	67.4%	70.6%	70.2%	60.7%	65.90%	51.20%	71.40%	52.00%		67.2%	66.40%	56.20%	62.4%	
	BTUH		50.1%	65%	51.6%	At Least	65%	63.20%	61.70%	58.80%	51.90%	51.30%	60.40%	69.40%	63.60%	55.90%		61.30%	55.30%	57.10%	59.80%	

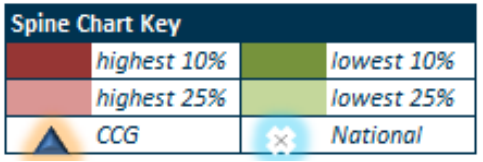
Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 3	Helping people to recover from episodes of ill health or following injury;	Access to psychological therapies (estimated release May 2014)			15% Q1 3.7% Q2 3.7% Q3 3.8% Q4 3.8%	• Implement recommendations from the Intensive support Team visit to deliver the 15% standard. Built into contract to ensure mechanism in place to hold provider to account for delivery.	KMK/ MT/ST	March 2015
		Survival from major trauma (estimated release May 2014)				• Working with NHS England to ensue that there is a co-ordinated Trauma Centre in place. • Ensure that response rates are met by the EEAST – Action plans to be developed to improve performance across the region. • Through contract ensure that we have a first class A&E services with access to specialist consultant support. Ensuring that there are sufficient ITU beds in place to meet demand.	KMK EH EH EH	 March 2015 March 2014 March 2014
		Proportion of stroke patients reporting an improvement in activity / lifestyle on the Modified Rankin Scale at 6 months (estimated release Autumn 2014)				• Implement the recommendations of the EoE Stroke review that sees SUHFT as a dedicated HASU. • Ensure related ambulances services and rehab provision are appropriate to support the local HASU. Ensure that there are appropriate support services in place post discharge, with ongoing stroke support.	EH	
	Helping people to recover from episodes of ill health or following injury;	Emergency admissions for acute conditions that should not usually require hospital admission.	738.6	1189.8	737	• Improve access to community based rapid response and crisis intervention team. • Roll out campaigns that maximise our marketing opportunities of NHS 111 e.g. book handing out at children's centres, media cover. • Enhance GP services to nursing and residential homes to prevent admissions, including dedicated support to care homes with high usage of ambulance services. • Ensuring very good uptake of flu vaccine in appropriate high risk groups through GP Federation and Locality Commissioning Groups. Sharing activity to identify practices that need greater support. • Ensuring access to urgent social care services in place for patients suffering with crisis. • Support lead commission MDT model in primary care through utilisation of risk stratification. • Implement risk stratification model such as Caretrack. • Improving timely access to day unit pathways e.g. DAU, MAU, SAU. • To establish a unique single arrangement to manage GP home visits, that a vast majority of home visits are taking place in the morning, so that those patients requiring acute review can be discharged home with	EH	

						appropriate support on the same day. • Improve optimisation of medicine usage by regular reviews of medication on appropriate patients. • Using technology to identify early indication of deterioration in long term conditions to avoid unnecessary admissions. • Work with Local authority to implement BCF initiatives around frail elderly and appropriate risk stratification. • Working with ECC to deliver streamlined models / pathways for the management/prevention of falls.		

Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 3	Helping people to recover from episodes of ill health or following injury;	Emergency admissions within 30 days of discharge from hospital	10.5		9	• Included in contract and monitored via SUHFT CQRG meeting. Ensure penalty applied if breached. • Ensure appropriate access to reablement and other support services through planning and discharge e.g. dedicated reablement posts based in acute. • Monthly monitoring of reported failed discharges across all providers	VG KMK	Feb 14 Apr 14
		Total health gain as assessed by patients for elective procedures				• Ensure structured discussions with patients in relation to having elective procedures, utilising NHS Choices tools • Review of Service Restriction Policy and ensure good evidence base for the significant improvement in health outcomes from elective procedures. • Supporting patients to optimise their health prior to the elective procedures e.g. stop smoking • Ensuring medical and physical therapies are tried prior to surgical intervention where appropriate. • Review of elective pathways for areas identified as outlying compared to peers (highest decile): o Neurology o Clinical Haematology o Cardiology o Urology o Trauma & Orthopaedics o General Medicine • Focus on Pathway Commissioning to deliver high quality episodes of care and incentivise productivity and delivery of efficiencies e.g. cataracts.	KMK EH DS EH	
		Emergency admissions for children with LRTI	195.5	401.9	194	• Increase flu immunisation uptake for children. • Ensure early diagnosis and treatment of LRTI through education and training of GPs.	TD/ D.Stotum	
		Improving recovery from fragility fractures		30 days: 21.7 120 days: 47.3		• Through Essex-wide review of falls and falls prevention services led by ECC ensure Falls Strategy are embedded into the community and mental health providers. • Establishment of Falls Team and support for patients following fragility fracture, ensuring appropriate scans are undertaken. • Education and training around the falls agenda to be rolled out. • Support the ECC commitment to invest in Falls Prevention services. • Agree a specification and service improvement plan with a view to having a revised agreed specification for 14/15. • Include longer term planning linked to BCF on Falls related services. • Roll out of the GP risk assessment toolkit to identify those at greater risk of falls.	TD/ EH EH/ DS TD KMK/ EH/ DS KMK TD/ RT	March 2014

Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 3	Helping people to recover from episodes of ill health or following injury;	Helping older people to recover their independence after illness or inquiry				• Working through BCF to develop and agree a service model that support frail elderly to remain independent. • Direct access to reablement assessment nurses. • Through community contestability ensure that we have high quality, responsive community services to match individual need. • Target support where there is a concern of patient isolation on discharge, to ensure that Befriending services are mobilised to support. • Ensure patients are given a named person and contact details to ensure rapid access to dedicated support if potential to fall into crisis.	KMK KMK EH EH EH	August 2014
		Improved PROMs scores for hip and knee replacements Improved scores in Outpatient Survey	TBC			• Through contract ensure all hip and knee replacements patients receive comprehensive post pre-op information. • Through contract ensure that appropriate pre-screening is undertaken to identify patients with greatest need.	VG VG	Feb 14 Feb 14

Domain 4: Ensuring that people have a positive experience of care



Period		National	Median	75th Percentile	CCG	% Var (Nat.)	CCG Percentile	Spine Chart (Diff from Median) (Limited to +/-100%)
Patient experience of GP out-of-hours services								
CCGOUT601	2012/13	70.84	*70.98*	*74.48*	68.25	▼ 3.7%	36.6	
Patient experience of hospital care - average number of negative responses per 100 patients (selected questions; weighted; crude								
LOA501	2012	141.99	*147.02*	*158.68*	134.64	▼ 5.2%	19.0	
Patient experience of primary care - average number of negative responses per 100 patients (selected questions; weighted; crude								
LOA601	2012	6.11	*5.85*	*7.13*	5.71	▼ 6.5%	46.6	

The above information demonstrates that further work is required in primary care to improve performance and move into the top 25% of performers. This work is set out within the primary care section of this plan (Section: 1.14).

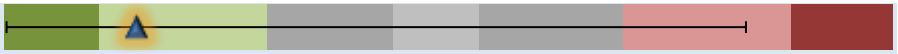
Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 4	Ensuring that people have a positive experience of care; and	Patient experience for acute inpatient care and A&E services, as measured by the Friends and Family Test				• Through contract hold secondary care providers to account for provision of high quality A&E services, meeting required national performance measures. • National CQUIN in place to support improvement in Friends and Family score. • Using CCG Patient Engagement Group (CRG) ensure direct involvement in the development of a robust marketing campaign to raise public awareness and reduce reliance on A&E. • Measure impact of above campaign through repeating initial Urgent Care survey and look to enhance campaign for Winter 2014/15.	VG TD KMK EH	Feb 14 Feb 14 March 14 Sept 14
	Ensuring that people have a positive experience of care; and	Responsiveness to inpatients personal needs				• Work with secondary care services to affect the culture of care delivery in line with the '6 Cs' philosophy. • Embrace the recommendations from Berwick and Francis Report. • Check and challenge quality visits through direct engagement with service users.	TD TD TD	
		Patient experience of outpatient services				• Through contract ensure that acute providers continue to undertake outpatient surveys and ensure that remedial actions are undertaken dependent on responses. • Discussions have been minuted to support the Trust in its ambition to generate timely and meaningful feedback. SUFHT now operates a system which expands on the Friends and Family test to identify how outpatient services can be enhanced. • Regular oversight at CQRG of staff surveys is key to ensuring that motivated staff are delivering front line patient services. The Trusts are challenged to address key issues that are identified to motivate and engage staff within provider organisations.	VG	
		Patient experience of primary care (2012/13)	TBC	76.3		• See local measures relating to implementation of primary care strategy and improvements in primary care provision. • The CCG is committed to addressing the need to improve access to primary care services. • Discussions have taken place in Locality meetings and Executive meetings to identify ways to improving access. • Plans for commuter clinics, telephone triage and the upskilling of Practice Nurses to aid same day consultations are being progressed at a strategic and local level. • Member practices are being actively encouraged to pilot modes of service delivery to enhance accessibility. • As lead Commissioners for NHS 111 the CCG is developing the potential for NHS 111 call handlers to directly book appointments in linked	KMK	

						General Practice Surgeries. • A review of secondary care wound management has revolutionised the way in which A and E works with practices to ensure that unnecessary wound care is delivered in surgeries rather than in the acute care setting at an enhanced tariff price. • Work has been undertaken to promote Access for All with the enhanced provision of LD Healthchecks by supporting being offered by SEPT LD services. The CCG is committed to working with the AT to address identified areas where individual surgeries to improve patient experience of care.		
		Patient experience of GP OOH services (2012/13)	64.04	70.21		• As host CCG for OOH contract monitor improvements in service provision and ensure recovery plans in place where required. • Undertake review of calls to out of hours and NHS 111 to ensure quality of consultation and episode of care.	EH EH	
		Overall experience of GP surgery (2012/13)	TBC	88%		• See local measures relating to implementation of primary care strategy.	KMK	
		Access to NHS dental services	TBC	94.9%		• Work with NHS England to ensure appropriate access to dental provision, following concerns raised through NHS 111.	EH	
		Women's experience of maternity services				• Implement recommendations from CQC arising from CQC report. • Ensure recovery plan in place for post natal care at SUHFT. • Capacity review to be undertaken in relation to maternity services in Essex due to increased birth rate. • The CCG is committed to ensuring that acute, community and Mental Health Providers are committed to the role out of the Friends and Family test and specifically within Maternity Services.	TD TD TD	

Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 4	Ensuring that people have a positive experience of care; and	Improving children and young people's experience of healthcare (TBC)				• Through commissioning community contestability improve C&YP services • CQUINs in place to improve services locally. • CAMHs review to be undertaken.	SMC	
		Bereaved carers' views on the quality of care in the last 3 months of life				• Support voluntary bereavement services to provide counselling sessions through usage of CCG estates. • Submit bid to secure funding to run dedicated survey of bereaved carers, piloting the Friends and Family test linked to improving the end of life care across the CCG.	TD	
		Patient experience of community mental health services				• Through contract monitor performance at CQRG to improve service provision. • To ensure that information on complaints from service users is collated and shared. • To improve information, advice and guidance on care options and access to relevant services.	MT	

Domain 5: Treating and caring for people in a safe environment; and protecting them from avoidable harm

Spine Chart Key			
	highest 10%		lowest 10%
	highest 25%		lowest 25%
	CCG		National

Period		National	Median	75th Percentile	CCG	% Var (Nat.)	CCG Percentile	Spine Chart (Diff from Median) (Limited to +/-100%)
Incidence of hospital care associated infection -Clostridium Difficile (per 100k population, unstandardised)								
OPA112	Jun 2013		*185*	*2.58*	0.55		13.3	
CCG Operational Planning Atlas #111 | Incidence of hospital care associated infection - MRSA (per 100k population, unstandardised								
OPA111	Jun 2013		*0.00*	*0.00*	0.00		0.0	

Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm.	Reducing inappropriate prescribing of antipsychotic medication				The community dementia nurses continue to provide training/support to care homes to ensure prescribing is appropriate. Supporting community pharmacists in medication reviews.	SW	
		Reducing premature death in people with a serious mental illness				Develop robust psychiatric liaison pathways Improve crisis response and care planning and management of people with severe and enduring mental illness. Increase the number of physical health checks as part of CPA process that lead to health intervention and make links to personal health plans and be aware of other long term conditions. Development of medication concordance programmes.	MT	
		Incidence of newly acquired grade 2,3,4 pressure ulcers				Through contract management ensure the level of pressure ulcers continues to decline. Supporting the University of Essex to undertake a research project to review the acquisition of pressure ulcers in the CPR locality, causes and potential areas of improvement.	TD	May 2014
Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm.	Zero cases of MRSA and C. difficile cases are at or below defined thresholds for CCG by March 2014	0 21 (SUHFT) 30 (CCG)		MRSA 0	The CCG IPC Quality Team are working with acute, community and MH providers to ensure that all contracted measures are in place to minimise the risk of a Hospital Acquired Infection. This work is directed and underpinned by tight trajectories 2013/2014/2015. Treatment of all patients in SUFHT to prevent MRSA prior to admission in line with National Best Practice. Screening of all podiatry patients by SEPT. Monthly reporting to CCG Locality Groups as to anti-biotic/ PPI prescribing and the evidence underpinning individual prescribing to reduce the risk for development of CDIFF during an acute care episode. Re-establishment of Non-Medical Prescribing Forum by Chief Nurse for CPR and Southend Practice Nurses. Monthly newsletter distributed by Hosted Medicines Management team to all practices outlining any new evidence with regards to risk prescribing for CDIFF/MRSA. Establishment of South Essex focus group by CCG IPC to tackle levels of CDiff/MRSA bacteraemia in a systematic way.	TD	

Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
		Hospital deaths attributable to problems in care (estimated release April 2014)				SHMI/HSMR reported by exception at CQRG's. CQC rating score monitored regularly and prompt action to be taken with all providers that are judged by the CQC as "require improvement" on "inadequate". CCG to notify the CQC if it is felt that a provider might have quality or risk issues requiring further investigation. Attendance at and alerts to the Quality Surveillance Group re patient concerns and never events. Open reporting of all Serious Incidents and review of RCA's by Chief Nurse. Check, challenge and audit of action plans to ensure lessons are learned. Quality Team developed data base to link themes and trends as reported via the STEIS reporting model.	TD	
		Deaths from Venous thromboembolism (VTE) events (release before March 15)				Monitored via Safety Thermometer and KPI data. Ensure that all patients are assessed and provided with prophylaxis as appropriate to reduce the risk of development of DVT and PE as per contract/CQUIN. Safety Thermometer CQUIN for 2014/2015 as per National guidelines. All deaths subject to SI and RCA processes.	TD	
		Patient safety incidents reported				Commissioning Intentions including measures to encourage 'Just Culture'. We have ensured that all providers have robust DATIX collection measures in place to identify themes and trends. All providers have established links to NPSA/MDA for reporting purposes. Monitoring of this occurs on a monthly basis through the contract. CAS alert system in place.	TD	
		Safety incidents involving severe harm or death				As detailed above with the added assurances around the SI process.	TD	
		Incidents of medication errors causing serious harm				Monitored through environmental audits to CQRG. Recent SI Healthsystem review of Preventable death due to medication omission. Lessons learned will be communicated to the family and the wider healthcare community.	TD	
		Admission to full-term babies to neonatal care	3.4 (SEE PCT)	5.1			TD	
		Incidence of harm to children due to 'failure to monitor'		1.017			TD	

1.2 IMPROVING HEALTH – COMMISSIONING FOR PREVENTION

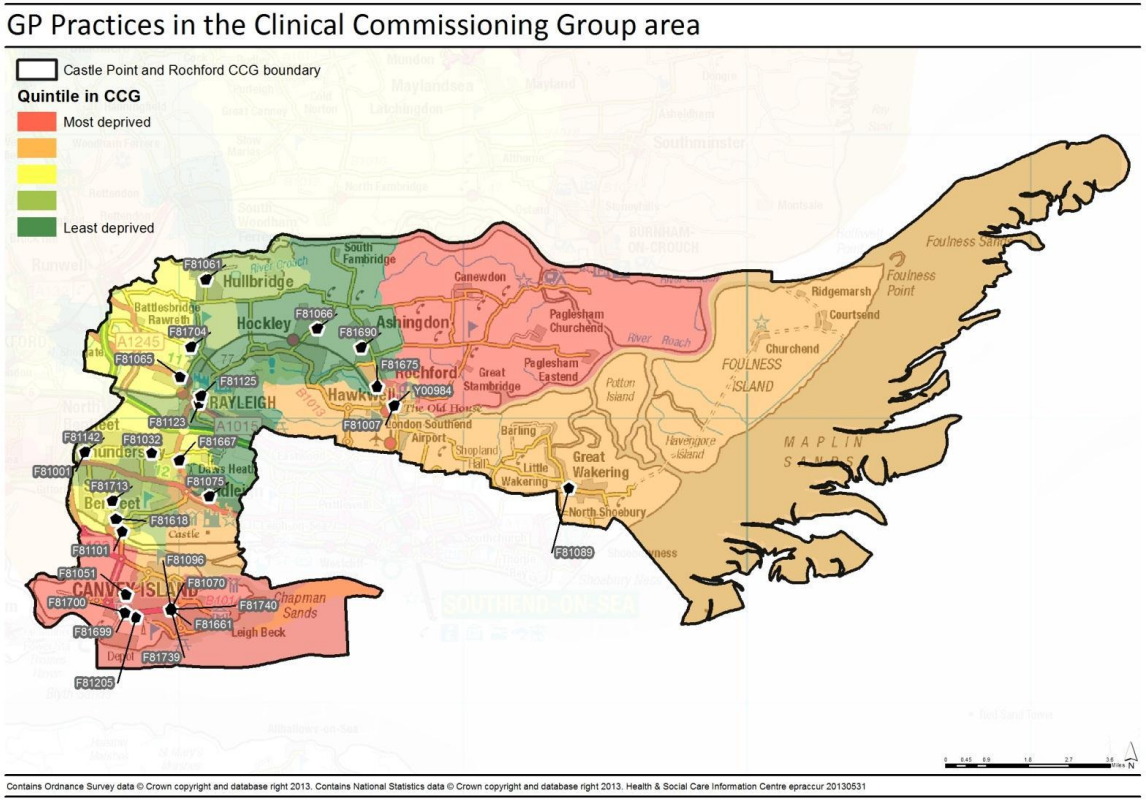
	Aim	Action Required	Lead	Deadline
1	Analyse key health problems	• We will identify and analyse the top health problems for CRP CCG working together with local authority Directors of Public Health.	DS	April 2014
2	Prioritise and set common goals	• The CCG will agree a set of common priorities and goals based on above analysis of epidemiology and current performance. These priorities will be few, highly targeted and shared with key partners such as Health and Wellbeing Boards, local government, providers and others. • They will also be quantifiable so that progress can be regularly tracked.	DS	April 2014
3	Identify high impact programmes	• The CCG will identify evidence-based prevention programmes that can deliver goals. These will encompass a mix of primary prevention, early detection and secondary prevention activities. • Not to pre-empt CCG goals, prevention of mental illness and hypertension screening, to take two examples, appear to be particular gaps in many parts of England given the burden of mental ill health, ischemic heart disease and stroke	DS	June 2014
4	Plan resources	• CCG will consider the full range of resources available across their health economy, including local government, schools, providers, employers and others. • The BCF may also be deployed to fund joint prevention activities. Crucially, in order to be cash releasing for our area as a whole (rather than simply shifting costs) reallocated funds will be linked to reductions in acute activity and capacity over the medium term.	DS	June 2014
5	Measure and experiment	• To ensure that our prevention programmes are delivering results - including reduced acute activity - they will be measured regularly with a mixture of process and outcomes measures. • Innovative approaches will be implemented with an evaluation method in mind from the start. • The CCG will need the intelligence to assess whether prevention programmes are working and will act decisively if they are not.	DS	April 2015

1.3 REDUCING INEQUALITIES

1.3.1 Groups with the worse outcome

In the period 2006 to 2010 in males the difference in life expectance between the most and least deprived individuals was approximately 5 years in Castle Point and approximately 4 years in Rochford. In females the difference was approximately 5 years in Castle Point and approximately 2 years in Rochford.

The areas of increased deprivation within Castle Point and Rochford are shown in the map below taken from the local JSHNA.



Cardiovascular death and deaths from cancer are the biggest causes of death and the greatest contributors to health inequalities. In order to reduce health inequities the risk factors for cardiovascular and cancer deaths need to be addressed. Most important of these is smoking but excessive alcohol consumption, inactivity, obesity, diet and undiagnosed or undertreated blood pressure are also important. In will be necessary to monitor the uptake of services to address these risk to see that those in the most deprived areas are accessing them at least as much as less deprived groups.

As set out in the Essex Health and Wellbeing Strategy 2013-2018 key themes to focus on across our locality are:

- Tackling health inequalities and the wider determinants of health and wellbeing
- Transforming services: developing the health and social care system
- Empowering local communities and community assets
- Prevention and effective interventions
- Safeguarding

Key areas of concern highlighted for Castle Point and Rochford are:

- Castle Point has high levels of children with tooth decay and one of the lowest levels of adults who eat healthily, and the highest number of obese adults in Essex. It also has one of the highest levels of hospital stays for alcohol-related harm.
- Rochford has the second highest level of increasing and higher risk drinking, and a relatively high level of hospital stays due to alcohol-related harm.

Actions to be taken to address health inequalities 2014/15:

Area	Action	Lead	Deadline
Obesity	• The CCG is commissioning a Tier 3 weight management service to bridge the gap between Tier 1 and 2 population wide services and lifestyle interventions and the specialist bariatric surgical services.	EH	April 2014
Obesity	• The CCG is undertaking a detailed review of Community Dietetics Service.	EH	July 2014
Obesity/CVD	• The CCG identified as our local priority for the remote monitoring DES weight gain associated with congestive cardiac failure. This DES will commence from April 2014.	EH	April 2014
Alcohol	• The CCG is fully supporting the Essex County Council Public Health Investment Programme in Alcohol Interventions, actively supporting and facilitating the system-wide developments. This includes investment in: ○ Alcohol Liaison Nurse Services ○ Community Based non medical interventions (psychosocial interventions) ○ Community based care recovery management and rehabilitation ○ Enhanced Justice Services ○ Alcohol Treatment Pathway	DS	April 2014
Alcohol	• Explore joint working with Education Service to deliver education and support into local schools and colleges. This includes linked GPs to local schools.	EH	Oct 2014
CVD	• 24 hour ECG and 24 hour BP monitoring services to be commissioned in the community to increase access and patient choice.	EH	April 2014
Smoking	• Continue to support public health smoking cessation programme through sharing practice level smoking data at Locality Commissioning Group meetings and raising poor performance at practice visits.	KMK	July 2014

1.3.2 Equality and Diversity

The CCG refreshed its Equality and Diversity Strategy recently and this will be submitted to Quality and Governance in February prior to ratification at the Governing Body in March 2014. This new Strategy will reflect the new requirements of EDS2. However a number of steps have already been taken to ensure that the CCG fulfils its public sector equality duty:

- Information about the composition of the CCG's workforce has been published on the dedicated equality and diversity section of the CCG website; Don't know it has been uploaded as of yet. Amanda S please arrange as a matter of urgency – it is in my in box
- Within the Equality and Diversity Strategy, the CCG has published its interim EDS goals;
- Equality and diversity (including the EDS goals) was discussed at the last CCG's patient group known as the Commissioning Reference Group (CRG). The CRG will be a key vehicle for agreeing priorities with the community and assessing progress;
- Equality and Diversity Policy in place;
- Chief Nurse appointed as Board-level lead for equality and diversity;
- Lay Member identified as Equality and Diversity Champion;
- Equality impact assessments are undertaken on all CCG policies, QIPP plans and commissioning cases;

1.4 PARITY OF ESTEEM

As outlined below NHS Castle Point and Rochford CCG supported by the Commissioning Support Unit Mental Health Commissioning Team plans to undertake a number of key actions to deliver the Parity of Esteem agenda locally.

Action	Clinical Lead	Commissioning Lead
Training NHS staff to better identify and respond to the needs of people with mental health needs	TD	JI
All GPs to have had training to recognise signs of risk indicators for suicide and severe mental illness and correct referral paths.	TD	JI
All medical and nursing staff in Basildon Hospital to have received training to identify mental health problems and correct referral paths.	TD	JI
All mental health inpatient and community staff to have received appropriate training in physical health care and the identification of physical health needs.	TD	JI
Integrating Mental and Physical Care •All people with low-level mental health need (clusters 1-3) to be principally cared for by their GP as their Named Accountable Professional. •Community mental health teams to form part of primary care multi-disciplinary teams	Dr Taylor	JI
Integrating mental and physical care cont. •IAPT services to be integrated into primary care federation based health teams, focusing on long-term conditions. •Psychogeriatricians and older people community mental health teams to be integrated into the new care of the elderly community 'step up' teams. •Introduce specified pathway of health prevention work with individuals who suffer from a mental health problem (e.g. obesity / alcohol).	Dr Taylor	JI
Other areas •Introduce audit programme of GP SMI registers and health checks for people with mental health needs. •Cross reference GP and secondary care SMI register to identify unidentified individuals. •Implement formulary for mental health services across primary and secondary care and supporting audit programme. •Implement the 'South Essex Recovery College' •Implement personal health budgets for people in recovery.	TD	JI

1.5 CHILDREN AND YOUNG PEOPLE

Service Re-design

The CCG is working with the other 6 CCGs in Essex and Local Authorities to ensure that there is a whole systems approach to the service redesign for CAMHs.

Maternity Review

The south Essex system is currently undertaken a review of maternity services locally to identify the capacity demands and future model of care required to meet the needs of the local population.

Clinical Leadership

All contestability reviews are undertaken with clinician and parent representation.

Governance

The Paediatric Clinical Executive Group gains whole system clinical feedback and GP leads receive weekly updates in relation to delivery against agreed plans.

The South Essex Network project works closely with parent/carer forums and clinical colleagues receive regular briefings.

Health are holding Integrated Commissioning Strategy Group with Children and Young People Commissioners – South Essex, NHS England / three Local Authorities / four CCGs in South and Commissioning Support Unit (CSU) are in attendance.

To ensure that services are safe and of high quality the Childrens and Young People Commissioning team attend the CCGs Clinical Quality Review Group and ensure that quality impact assessments are undertaken on all commissioning reviews / service redesigns.

Collaboratively Working

The SEN includes:

- Working with Local Authorities
- Attending regional events
- Attending national events
- Incorporating new KPIs and information requirements in line with new guidance
- Include new guidance within all provider contracts.

Patient and Public Engagement

Friends and Family Test in place to receive feedback in relation to the current CAMHs service and exit surveys undertaken. Peer group review of treatment in place and a report is submitted to the CORQ (quality monitoring / benchmarking against other CAMHs services nationally).

Choose Well leaflets have been provided to parents / carers to ensure that they are able to make informed decisions about services, care and treatment.

The CAMHs SEN is chaired by a parent/carer.

The friends and family test results relating to A&E, IPY and maternity services are reported at the monthly CQRG meeting and key themes identified to ensure actions are put in place to improve performance in these areas.

The Children and Young People Commissioning (CYP) Team has held CAMHs and SEN events with our local population to ensure that they have been fully included in all aspects of service design and change.

Mechanisms in Place to Monitor Treatment Outcomes

The following measures are currently being monitored to ensure that there is improvement in patient outcomes and that patients are staying well after treatment has been under taken:

- Asthma Pathway – monitoring frequent flyers
- Diabetes – effective monitoring and keeping the CYP stable and out of acute through BPT.

The SEN MAPIT Tool (audit evaluation tool) has been put in place to identify patients receiving poor care and where poor care is to be found.

Training and Education
SEN key worker training is currently being rolled out and IAPT pilot for children and young people evaluation to be undertaken by March 2014.
The CYP Team ensure that serious case reviews and CDRs are shared appropriately, so that lessons are learnt and actions are identified where necessary to mitigate risks for the future.

Continuing Health Care
The CCG will ensure

Information Sharing and Information Governance Protocols are in place.

ISPs have been signed between ecdp (the delivery partner) and both Essex and Hertfordshire CCGs. Patient sharing information forms and processes have also been developed and agreed and ecdp will be using EGRESS to ensure electronic patient data is stored and shared in line with Information Governance and Information Sharing Protocols. The ISP has been signed by the provider data controller.

Patient consent is required to refer prospective PHB recipients to the delivery partner and a referral form and process have been agreed between ECDP and with both PHB Steering Groups and agreed with the Central Eastern CSU Information Governance lead.

Safeguarding
The CCG will ensure that providers are compliant against the *Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework* through the CQRG providers performance dashboard. The CQRG meet monthly and is chaired by the CCG Chief Nurse. This is also covered within the Section 11 Audit, Children's Act 2004, which is completed 3 yearly but reviewed annually and shared with the LSCB. This can also be reflected in the KPIs and monitored by the CQRG and Contracts.

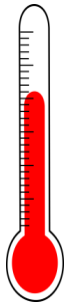
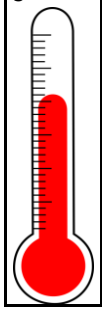
The CCG's plans are aligned with SET priorities.

The CSE is led by all three LSCBs and they have a county wide strategic CSE group. The designate nurses are also the Champions for CSE. The LSCBs are currently putting CSE training together and sharing information intelligence form. This will be rolled out to front line staff. The Champion for Southend (Designate Nurse) has attended training. There is also a Domestic Abuse strategy in place which is led by Adult Safeguarding (Andrea Metcalfe).

There is a Safeguarding KPI/contract and Safeguarding assurance protocol which is being embedded in all contracts with Providers. This will assist providers in demonstrating how safeguarding duties are discharged and reported.

1.6 SPECIFIC CLINICAL OUTCOMES

1.6.1 Key National Clinical Outcome Measures

	Performance Measure	2013/14 Baseline	2014/15 Standard	Action Required	Lead	Deadline
1 	Clostridium difficile reduction	TBC	26 - CCG Target	Explore the options to set up a scrutiny panel with AT to consider how unavoidable cases can be removed from local trajectories. Epidemiology review to be undertaken with Public Health. RCA's to be undertaken on all post 72 hour cases with regards to anti-biotic prescribing. Further work to be developed with GP's for reviewing patients with on-going diarrhoea in the community. SUFHT to re-examine GDH positive cases to see if they have had any previous hospital admissions.	TD/IPC	March 2015
2 	Dementia diagnosis	TBC	58% (Stretch of 65%)	The CCG will be validating the QOF vs SEPT registers - we are expecting the data to be collated by the end of March to enable us to develop an action plan. The Dementia SEPT CQUIN in 13/14 enabled the development with ARU, a training program to enable nurses to independently identify dementia syndrome within the care home population. Through the MH Commissioning Team the CCG are currently reviewing the memory service specification - to ensure that we have capacity in the future increase the diagnosis rates in a timely fashion.	IL	March 2015
3 	IAPT coverage and recovery	TBC	15%	A number of key actions are outlined in the dedicated section on the following page in relation to improving performance in this area.	JI	Mar 2015

1.6.2 IAPT Recovery Plan

As host of the South Essex Partnership NHS Foundation Trust, the CCG is committed to ensuring that the local IAPT standard of 12.6% is achieved during 2013/14, moving to a standard of 15% during 2014/15.

Current Performance
IAPT Performance as at the 12th February 2014 is included within the following table and sets out the numbers of patients to be seen on a weekly basis to ensure that the 12.6% standard for 2013/14 is achieved.

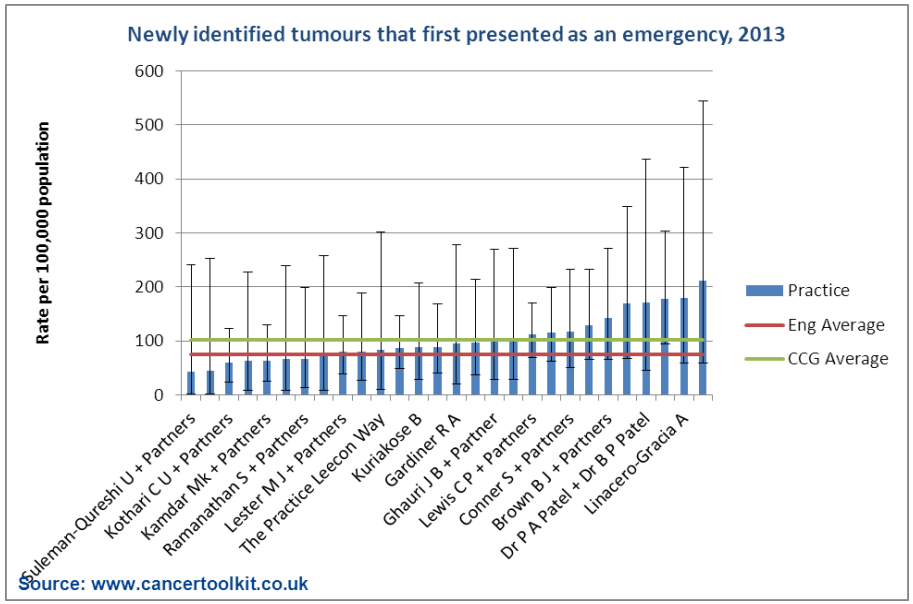
CCG	Population	Target	Currently Achieved	Difference	% previous week	% as at 12.02.14	Weekly Target
B&B CCG	32743	4126	2886	1240	8.6%	8.8%	124
CP&R CCG	21110	2660	2001	659	9.3%	9.5%	66
SCCG	22104	2785	2029	756	8.9%	9.2%	76
TCCG	20240	2550	1346	1204	6.4%	6.7%	120
Total	**96197**	**12121**	**8262**	**3859**	**8.4%**	**8.6%**	**386**

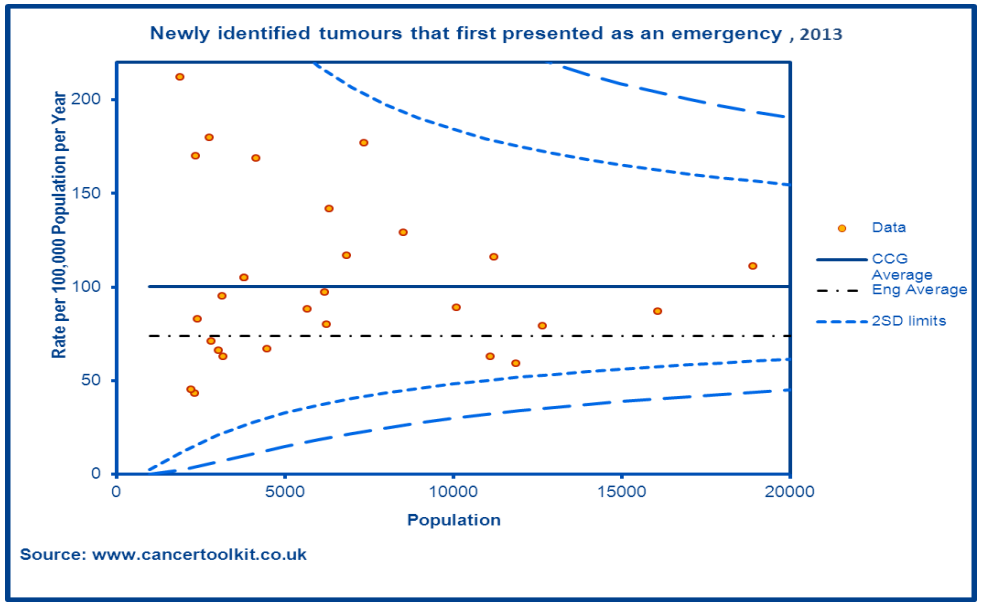
Key actions being taken to ensure delivery of the 12.6% target in 2013/14 and 15% in 2014/15:

- Performance notice accepted and Recovery Action Plan (RAP) agreed.
- Progress against RAP monitored at weekly IAPT performance meeting and milestones on track.
- Intensive Support Visit undertaken and draft report received outlining a number of key recommendations to be implemented.
- Data cleansing undertaken and additional admin support in place to support information reporting requirements.
- Draft self populating Referral form developed for GPs to add onto SystemOne – March 2014.
- Request sent to all south Essex Accountable Officers to agree a specific mental health READ code to assign to IAPT, enabling the service to add a hyperlink to patient notes.
- Pre-paid envelopes provided to support self referrals.
- Additional work taking place with third sector organisations and Public Health to increase referrals from other sources.
- Media campaign being rolled out including stands in Lakeside, and other large stores in the area, four page advert in the local paper, leaflet drops, posters and cards in surgeries etc.
- Additional group sessions arranged and model adapted so that these can be accessed if living outside of the CCG boundaries e.g. Castle Point resident can attend Westcliff group.
- Modelling undertaken to ensure sufficient capacity in place to meet 12.6% by March 2014.
- Executive Director lead assigned by SEPT to IAPT and monitoring performance on a daily basis internally.
- Service user feedback results shared on a monthly basis.
- Internal communications developed for GPs in relation to IAPT and frequently asked questions sheet currently being developed with the support of the service.
- Develop an action plan to roll out IAPT into Long Term Conditions Management
- Transfer of PbR clusters 1-3 from secondary care into IAPT service
- Boost effective partnership working between the Trust and Voluntary Sector Organisations to support and promote coverage.
- Develop a CQUIN to support IAPT in addressing inequalities

1.6.2 Quality Premium Local Priority Measure

NHS Castle Point and Rochford CCG has identified 'Cancer diagnosis via emergency routes' as our local priority indicator. This is because Castle Point and Rochford has a higher number of cancers first presenting as emergencies (due to the age of the population). The data analysis shown below does not identify any one practice within the CCG as a statistical outlier but demonstrates that there is a need to undertake further analysis to identify where additional support and resource in primary care could improve performance in this area.





		2013/14		
	Indicator Definition	**Numerator**	**Denominator**	**Measure**
Local Priority 1	C1. 16 Cancer: Diagnosis via emergency routes	182	749	24.3%
		2014/15		
Growth assumed at 2.4%	**Indicator Definition**	**Numerator**	**Denominator**	**Measure**
Local Priority 1	C1. 16 Cancer: Diagnosis via emergency routes	182	767	23.7%

1.7 IMPROVING OUTCOMES – MEASURES TO REDUCE HARM

	Key areas to make improvements to reduce harm	Success will be delivered through	Lead	Deadline
1	To review CCG governance for Patient Safety and Quality	Review the functionality and Governance of the Quality and Governance Committee, making recommendations for change and implementing agreed Quality Outcome framework	TD	March 2014
		Review the delivery of the functions of the Quality Support Team in view of BB CCG decision to withdraw from hosted arrangement.	TD	March 2014
		Attendance at appropriate meetings internal and externally to the organisation, promoting the PS&Q agenda in all forums	TD	Completed & Ongoing
2	Continue to work with partners to gain the required level of assurance for patient safety and quality of care within SEPT services and SUFHT services	To work with the Trust to drive improvement. Monitoring compliance with recommendations from Francis, and Berwick.	TD	Completed & Ongoing
		To ensure the contract is used to its best effect to provide safety, good quality care that provides a good patient experience	TD	March 2014
		To have a programme of assurance reports as per the CQRG programme to monitor standards of patient safety and quality of care	TD	March 2014
		To work with regulatory partners to share intelligence and drive improvements	TD	Completed & Ongoing
		To work with key stakeholders to enable sound knowledge of standards achieved by the Trust and provide assurance of processes of monitoring	TD	Completed & Ongoing
		To continue programme of announced and unannounced visits to check and challenge service provision and gain instantaneous patient and staff feedbacks	TD	March 2014 & ongoing
3	Continue to work with partners to gain the required level of assurance for patient safety and quality of care within all commissioned services	To work with partner CCGs to ensure Castle Point and Rochford CCG gains assurances of the standards of care with all commissioned providers • SEPT • SUHFT • EEAST • Private hospitals • Hospices • Continuing Health Care • NHS 111	TD	March 2014
		Monitoring compliance with recommendations from Francis, Keogh and Berwick reports.	TD	March 2014

	Key areas to make improvements to reduce harm	Success will be delivered through	Lead	Deadline
4a	Take a strategic lead to ensure responsibilities of the NHS for safeguarding (children and adults)are embedded and delivered	Ensuring appropriate measures are in place to Safeguard Children in the locality and across the South Essex Health system.	TD	Completed and ongoing
		Work collaboratively across Essex to best provide for safeguarding of children through integration and intelligence sharing of best practice.	TD	Completed and ongoing
		Chief Nurse to attend and contribute to the Health Executive Forum for Children's safeguarding as a sub-committee of the Essex Safeguarding Children's Board	TD	Completed and ongoing
		Work with designate staff to hold commissioned organisations to account for processes and systems in place to safe guard children	TD	Completed and ongoing
		Work in partnership with local authority to drive the safeguarding agenda for children	TD	Completed and ongoing
		Ensure the section 11 audit is completed, implemented and improved	TD	July 2014
		Ensuring appropriate measures are in place to Safeguard Vulnerable Adults in the locality and across the South Essex Health System.	TD	Completed and ongoing
		Work collaboratively across Essex to best provide for safeguarding of vulnerable adults	TD	Completed and ongoing
		Chief Nurse to attend the Essex Safeguarding Adults Board	TD	Completed and ongoing
		Work with commissioned organisations to hold to account for processes and systems in place to safe guard vulnerable adults	TD	Completed and ongoing
		Work in partnership with local authority to drive the safeguarding agenda for vulnerable adults	TD	Completed and ongoing
		Ensure the section 11 audit is completed, implemented and improved	TD	September 2014
		Work with partners to implement the Winterbourne recommendations	TD	Completed and ongoing
5	To develop integrated working patterns with the local authority with specific regards to resident safety and quality of care within care homes	To establish a pro-active, collaborative working relationship with the local authority in regards to care homes	TD	Completed and ongoing
		Ensure the sharing of intelligence about standards of care in care homes, to enable the best outcomes to improve standards	TD	Completed and ongoing
		To work in partnership with the local authority, to monitor care homes where health care is delivered, to drive improvement	TD	Completed and ongoing
		To ensure the input of the Continuing health Care Team is appropriate and timely to monitor and improve standards with care homes	TD	Completed and ongoing
		To work with the Individual Placement Team to ensure that the most effective option is available to individuals.	TD	Completed and ongoing
6	To work with partner organisations to re-design services which promote clinical effectiveness, patient safety, quality of care and enhances patients experience	To ensure that there is patient / carer engagement in all re-design projects	TD	Completed and ongoing
		To ensure quality is central to all service re-design initiatives	TD	Completed and ongoing
		To work collaboratively with the local authority and other CCGs on re-design projects and promote innovation at every opportunity.	TD	Completed and ongoing

1.8 INNOVATION

1.8.1 NHS Castle Point and Rochford CCG Innovation Group

CPR CCG acknowledge that we need to find ways to raise the quality of care for all in our communities to the best possible standards while closing a significant funding gap by 2020/21. This calls for creativity, innovation and transformation.

This will require a significant shift in activity and resource from the hospital sector to the community. The funding and implementation of the Better Care Fund has the potential to improve sustainability and raise quality, including by reducing emergency admissions; hospital emergency activity will have to reduce by around 15 per cent for our CCG. Our CCG will need to make significant progress towards this during 2014/15.

CPR CCG is committed to innovation to deliver significant improvements in quality and efficiency across our system. In 2014/15 we intend to access the **Regional Innovation Fund** to support and promote the adoption of innovation and the spread of best practice across South East Essex. We will be looking to facilitate fresh perspectives and partnerships, bringing in different types of expertise or capacity to support the adoption of current innovations or the development of new ideas.

Next Steps

- We have established a CCG dedicated 'Innovation' Group using our clinical leadership tasked to adopt innovative approaches using the delivery agenda set out in Innovation Health and Wealth: accelerating adoption and diffusion in the NHS.

1.8.2 High Impart Early Adopter Interventions

The CCG Innovation Group are supporting in a range of recommended interventions for local adoption, namely:

- *Early Diagnosis* - Early detection and diagnosis to improve survival rates and lower overall treatment costs
- *Reducing Variability Within Primary Care by Optimising Medicines Use* - Reducing unwanted variation in primary care referring and prescribing
- *Mental Health – Rapid Assessment Interface and Discharge (RAID)* - Psychiatric liaison services provide mental health care to people being treated for physical health conditions
- *Dementia Pathway* - Fully integrated network model to improve health outcomes and achieve efficiencies in dementia care
- *Palliative Care* - Community based, consultant-led integrated palliative care service
- *Acute Visiting Service* - Reducing demand for emergency care through providing a rapid-access doctor at home
- *Reducing A&E pressure* - Acute GP unit to triage emergency arrivals; occupational therapists in A&E to reduce low-risk admissions
- *Acute Stroke Services* - Creating a hyper-acute stroke unit at SUHFT to optimise acute stroke services and ensure 24/7 access to specialist care
- *Integration of Health and Social Care for Older People* - Integrating care through organisational, procedural and cultural changes

- *Electronic Palliative Care Coordination Systems* - Improving care and helping patients to die in the location of their choice through a shared electronic record (this sees all providers using System1 – acute community and voluntary sector)

1.8.3 Technology

CPR CCG believes that technology is an enabler to meet growing demand in health and social care services in a more timely and effective manner while still providing overall value for money. CPR (working with colleagues in public health have are interested in some technology trends which, if applied at scale, hold the power to significantly impact the way care is delivered over next 5 years. These include: App-Driven Wellness Culture; Self-Care and Proactive Health Management; Assisted-Living Technologies (in partnership with local authority); Remote Consultations; Telemedicine; Case Managers and Patient Navigators; Predictive and Visual Analytics and Evidence-Based Medicine; Technology-Enabled New Work Models, and Seamless End-to-End Health and Social Care Provision.

Specific Innovation where CCG already Engaged

Analytic Tool for prediction of falls: Castle Point and Rochford CCG is working with Anglia Ruskin University, Essex County Council and an external commercial organisation to develop an analytic tool for prediction of falls. The idea is to try to use a large amount of data which is already present in NHS and Social Care records ("big data") and carry out an analytical process to produce a more accurate tool for the prediction of falls in the elderly.

Better Sharing of data between Health and Social Care: Castle Point and Rochford CCG is working with Essex County Council, NHS England, other CCGs in Essex and other organisations on improving the flow of information between Health and Social Care. This should result in improved outcomes and save money while still having appropriate safeguards in place. It will eventually result in a single health and social care record.

1.9 RESEARCH AND EDUCATION

Research and evaluation across the whole patient pathway, including with partners in local government and Public Health England will contribute to improving outcomes and spreading innovation and economic growth. A additional marker of quality within NHS organisations is those with research activity able to demonstrate evidence of improved patient outcomes and health service delivery.

Our CCG our actively seek out research opportunities, understand where research is taking place within the providers with whom they contract and support that activity wherever possible, through their commissioning decisions.

The CCG Research and Education programme is outlined below and lead by the Chief Nurse and Accountable Officer.

Area	Action	Lead	Deadline
Member practices	Encouraging all member practices to be research ready (toolkits completed)	TD	Sept 2014
	Ensure high level support continues through the provision of CCG hosted Clinical Education Service.	TD	
Primary Care Development	To better educate nurses and encourage recruitment and retention into primary care of experienced nurses.	TD	Sept 2014
	Lead Practice Nurse Forum for CPR locality.	TD	Jan 2014
	Establish Non-Medical Prescribing Forum	TD	Jan 2014
	Encourage the number of GP training places by 15%	TD	April 2014
	Review varying models to support the recruitment and retention of salaried sessional and partner GPs into the locality. Ongoing work with LMC to develop local business case which could be delivered across the County.	SG	March 2015
Succession Planning	ST4 commissioning fellow supported to achieve leadership qualification and commissioning experience in healthcare commissioning.	SG	Aug 2014
Academic Research Network	Strengthen membership with ARU Health Partnership through attendance at all partnership meetings and acting as an active stakeholder. Encouraging research where it will benefit health and social care domains.	TD	Jan 2014
Partnership Working	Establishment of CCG Research Network with CLRN	TD	April 2014
	Ongoing membership of LETB Board	SG	Jan 2014
	Ongoing membership of Postgraduate Medical Institute Board of ARU	SG	Jan 2014
	Further collaboration with acute partners to target research initiatives crossing primary and secondary care domains e.g. GCA	SG	Jan 2014
	Building on existing relationships with Higher Education Institutions to strengthen research activity in CPR locality.	TD	July 2014
	Work with County Partnership Group and local Higher Educational Institutions to employ apprenticeships with a view to long term employment opportunities within the healthcare domain.	VG	June 2014
	Deliver Pressure Ulcer Project with University of Essex to improve the incidence of pressure ulcer development in the care homes of CPR.	TD	May 2014
	Linked prescribing incentive scheme and educational CPD for practice nurses at the University of Essex.	TD	Jan 2014

1.10 PERSONAL HEALTH BUDGETS

The CCG are working in collaboration with Basildon & Brentwood CCG to meet the mandate for delivery of PHB from April 2014. There are two options for the CCG, both are required deliver a range of services (Appendix 1):

1 To provide the service internally
2 To commission a PHB service from an external provider.

Options appraisal:

Descriptor	Positives	Negatives
1. Establish an internal team to the CCG to provide this service	• Direct ownership and reporting.	- Cost of establishing team - Ongoing employment liability - Currently the demand for PHBs is unknown and it is possible that there will be significant variation in requests, there will be time delays in recruiting additional staff. - There is limited experience of delivering PHBs and therefore people with the requisite skills are at a premium.
2. To commission a PHB service from an external provider	• The cost per case can be defined • Scalability of response to requests for PHBs • Maximise the limited experience of administering PHBs	- Subject to procurement regulations - There is likely to be a limited market initially.

Recommendation

The recommendation that will be formally considered by our Procurement Committee in by the end of February 2014 is for them to formally accept the preferred option which will recommends the following approach:

1. We will undertake a short pilot for the provision of the service. This will cover the 'optional' provision phase, plus a further period following the mandatory phase (from 1st October). It is suggested that this will require a period of 9 months (April to October, then 3 months from 1 October) **plus** a further 3 month period to allow for a new procurement process to be undertaken. The pilot will, therefore, operate for a total period of around 12 months.
2. The pilot will be used to obtain better commissioning information, to allow for a full procurement of the service to be undertaken at a later date in a more informed manner. Better information will be available regarding take-up of the provision by service users and also of the kind of PHB support service users are requiring. This will also allow time for the provider market to become more mature.
3. We are aware that ECDP are providing a similar service for ECC. They are a local provider of this type of service, with appropriate local connections and it is considered that they are best placed to operate this pilot on behalf of CPR & B&B.

1.11 IMPROVING SUPPORT FOR CARERS

Support for Carers

NHS Castle Point and Rochford CCG understand that Carer breakdown is a main trigger for admission to hospital/residential and nursing care.

We are committed, therefore, to support the implementation of the 'Essex Carers Strategy' and weaving requirements into contracts. This work will be reflected in our Strategic, Operational and Better Care Fund Plans

There is a range of Carer support arrangements in place across the county. These include carer befriending scheme, hospital link worker, Macmillan carer service, carer wellbeing checks (not universal coverage). In Castle point and Rochford CCG and South Essex CCGs we have carer recognition workers in primary care and secondary care settings, 'Who Cares' project and Carer champions.

In 2014/15 we will develop the business case for improved carer support and commission jointly between Essex County Council, for implementation late 2014/15.

Support for professional carers to raise standards in care homes, linking with providers of community services.

It is clear in CPR CCG that there are high numbers of patients present to A & E from residential and nursing homes.

In 2014/15 ECC and CCG partners will work with care homes to reduce falls and improve experience at End of Life through the 'My Home Life' Programme. Benefits would include reducing admissions to acute hospitals from residential and nursing homes.

Other Carer Support Areas

Dementia Support Services within Memory Services. WE will continue to use Voluntary Sector Organisation opportunities to support carers. These are jointly commissioned services provided by specialist voluntary organisations (e.g. Alzheimer's Society and Mind) to provide sensitive, responsive and individualised information, signposting, guidance and support to all people newly diagnosed with dementia, and their families and carers, to enable them to manage the impact of assessment and diagnosis of dementia on their lives.

Assistive Technology - Used wisely, we know that Assistive Technology offers local care partnerships an opportunity for transformational change in the way customers and their carers receive support, and in the types of support that can be offered and providing a more joined up, whole systems approach to health and social care delivery. Working with ECC through better Care Fund we will be looking to maximise opportunities for our patients and carers to avail of Assistive Technology.

1.12 PATIENT AND PUBLIC ENGAGEMENT

Since authorisation the CCG has established our Commissioning Reference Group (CRG), with dedicated GP leadership, and has undertaken a number of mechanisms to obtain patient and public engagement as outlined below:

- CCG launch event with patient survey.
- Two public events in Castle Point and Rochford based on nationwide NHS Call to Action campaign.
- Supported by councillors from both Rochford District Council and Castle Point Borough Council, including Mayor of Castle Point Borough Council, and Leader of Rochford District Council and Healthwatch Essex, demonstrating our commitment to working with our Local Authority partners to improve healthcare.
- CCG's PPI group (Commissioning Reference Group) was an integral part of the 2 events-helped to shape agenda.
- Commissioning Reference Group Urgent Care Survey seeking the views of patients using emergency care services which culminated in informing comprehensive winter planning/111 campaign including production of www.getwellessex.com

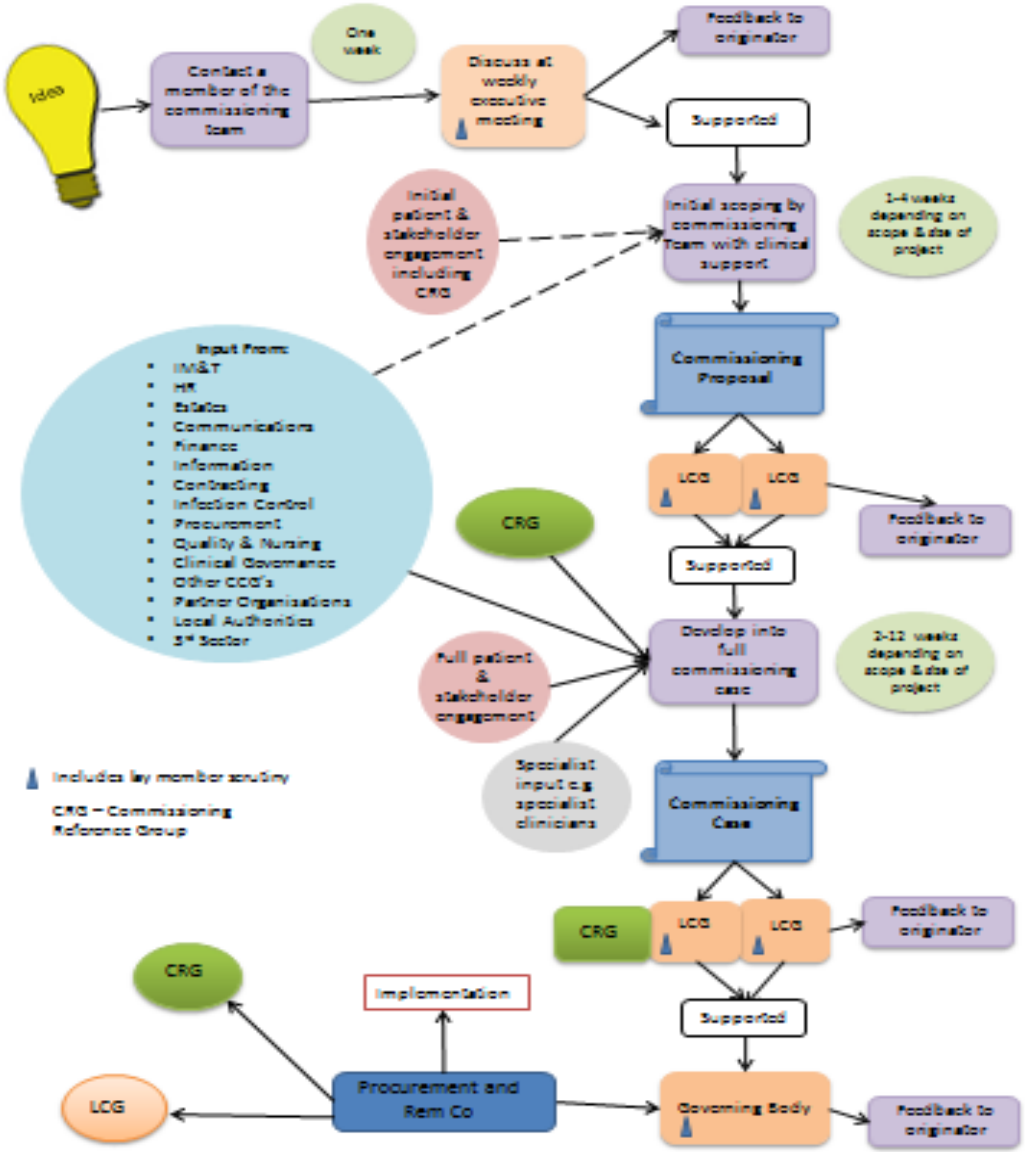
Some being addressed:

- Empowering patients to self care
- A&E communications campaign to run over Winter explaining how to use emergency services appropriately
- Challenges our local NHS faces: ageing demographic, rising cost of drugs, increased demand.

The outcomes of the above events have been pivotal in shaping our longer term planning and noted below are the actions to be taken during 2014/15 to commence the process of community led commissioning.

Action	Lead	Deadline
Distribute children's story book ' the Birthday Bug' through Children's Centres as recommended by the CRG Project Group	EH	May 2014
Liaise with GP practices in relation to running NHS 111 information on practice televisions.	EH	June 2014
Hold follow up call to action events across our locality.	TD	May 2014

Through direct engagement Commissioning Reference Group and CCG leads engagement with local partners and attendance at public events the CCG is building insightful methods that are in turn being used for patients and carers to participate in CCG planning, managing and making decision about their care and treatment through the services that they commission. Our commissioning cycle below sets the varying stages of CRG engagement and involvement in our commissioning processes.



Call to Action

Of particular note is a new requirement to set aside 1% relating to a "Call to Action" fund. The fund has been earmarked nationally to ensure the CCG meets its expectation "to support practices in transforming the care of patients aged 75 or older and reducing avoidable admissions by providing funding for practice plans to do so. They will be expected to provide additional funding to commission additional services which practices, individually or collectively, have identified will further support the accountable GP in improving quality of care for older people. This funding should be at around £5 per head of population for each practice". The CCG are actively working with our local GP Federation to submit a bid in response to the Prime Ministers Challenge Fund in alignment.

1.13 GOVERNANCE ARRANGEMENTS

1.13.1 Governance & Delivery Arrangements for Implementing the Plan

The CCG is a membership organisation with member practices accountable for exercising the organisation's statutory functions (including those it has delegated) and delivering against its responsibilities and objectives.

The CCG Constitution, which includes the Scheme of Reservation and Delegation, sets out the key functions of the CCG and who in the CCG has delegated responsibility for fulfilling these. In summary, the CCG Governing Body and its sub-committees will act under delegation from CCG members with the responsibility for ensuring delivery of the Integrated Plan.

Full details of the CCG Governance arrangements are included in *NHS Castle Point CCG Constitution* and the *NHS Castle Point CCG Organisational Structure & Governance Arrangements* document, with this section highlighting the role of committees in respect of delivering and monitoring progress against the major programmes of work included in this plan.

To deliver the major programmes of change included in the Operational Plan, the following have been established by the CCG.

- Two Locality Commissioning Groups
- CCG Executive Team

To review progress against the implementation of the Operational Plan, the following committees and sub-groups will/have been established by the CCG:

- Quality and Governance Committee
- Engagement and Patient Experience Committee (Commissioning Reference Group)
- Finance & QIPP sub-group

To consider the implementation of the Operational Plan and play a lead role in completing the annual refresh, the following committees have been established by the CCG:

- Commissioning Executive Committee
- Engagement and Patient Experience Committee
- Locality Commissioning Groups (for Integrated Plan engagement and approval)

In each area and across all areas of remit, Committees will be mandated to engage with member practice locality group and with locality patient participation groups.

The Governing Body

This is the body with ultimate responsibility for the delivery of the Integrated Plan. The body will consider Integrated Performance Reports monthly to track the overall position against all aspects of performance, quality, finance and QIPP delivery. The Governing Body will delegate responsibility for implementation of the

Integrated Plan to the Locality Groups and will delegate the responsibility for tracking performance against the Integrated Plan and the oversight of mitigating and remedial actions to the Quality and Governance Committee and its sub-groups.

The Governing Body has appointed the following committees and sub-committees to oversee implementation of the Integrated Plan. All of the committees set out above are accountable to the Governing Body and the Governing Body has approved and keeps under review the terms of reference for the committees.

Two Locality Groups:

Responsibility in relation to Integrated Plan: Multi-disciplinary and multi-organisational groups responsible for the delivery of programmes of work and QIPP in each priority area.

Description: Locality will include every practice member from within locality. The LCGs will act to oversee the implementation of the CCG's key commissioning programmes and QIPP initiatives.

Quality and Governance Committee:

Responsibility in relation to Operational: Oversees the delivery of all aspects of the plan. *Description:* Monitors and provides the Governing Body with assurance on overall progress against the Operational Plan, including all domains of finance, QIPP, performance, quality and safety. The Committee maintains the CCG's assurance framework and risk registers. It will act to shape the management agenda for the locality CCGs.

Commissioning Executive Committee:

Responsibility in relation to Operational Plan: Review implementation of current plans and performance and assume responsibility for annual refresh of Integrated and Strategy Plans.

Description: Oversees the development of the CCG's strategic plans and commissioning intentions, scrutinising the ongoing efficacy of current plans, commissioned services and scopes service developments. The Committee receives reports from locality CCGs and instructs them to undertake designated actions working through the member practices in the localities; receives reports from lead individuals charged with overseeing major commissioning programmes.

Engagement and Patient Experience Committee (Commissioning Reference Group):

Responsibility in relation to Operational Plan: Assuring that plan and work programmes engage with members of the public and patients.

Description: The Committee is responsible for ensuring that a range of patient experience data is captured and acted upon and informs commissioning decisions and to monitor patient engagement and advise the Governing Body on the subject.

Finance and Performance Committee

Responsibility in relation to Operational Plan: Focussed group assuring full delivery of annual QIPP programme and financial responsibilities.

Description: The purpose of the sub-committee is to act as the oversight body with responsibility for CCG financial performance and QIPP delivery. The sub-group will have one over-arching responsibility: to act in an advisory capacity in relation to the CCG Governing Body's delegated finance and QIPP delivery targets, and to recommend corrective action to the Quality and Governance Committee and CCG Governing Body as appropriate

1.14 PRIMARY CARE

1.14.1 Why Our Primary care Services Need to Change?

Our CCG clearly acknowledge that primary care needs to change if it is to cope with future demands and challenges. Some of the key challenges impacting this need to change are:

- Increase in Older Population.
- More Chronic Diseases.
- Rising GP workload exacerbated by recruitment difficulties
- Financial Pressures on NHS.
- Increased Patient Expectations

Our key priorities for primary and community care can be summarised as:

- Reducing variation in the quality of primary care
- Support for preventative care, wellbeing and early diagnosis of health problems
- Improved access to primary care on a 24/7 basis, supported by 111/OOH
- Integrated approaches (linked to Better Care Fund) to care for the elderly and those with long term conditions
- Personalised care-planning and self-management
- Rapid, convenient access to planned & outpatient care, with more care provided out of hospital.

Primary care plays a vital part in the delivery of our Strategic Plan and in improving patient outcomes. One of the five CCG goals included in our plan is to reduce the variability of primary care quality and outcomes so that patients across the localities receive the same high standard of care.

The CCG would like to commission a project looking at primary care quality and their capacity to deliver this Strategic Plan and achieve improvement in the outcome indicators. This work would be completed during 2014/15 to inform a longer-term strategy to improve primary care quality and reduce variation in patient outcomes across the CCG geography.

The intention is that our CCG will support the Area Team to invest in a programme of targeted primary care development to enable delivery of the Strategic Plan and the outcomes included in the High level Ambitions. The purpose of this development programme is to:

- Support high quality care in primary care and community settings (ensuring access for all)
- Improve the identification and management of a range of conditions

- Provide more care closer to the patient and by doing so decreasing reliance on acute hospital care.
- Aim is to shift 5% of resources currently invested in secondary care to primary care with the workload.

The primary care development programme would operate using a variety of different training approaches including - peer-to-peer and specialist-led programmes; formal learning events; clinical protocols and practice-based audits – to achieve targeted improvement in the following areas included in the Integrated Plan:

- Early identification and accurate diagnosis of long-term and other priority high prevalence conditions
- Enhanced ability to manage long term conditions, to avoid hospital referral and support better patient outcomes
- Medicines management knowledge in order to provide quality, cost-effective prescribing and support
- Management of patients in primary care where part of an agreed pathway/shared protocol
- Good understanding of agreed local pathways and local service configuration to enable referrals to be made to the right service for each patient's needs, at the right time

Practice staff training will focus on our strategic priority areas, which include long-term conditions (diabetes, respiratory and CVD) mental health (including dementia care) and planned care aimed at supporting a shift of care setting in specialities like dermatology and ophthalmology.

The scope of the development programme would not include formal GP training, nor is it intended to replace the CPPD programme. The programme is designed to be complementary to other training resources for primary care staff and will operate in alignment with formal training programmes. We would ensure that the wider training and workforce issues emerging from our Strategic Framework and this Integrated Plan are reflected in training plans over the next five years and beyond.

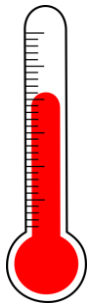
1.14.2 Primary care vision in CCG

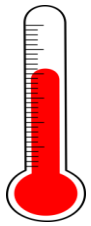
Our CCG vision for primary (and community care) is providing easy access to high quality, responsive primary & community care as the first point of call for people in order to provide a universal service for the whole population and to proactively support people in staying healthy.
The aim is to increase the proportion of episodes of morbidity that are commenced and completed in primary care without recourse to the acute services. Core aspirations linked to emerging Primary Care strategy and local strategic plans are set out in table below.

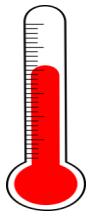
	Headline Aspirations	**Month / Year Complete**
	Core Primary Care Strategy Aspirations supported by our CCG	
1.	Make full use of premises. Endeavour to ensure that any void primary care estate is fully utilised	Dec 14
2.	Encourage Individual GP practices to move towards having a minimum list size of 4,500 patients serviced by the equivalent of 2.5WTE GPs and/or develop close associations with neighbouring practices to share skilled resources.	Mar 16
3.	CPR would support Primary Care Strategy aim to increase number of GPs working in CP&R through the establishment of more training practices and enhanced roles within hubs/localities that attract professionals	Linked to Strategy
4	CPR would support Primary Care Strategy aim to increase number of nurses working in CP&R through the enhancement of nurse practitioner training and enhanced roles within hubs supported by LETB	Linked to Strategy
5.	As per above initiatives to increase quality and reduce variability we will be working with our practices who are currently unable to evidence they are delivering high quality care in line with CQC standards to avoid the risk of potential decommissioned.	Ongoing
6.	Increase the % of CPR GPs using text messaging service to remind patients of their appointments	Apr 15
7.	CPR GP practices aim to create Federated structure forming a virtual hub covering CCG population	Apr 15
8.	CPR has arrangements in place with community provider to ensure HV/District Nurses are aligned to individual practices.	Jan 14
9.	10% shift of activity alongside 5% in resources from acute to primary care.	Apr 18
10.	CPR patients with LTC to have a named clinician/managed by a specialist within a hub or hub created as specialist practice for patients with LTC.	Apr 15
11.	Commuter clinics provided by GP practices / within a hub / hub delivering clinics in evenings and at weekends.	Apr 15
12.	The CCG will support AT initiative that will undertake triage, diagnosis and treatment of minor illness in a pharmacy setting / write prescriptions for a limited list of medications from pharmacy or as part of primary care team in general practice / fully integrated into primary care team delivering consultations, prescribing, immunisations	Apr 15
13.	Pharmacists take on a greater role in managing supplies of repeat medicines enabled by batch prescribing and electronic prescriptions / pharmacists will request or carry out appropriate routine monitoring e.g. blood tests and be able to re-authorise repeat medicines. This will be integrated with face to face discussions with the patient about their medicines / A holistic patient centred medicines service focussed on patient wellbeing, enablement and joint decision making, working closely with the patients GP.	Apr 15
14.	Pharmacists managing straightforward conditions such as allergic rhinitis, hayfever, dry and itchy skin / management of long term conditions such as asthma or chronic pain, in the pharmacy, linked to and supported by GP hubs / specialist pharmacists will be employed within hubs to be part of specialist teams caring for patients with LTC.	Jan 14

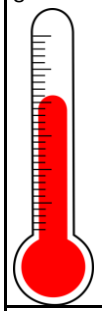
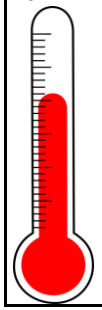
	CPR Specific Aspirations	
15.	CCG Innovation Group agrees approach to reducing variation, including training and development plans, access and productivity initiatives	Dec 14
16.	Secure support to deliver training programme and agree future priorities and funding	Jun 15
17.	Plan and deliver a programme of Practice Visit to present emerging CCG Strategic and Operational Plans so Practices clearly understand their role and responsibility in delivery	Jun 14
18.	Agree and support individual practice to operationalise their development plans	Ongoing
19.	Working with Better Care Fund Programme implement a plan to address gaps in supporting self-management in Long term conditions such as local Diabetes Integration initiative	Apr 15
20.	Further develop risk stratification, linking to Better Care Programme work, care-co-ordination and Community Multi-Disciplinary Team development.	Apr 15
21.	Continue to develop referral support services in particular peer review	Apr 14
22.	Develop diagnostics strategy and implementation programme	Dec 14

2 NHS CONSTITUTION

	Performance Measure	2013/14 Baseline	2014/15 Standard	Action Required	Lead	Deadline
1 	RTT Despite meeting the national standards for admitted and non-admitted in Q3 (unvalidated) SUHFT continue to underperformance in a number of specialties and a recovery plan is in place to address this.	Admitted = 86.10% Non-Admitted = 95.10% Incompletes = 52+ week waits = 0 (Dec 2013)	Admitted = 90% Non-Admitted =95% Incompletes = 92% 52+ week waits = 0	Continue to monitor progress at weekly performance meetings with SUHFT and support host CCG in respect of raising contract queries as required. Speciality level areas currently underperforming: • General Surgery • T&O • Urology • ENT • Oral Surgery Significant issues identified relating to the roll out of the new PAS system and the impact on the Trust's RTT backlog and contract notice raised.	VG	TBC
2 	Diagnostic Waits - Percentage of patients who have waited less than 6 weeks for a diagnostic test	99%	99%	Continue to monitor performance through CQRG.	MA	Ongoing

	Performance Measure	2013/14 Baseline	2014/15 Standard	Action Required	Lead	Deadline
3 	A&E - Percentage of people who have been admitted, transferred or discharged within 4 hours of their arrival at an A&E department	As at 31.01.14 YTD = 93.65 Q1 = 91.04% Q2 = 96.54% Q3 = 94.21% Q4 = 91.14%	95%	• Continue to monitor progress against the Recovery Action Plan at weekly performance meetings with SUHFT and support host CCG in respect of raising contract queries as required. • Implementation of A&E CQUIN to ensure that cancer patients are seen in a more appropriate environment e.g. CAU • Contract notice raised.	KMK	March 2015
4 	Number of people who have had to wait for longer than 12 hours following a decision to admit them in A&E.	0	0	Continue to monitor through weekly performance meetings with the Trust. A&E Recovery Plan in place and Urgent Care Network monitoring progress against the plan as a system.	KMK	Mar 15
5.1 	Cancer waits 2 week waits (patients referred urgently with suspected cancer by a GP) 2 week waits (patients referred urgently with breast symptoms (where cancer was not initially suspected)	 96.9% (Nov 13) 97.8%	 93% 93%	Continue to monitor through weekly performance meetings with the Trust. Regular review of Patient Tracking Lists and early identification of issues arising at Trusts and in Primary Care for resolution. Inter-Trust Cancer Policy developed but not yet agreed. Host CCGs for SUHFT and BTUH working with the Trusts to resolve this.	KMK	Mar 15
5.2 	31 day (wait from diagnosis to first definitive treatment for all cancers) 31 day (wait for subsequent treatment where that treatment is surgery) 31 day (wait for subsequent treatment where that treatment is an anti-cancer drug regimen) 31 day (wait for subsequent treatment where the treatment is a course of radiotherapy)	100% (Nov 13) 94.4% (Nov 13) 100% (Nov 13) 96.2% (Nov 13)	96% 94% 98% 94%	As above	KMK	Mar 15

	Performance Measure	2013/14 Baseline	2014/15 Standard	Action Required	Lead	Deadline
5.3 	62 day (wait from urgent GP referral) 62 day (wait from referral an NHS screening service) 62 day (wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient)	88.1% (Nov 13) 100% (Nov 13) 100% (Nov 13)	85% 90% No operational standard set	Ensure full implementation of the Cancer Waits recovery plan. Performance as at Q3 is showing all cancer waiting time standards achieved at SUHFT. Inter Trust Policy singed between BTUH and SUHFT. Discussions around localisation of site specific "Timed pathways" implemented in Anglia.	KMK TA/MC	March 2014
6 	Category A calls for an ambulance resulting in an emergency response within 8 minutes (R1 / R2) and ambulance arriving in 19 minutes	As at November 2013 Red 1 = 70.37% Red 2 = 61.45% 19 minutes = 98%	Red 1 = 75% Red 2 = 75% 19 minutes = 95%	The concerns around East of England Ambulance Trust's performance have been escalated and support is being provided to the Trust collaboratively to address these issues. Discussions are currently focussing on capacity and recruitment issues and the six key priority areas for EEAST to provide a safe and high quality service are noted below: • EEAST six key priorities to provide a safe and high quality clinical service: • Recruit 400 student paramedics in 2014/15 • Up skill Trust ECA's to Technicians and Technicians to Paramedics • Maximise clinical staff on front line vehicles • Reduce response cars and increase Ambulances • Accelerate fleet and equipment replacement programme • Re-invest corporate spend into front line delivery	EH	March 2014
7 	Number of people who breach mixed sex accommodation requirements	0	0	Governance process in place via the monthly Provider update for the CCG Quality report which goes to the CCG Quality and Governance Committee, Locality Commissioning Groups and the CCG Governing Body meetings. Schedule of planned and unplanned visits in place to monitor compliance.	TD	March 15

	Performance Measure	2013/14 Baseline	2014/15 Standard	Action Required	Lead	Deadline
8 	Cancelled Operations - Number of patients who are not offered another binding date within 28 days > 0	38 YTD as at Dec 13	100% patients to be offered another binding date within 28 days No urgent ops cancelled for the 2nd time		EH	March 2015
9 	The proportion of people under adult mental illness services on CPA who were followed up within 7 days of discharge from inpatient care.		95%	Improving CPA quality standards by addressing care planning and management process weaknesses especially S117.	JI	Mar 2015
10 	Percentage of ambulance handovers completed by 15 minutes of arrival and to be ready to accept a new call by 30 minutes of arrival	No. of handovers >15 minutes = 4178 YTD Of which >30 = 916 YTD	15m: 100% 30m: 100%		EH	March 2015

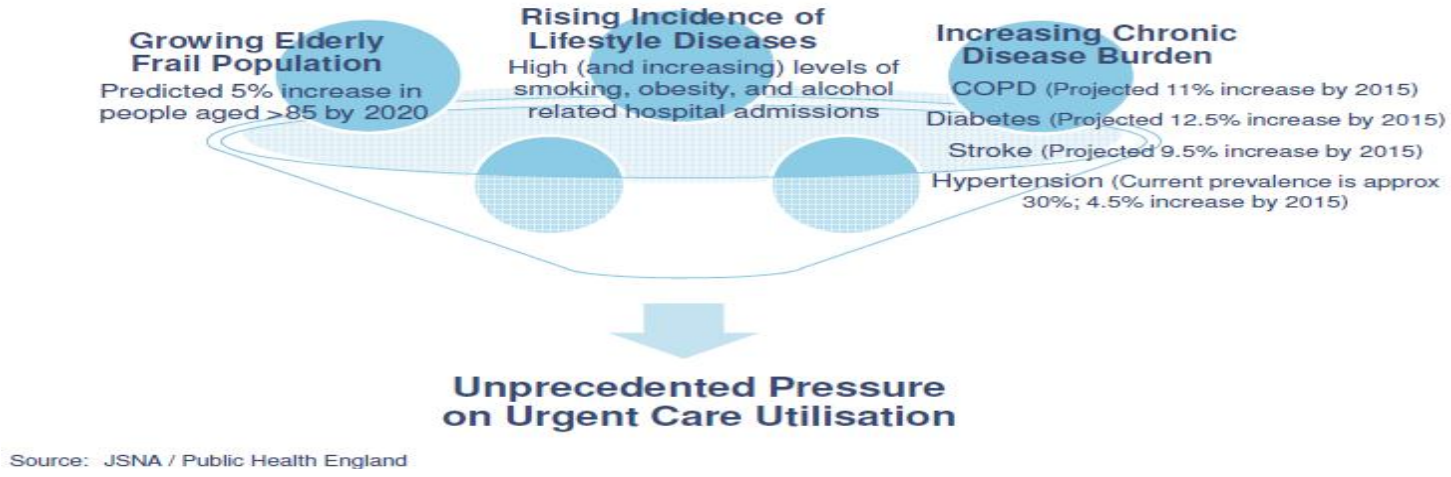
2.1 URGENT CARE

South East Essex Urgent Care System Headlines

- We are a mature and historically well performing health system serving a population of more than 345K
- Current emergency admissions are draining considerable resources. We have recently encountered performance issues which we are addressing aggressively in partnership with SUHFT
- Our efforts have gained traction but we are very mindful of the medium and long term risks we face given our aging population, and the increasing incidence of lifestyle and chronic disease burden
- In order to tackle this critical agenda, we need to ensure that:
    - We deal with problems in non-urgent components of the health and social system which are creating excessive demand for urgent care
    - Reduce clinical practice variation
    - Improve methods of mainstreaming protocols
    - Add capabilities to deliver timely data reporting and insights to support effective decision making
    - Improve whole system engagement and planning

Looking Ahead

We are very mindful of the medium and long term risks we face given our aging population, and increasing incidence of lifestyle and chronic disease burden.



Source: JSNA / Public Health England

The Future of Urgent Care Services in South East Essex

The challenges facing our urgent and emergency care system in South East Essex are clear, as are the opportunities for improvement. Castle Point and Rochford CCG in partnership with Southend CCG will take action. Our plan sets out our key areas of focus for the future of urgent and emergency care services in South East Essex. Based on guidance, there are five key elements, summarised below, which Castle Point and Rochford CCG intend to take forward in collaboration to ensure success:

1. **Firstly, we will provide better support for people to self- care**. To achieve this, we will need to provide better and more easily accessible information about self-treatment options so that people who prefer to can avoid the need to see a healthcare professional. We will also need to accelerate the development of comprehensive and standardised care planning, so that important information about a patient's conditions, their values and future wishes are known to relevant healthcare professionals. This way, patients will be better supported to deal with that condition before it deteriorates, or if additional help is required.

2. **Secondly, we will help people with urgent care needs to get the right advice in the right place, first time**. To achieve this, we will greatly enhance CPR CCG hosted South Essex NHS 111 service so that it becomes the smart call to make, creating a 24 hour, personalised priority contact service. This enhanced service will have knowledge about people's medical problems, and allow them to speak directly to a nurse, doctor or other healthcare professional if that is the most appropriate way to provide the help and advice they need. It will also be able to directly book a call back from, or an appointment with, a GP or at whichever urgent or emergency care facility can best deal with the problem.

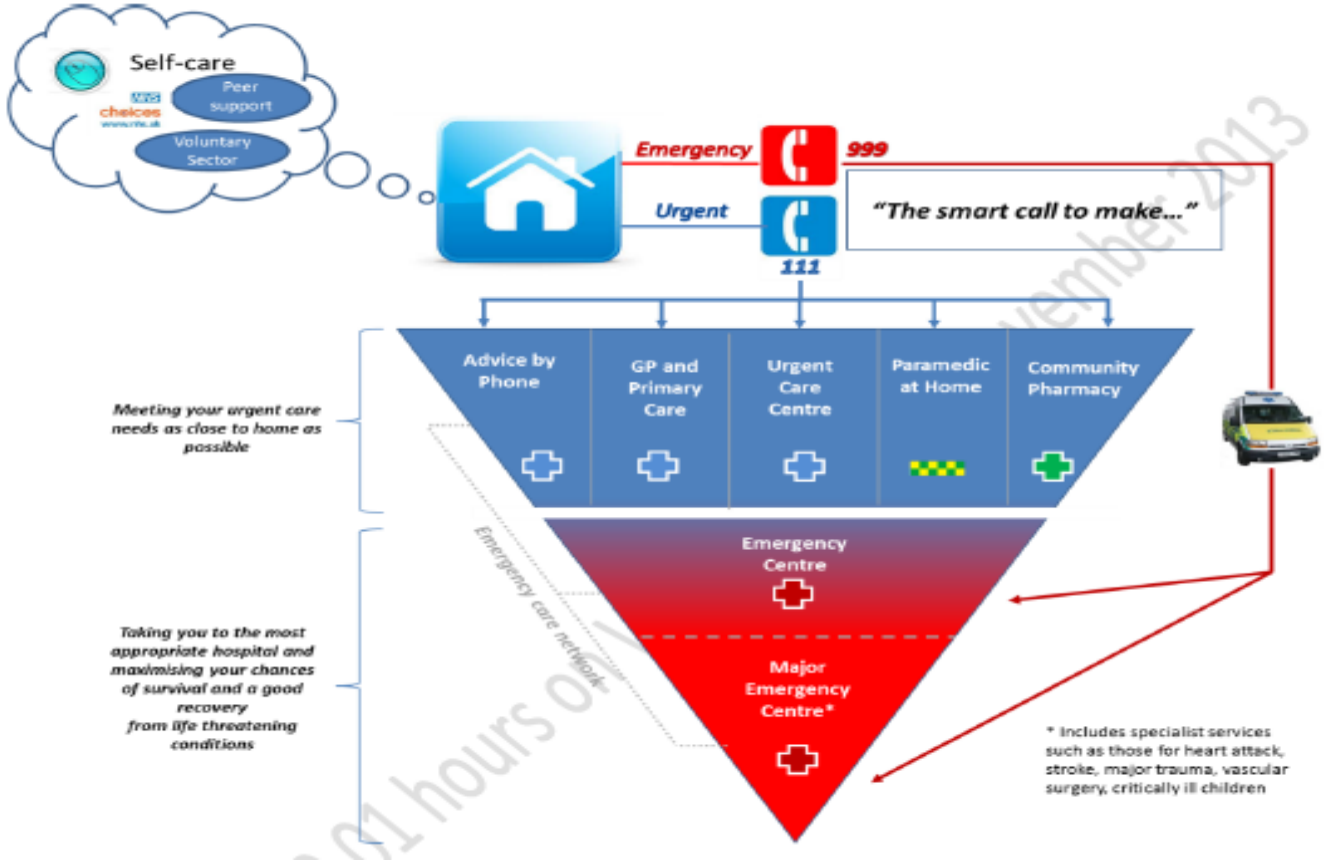
3. **Thirdly, we will provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E.** This will mean providing faster and consistent same-day, every-day access to general practitioners, primary care and community services such as local mental health teams and community nurses for patients with urgent care needs. It will also mean harnessing the skills, experience and accessibility of a range of healthcare professionals including community pharmacists and ambulance paramedics. We will work with our Ambulance service to ensure the extension of paramedic training and skills, and supporting them with GPs and specialists, we will develop our 999 ambulances into mobile urgent treatment services capable of dealing with more people at scene, and avoiding unnecessary journeys to hospital.

4. **Fourthly, we will ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery.** Once we have enhanced urgent care services outside hospital, in line with national guidance we will introduce the two levels of hospital emergency department – Emergency Centre and Major Emergency Centre. In time, these will replace the inconsistent levels of service provided by our A&E Department. The presence of senior clinicians seven days a week will be important for ensuring the best decisions are taken, reassuring patients and families and making best use of NHS resources. Emergency Centres will be capable of assessing and initiating treatment for all patients and safely transferring them when necessary. Major Emergency Centres will be much larger unit, capable of not just assessing and initiating treatment for all patients but providing a range of highly specialist services. This centre will have consistent levels of

senior staffing and access to the specialist equipment and expertise needed to deliver the very best outcomes for patients. We envisage there being a Major Emergency Centres in South East Essex.

5. **Fifthly, we will connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts.** Building on the success of major trauma networks, we will support the emergency care network in South East Essex. The network will dissolve traditional boundaries between our hospital and community based services and support the free flow of information and specialist expertise needed to achieve the delivery of patient care in the most appropriate and convenient setting. The Major Emergency Centres will have a lead responsibility for the quality of care and operational performance of services across the network they support, including linked Emergency Centres. The network will also support the introduction of an efficient critical care transfer and retrieval system so that patients requiring specialist help reach the best possible facility in a timely fashion.

The Proposed Design and Look of New System *(ref NHS England)*



Urgent Care System Emerging Action Plan for 2014/15
We anticipate that it will take 3-5 years to enact the major transformational change set out within this plan. However, we expect to make significant progress over the next 6-12 months:

There were a number of successful actions and initiatives taken during the winter period of 2013/14 which demonstrate the commitment from all partners to deliver a sustainable urgent care system for the population of South Essex. These successes will be embedded into business as usual and built upon as we move into the next phase of change.

- Distinct shift in approach to a system that is working effectively in partnership with improved communication and transparency. Issues seen as being owned by the system, not by one organisation/department
- Dedicated medical outlier ward with robust medical input maintained efficient discharge and reduced length of stay.
- Significant operational improvements to SPOR resulting in increased usage by GPs
- Increased use of admission avoidance and community pathways by EEAST ambulance crews, reducing conveyance rate to A&E
- Increased reablement capacity and implementation of 'holding' care packages
- Social care becoming integrated with hospital teams, and extension to Sunday working.

Following a system wide review in February 2013, a number of key areas of focus were agreed with partners. These are in the process of being fully developed and agreed through the Urgent Care Steering Group. An indicative plan is outlined below, this is subject to further detailed discussions and approval.

This plan reflects the system wide learning and outcomes from the 13/14 winter surge period, with all system partners engaged in the vision and delivery of the emerging action plan. The action plan will be overseen by the Urgent Care Steering Group which will refocus from operational delivery to sustainable transformation and change management.

It is anticipated that a number of these initiative may require non-recurrent investment as the system transfers focus towards the earlier stages of a patients pathway.

Action	Description	Owner	Timescale
Use of Winter Monies	Review of outcomes for each initiative to determine short term success and inform longer term planning	Yvonne Campen (Southend CCG)	March 2014
Non-Emergency Patient Transport	Full review of service to support same day access and discharge processes	Emily Hughes	May 2014
	Short term solutions implemented to support system	Emily Hughes	August 2014
	Service redesign and potential recommissioning/procurement	Emily Hughes	December 2014
Intermediate Care Beds	Reprovision of community based step up and step down model	Liz Paddison (CP&R CCG) and Yvonne Campen (Southend CCG)	September 2014
A&E Recruitment Programme		SUHFT	
Feedback on Poor Discharges	Improved processes to allow timely feedback to enable swift learning and actions to be taken	Amanda Yeates (SEPT)	March 2014
Care Homes	Implementation of new model and pathways to support admission avoidance in nursing and residential homes	Liz Paddison (CP&R CCG) and Yvonne Campen (Southend CCG)	June 2014
Integrated Community Teams	Clarity regarding services available to support the system	Amanda Yeates (SEPT)	March 2014
Continuing Health Care (including Fast Track)		Matt Gillam	August 2014
Primary Care	• Options regarding 7 day working • Messaging from Practices to Patients • GP Admissions Pathways • Education of locums re: community pathways/admission avoidance schemes • Impact of 'batching' of GP admissions	NHS England (Ian Ross) in partnership with CCGs	

Action	Description	Owner	Timescale
Consultant Triage of GP admissions	All GP admissions to be triaged by a consultant, initiative supported by CQUIN scheme	SUHFT	September 2014
System Dashboard	Development of system wide 'live' dashboard to enable swift action and predictive modelling	Yvonne Campen (Southend CCG)	July 2014
Frail Elderly Ambulatory Care	Further development and implementation of Frail Elderly Ambulatory Care model and associated pathways, including: • Redesign of Community Geriatrician service • 'Front End' Pathways within Acute • Expansion of SPOR and DAU	Liz Paddison (CP&R CCG) and Yvonne Campen (Southend CCG)	October 2014
NHS 111	Increase awareness and usage of successful NHS 111 service as the 'first point of call' for urgent care	Emily Hughes	September 2014
7 day Working	Initiating local initiatives (demonstrator site) to trial new models of delivery for 7 day services supported by NHS Improving Quality	Yvonne Campen	
Consultant review in A&E	Early specialist review of patients		
A&E - Front Door	Continued redesign of access and pathways through A&E, consideration of primary care model.		

Measures of success of the above action plan will include:

- Sustained achievement of the A&E 4 hour target
- Reduction in medical outliers during surge periods
- Reduction in emergency admissions for Frail Elderly
- Increased activity of NHS 111
- Reduction in CHC Fast Track applications, to be comparable with peers
- Reduced use of 'ad hoc' patient transport

3.1 ACTIVITY

	Activity	Area	2013/14 Baseline	Growth (2.4%)	QIPP	Plan	Action Required	Lead	Deadline
1	Elective FFCEs	Ordinary	5231	5356	-	5356	Explore opportunities for re-modelling MSK pathways across the system, to reduce specialist activity whilst improving patient outcomes and experience.	EH	Sept 2014
		Daycase	21782	22304	-	22304	Develop bundled pathway for cataracts.		
							Reviewing and updating SRP to reflect latest guidance.	EH	May 2014
								EH	April 2014
2	Non elective FFCEs	Non-elective	15522	15895	- 1795 *Urology* *- 225* *Int care* *- 468* *DAU* *-969* *CAU* *-97* *Care Homes* *-36*	14100	Introduction of new catheter care pathway.	EH	April 2014
							Commission community based intermediate care beds.	EH	Sept 2014
							Redesign DAU to offer same day access to complex geriatric assessment to avoid onward admission into the hospital.	EH	April 2014
							Commission dedicated Cancer Assessment Unit .	EH	April 2014
							Provide additional resource and support to practices in relation to managing patients in care homes.	EH	April 2014

	Activity	Area	2013/14 Baseline	Growth (2.4%)	QIPP	Plan	Action Required	Lead	Deadline
3	Outpatient attendances	All Firsts	51582	52820			Explore opportunities for re-modelling MSK pathways across the system, to reduce specialist activity whilst improving patient outcomes and experience. Develop bundled pathway for cataracts. Reviewing and updating SRP to reflect latest guidance. Continued improvement in outlying areas of GP referral management.	EH EH EH EH	Sept 2014 May 2014 April 2014 April 2014
		All Subsequents	121792	124715	-2100 (glaucoma)	122615	Implementation of stable glaucoma pathway.	EH	June 2014
4	A&E attendances	Type 1	43908	44962	-1278		Attendances avoided through communications and marketing campaign to redirect patients from A&E via NHS 111 onto alternative services.	EH	April 2014
		All attendances	45336	46424	-880 (NHS 111) -398 (A&E impact of Admission Avoidance Schemes)				
5	Referrals	GP Referrals	40391	41360	As above	As above	See outpatients above	EH	As above
		Other Referrals	20222	20454	As above	As above			
		First Op following GP Referral	32924	33302		33302			

3.2 QIPP PLANS 2014/15

3.2.1 Overview

QIPP management is a critical component of our CCG operational arrangements and is considered as part all CCG decision-making. Core themes across our QIPP planning are:

- the development of integrated commissioning in partnership with the Local Authority and neighbouring CCGs;
- clinical ownership and leadership across our localities and member practices, and
- our commitment to improving community health care to reduce reliance on acute services.

The QIPP plans for 2014-15 are still in development as part of the 2014/15 planning round. To support this, the CCG will employ a QIPP lead to work with the project leads and stakeholders to develop robust, deliverable plans. In 2013/14 the CCG developed a robust QIPP activity and financial analysis process for our QIPP programme enabling both detailed planning and strong monitoring processes, supported by key members of the Business Intelligence and Contracting team of the CSU.

The CCG continues to work with local stakeholders to develop QIPP schemes to address the financial gap identified and has in place an clinically led Innovation Forum to generate new ideas, led by the Clinical Accountable Officer.

3.2.2 QIPP Monitoring and Delivery

Delivery of our CCG QIPP plans requires a strong Programme Management Office (PMO) function. The CCG is currently reviewing our PMO arrangements for next year and will confirm these arrangements shortly. Fundamentally the following components will be intrinsic to our consolidated PMO arrangements:

- A member of the CCG Executive will oversee each scheme in order to ensure milestones are met and any blocks to delivery are quickly addressed.
- All schemes will have a detailed project plan with measureable milestones.
- The QIPP schemes will be reviewed at regular intervals with each of the programme leads and then by exception at a monthly QIPP meeting.
- The GP leads and their commissioning managers will be held to account for delivery by our CCG Finance and Performance Committee if scheme slippage occurs.
- QIPP delivery will be reviewed by our Governing Body as part of the monthly finance reporting.
- QIPP will be visible and owned by all areas/localities within the CCG and will be subject to both high level and operational scrutiny within the CCG.
- The attached QIPP checklist evidences how well the PMO processes for QIPP will be embedded within the CCG.

3.2.3 QIPP Plans and Impact

As identified in Finance Plan section the CCG has an £8.4 million funding gap /QIPP challenge for 2014/15. The QIPP plans for 2014-15 are still in development as part of the 2014/15 planning round. The table below details the QIPP schemes for 2014/15. We are confident of meeting our 2014/15 QIPP challenge and we have identified the work streams and services line savings we will be aggressively pursuing to ensure we deliver our financial statutory obligations.

There are three tables below set out how we intend to deliver our QIPP challenge, namely: (a) Legacy Schemes impacting on 2014/15 (b) New schemes in advanced planning/scoping and (c) Remaining Service Lines /workstreams and target savings for each

Summary

Funding Gap/QIPP Target	-8,400,000
Legacy 13/14	929,184
New QIPP Scoped	2,647,415
New QIPP Service Lines targeted for savings	5,214,234
Contingency	**390,833**

It should be noted that all QIPP schemes are currently being rebased to reflect latest delivery and activity profiles and to align with the contract model principles.

The activity implications of QIPP schemes are being reflected in the contract activity models.

(a) 2013/14 Legacy Schemes (impacting on 2014/15

A number of legacy schemes implemented in 2013/14 will deliver an incremental saving in 2014/15. These 'legacy' schemes are fully implemented and require minimal resourcing to monitor.

Workstream	Scheme	Scope	GB Clinical Lead	14/15 Planned Saving (CP&R)*
Legacy Planned Care	Dermatology	CP&R	Dr Siddiqui	£17,215
	Repatriation	CP&R	Vacancy	£21,368
	BPH – Decommissioning	CP&R	Dr Turner	£7,200
Legacy Unplanned Care	DVT	CP&R	Dr Siddiqui	£8,000
	Urology / TWOC	South East Essex	Dr Saad	£117,619
	Minor Injuries	CP&R	Dr Gardiner	£2,340
	NHS 111	South Essex	Dr Gardiner	£73,589
	DAU	South East Essex	Dr Mike Saad	£308,533
	Respiratory	South East Essex	Dr Taylor	£161,320
	SHAARC	CP&R	Dr Gardiner	£212,000
			Total	**£ 929,184**

**subject to rebasing*

(b) 2014/15 QIPP Workstreams - Scoped

Workstream	Scheme	Scope	GB Clinical Lead	14/15 Planned Saving (CP&R)*
New Planned Care	MSK	South East Essex	Dr Saad	TBC
	Ophthalmology	South Essex	Dr Taylor	77,000
	Community Contestability	South Essex	Dr Gupta	107,294
	Diabetes	South East Essex	Dr Kent	TBC
	PR Maintenance Programme	South East Essex	Dr Taylor	5,012
New Unplanned Care	Intermediate Care Beds	South East Essex	Dr Saad	226,718
	Cancer Assessment Unit	South East Essex	Dr Kuriakose	268,216
	Care Homes – Primary Care Federated Model	CP&R		TBC
	Falls	CP&R	Dr Gardiner	40,320
Medicines Management	Gastro Intestinal	South East Essex	Dr Taylor / Dr Grauri / Dr Lester	88,727
	Cario-vascular			293,521
	Respiratory			350,823
	CNS			371,490
	Endocrine			403,001
	Nutrition			310,151
Childrens	High Impact Pathways	CPR	Dr Siddiqui	14,399
	Lighthouse			87,500
	Child Death Review			3,243
	CAMHS Redesign			TBC
			TOTAL	**2,647,415**

(c) 2014/15 Area of Commissioning Spend targeted for QIPP savings

Area of Commissioning Spend targeted for QIPP savings	Budget Holders	QIPP Target
Mental Health Contracts	Kevin McKenny	-614,500
Child & Adolscent	Kevin McKenny	-45,600
Mental Health Other providers (e.g non NHS etc)	Kevin McKenny	-5,800
Acute - Southend Hospital	Kevin McKenny	-2,298,101
Acute – Other NHS	Kevin McKenny	-246,185
Acute – (Private & Other)	Emily Hughes	-185,960
Out of Hours/111	Emily Hughes	-45,791
Oxygen Services	Sunil Gupta	-45,791
Continuing Health Care - Adult	Tricia D'Orsi	-1,408,799
Continuing Health Care - Children	Kevin McKenny	-23,327
Funded Nursing Care	Tricia D'Orsi	-72,733
Community Services	Emily Hughes	-133,630
Hospices and Palliative Care	Kevin McKenny	-26,774
Non Acute Commissioning	Kevin McKenny	-37,888
Patient Transport	Emily Hughes	-23,355
	TOTAL	**-5,214,34**

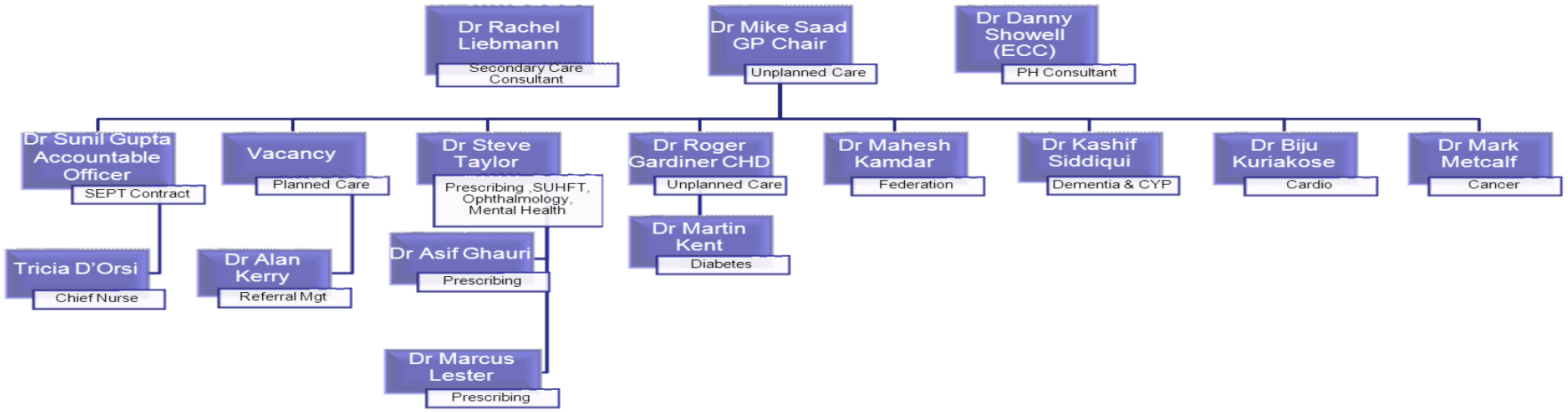
3.2.4 Further QIPP Ideas in Scoping

Our GP leads and member practices have identified a range of ideas that currently also being scoped. These include:

- Cellulitis Pathway
- Dietetics
- SALT (Dementia)
- Non-Emergency Patient Transport Services
- GP Home Visit Car covering localities
- Heart Failure -A work stream to bring about earlier diagnosis and better management of heart failure
- Atrial Fibrillation - A work stream to improve the detection of people who have Atrial Fibrillation.
- GP visits - A work stream to ensure patients who were in hospital due to an emergency admission and discharged on Thursday, Friday, Saturday or a Sunday are visited by a GP the day after they are discharged.
- Experience GP at front door A&E

3.2.4 CCG Clinical Leadership Structure

To ensure that all service redesign / QIPP schemes are clinically led, the CCG has identified clinical leads for all priority areas and CCG QIPP schemes.



4 BETTER CARE FUND

Overview

We are worked very closely with our partners to develop our plans for Better Care Fund (BCF) with Essex County Council, Southend CCG and Basildon and Brentwood CCG, alongside local providers. We have already agreed areas of joint work and are keen to develop new governance arrangements to oversee the implementation of these key programmes. Together Castle Point & Rochford CCG, Basildon and Brentwood CCG and Essex County Council are implementing the Better Care Fund agenda, aligned to key QIPP and JSNA priority areas for 2014/15. It is imperative that we develop our plans in collaboration with our colleagues in Southend CCG (our partners in our shared South East Essex system). Our shared priorities include:

- Focus on frail elderly across health and social care with particular focus given to admissions avoidance and reablement, and in particular in working to shift the balance of care in Castle Point & Rochford.
- Children and Young people's services including safeguarding.
- Mental Health and Learning Disabilities

Developing integrated Care through Better Care Fund is an important part of the CCG's approach to delivering its strategy. In 2013/14 SEE CCG commissioning teams have been working collaboratively on a programme of work focusing on Integrated Care that brings together all key providers and commissioners in the local health system, with focus on the development of integrated care and service models that reduce rising number of acute unplanned admissions across South Essex. Examples include: lead provider now contracted to deliver care using 'integrated team' specifications, and we have commissioning a Single Point of Referral (SPOR) shared health and social care telephone referral service for clinicians.

Our aim for BCF is to deliver sustainable integrated local health and social care models and services. It will being delivered through a partnership between Southend CCG, Castle Point & Rochford CCG, Basildon & Brentwood CCG acute and community providers, local GP practices and partners in Local Authorities. The aim of the programme is to jointly redesign the health and social care system and redefine the way professionals engage with each other around the assessed needs of individuals.

The BCF will fundamentally change the way in which people are supported in taking charge of their own care and conditions. The programme's initial focus, through integration with local authorities, is on caring for older people and its scope will be systematically broadened over the next four years (2014-18) – with Frail Elderly and Long Term Conditions being the focus the first phase of work.

The aim of the collaborative BCF (Integrated Care) Programme is to drive up the quality of care and drive down costs of providing it:

- improving the value of care we provide to local people by joining up care around people, across providers;

- identifying and managing people's care needs better and intervening earlier;

- ensuring care is provided in the most appropriate setting, particularly at times of acute crisis and by ensuring the right incentives exist for providers to work in integrated ways.

Our key objectives of the Better Care Fund (BCF) are:

- To commission services that target frail and older people who are vulnerable or at risk of losing their independence.
- To work with primary care to develop and commission integrated health and social care services that will reduce the need for people with a long term condition to utilise health and social care services.
- To move care closer to home so that our hospitals have manageable demand
- To work together to ensure people are supported to look after their health and wellbeing.
- To support providers to join up, share information, and make services easier to navigate
- To create an Integrated Commissioning Board or similar to align our work and have a single commissioning process

In 2015/16 the system will be led by a board of health and social care providers with an overarching integrated board structure. The board will work in partnership with clinical commissioners and be responsible for the shared delivery of care along agreed pathways.

During 2014/15 BCF work stream will develop:

- patient-based risk registers and increase reporting in GP practices,

- holistic health assessment (including mental health) and case management for older people through GP practices and
  Urgent access 'hot' geriatric outpatient clinics/Day Assessment Unit for rapid diagnosis of older people.

Metrics

There are a range of core and local metrics that are set out below alongside target levels of achievements at key (pay) point over the next 18 months

		Essex(Total of 5 x CCG & ECC)	CP&R CCG Baseline	CP&R CCG By April 2015	CP&R CCG By Oct 2015
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	583.0	565.0	N/A	503.1
	Numerator	1575	215		204
	Denominator	270160	38055		40600
		(April 2012 - March 2013)	(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	82%	82%	N/A	82%
	Numerator	692	133		169
	Denominator	844	163		207
		(April 2012 - March 2013)	(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	199.3	23.2	22.4	21.7
	Numerator	2212	32	31	30
	Denominator	1109834	138052	139500	140300
		2012-13 outturn		(April - December 2014)	(January - June 2015)
**Avoidable emergency admissions (composite measure)*	*Metric Value*	1674	1636	1635.2	1635.5
	Numerator	5296.4	603.1	612.2	617.1
	Denominator	316466	36864	37437	37731
		(TBC)			(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]					
		(insert time period)			*(insert time period)*
Additional Local Measure - Coverage of reablement	*Metric Value*	1451.0	1842.1	1874.4	2196.4
	Numerator	3920	701	744	892
	Denominator	270160	38055	39700	40600
		2012-13 data			*(insert time period)*

Please note that these are initial speculative and subject to robust analysis and evaluation before the CCG can confirm that this is the metric we are prepared to measured against

Financials Implications

We see the implementation of the BCF as a phased programme with 2014/15 being, in the main, the development phase for the main bulk of the funding transfer being executed in 2015/16. We are therefore developing the programme timeline accordingly and we will make full use of the time afforded to us to undertake a number of design and resilience testing activities to ensure to provide all parties to the integration with assurance that system change is not only going to work but that it will be both robust and sustainable.

CP&R CCG and ECC are having productive discussions around the sums that should go into the integrated fund, both parties recognise that if we simply deposit the minimum amounts as allocated by DH then it is unlikely that there will be sufficient monies to bring about real transformation of our health and social care systems in Essex. So whilst we still have considerable work to do we are confident that we will collectively be contributing more to the pooled fund than the minimum amounts stipulated.

As stated we see this as a two stage implementation, consequently the functions and resources that will transfer and be managed through the integration arrangements for 2014/15 will be considerably different and smaller scale than those transferring in 2015/16. As we have established the size of the BCF will grow from 2014/15's allocation of £4.85M, which is mainly constructed from similar S256 amounts from 2013/14, to approximately £11.0 - £11.5M for 2015/16. Whilst we still have work to do and challenging conversations to have the table below sets out our initial assumptions:

Scheme identifier/Service name	Maximum		Scheme identifier/Service name	Minimum	
Transfer of social care money	£	2,672,270.00	Transfer of social care money	£	2,672,270.00
Reablement Monies	£	904,000.00	Reablement Monies	£	904,000.00
Social Care Uplift	£	749,728.00	Social Care Uplift	£	749,728.00
Integrated Community Teams	£	3,367,013.01	Integrated Community Teams	£	3,367,013.01
Collaborative Care Team	£	243,037.74	Collaborative Care Team	£	243,037.74
SPOR (Health Element)	£	97,998.44	SPOR (Health Element)	£	97,998.44
Intermediate Care Beds	£	350,000.00	Intermediate Care Beds		
Tissue Viability	£	43,414.20	Tissue Viability	£	43,414.20
Leg Ulcer	£	92,503.03	Leg Ulcer	£	92,503.03
Stroke (Community Service)	£	159,950.53	Stroke (Community Service)	£	159,950.53
Pressure Relieving Equipment	£	112,980.63	Pressure Relieving Equipment	£	112,980.63
Continence	£	356,832.24	Continence	£	356,832.24
Dementia Intensive Support Team	£	70,118.09	Dementia Intensive Support Team		
Older People Community Mental Health Teams (inc. Assessment Service)	£	780,107.00	Older People Community Mental Health Teams (inc. Assessment Se	£	780,107.00
Older People Day Care (Mental Health)	£	169,584.00	Older People Day Care (Mental Health)	£	169,584.00
Community Geriatricians	£	85,000.00	Community Geriatricians	£	60,000.00
Wheelchair Services	£	305,600.38	Wheelchair Services	£	305,600.38
Havens Hospice	£	410,688.80	Havens Hospice	£	410,688.80
Rosedale Rehab/Reablement Beds	£	130,314.50	Rosedale Rehab/Reablement Beds	£	130,314.50
Rosedale Therapy Input	£	154,332.00	Rosedale Therapy Input	£	154,332.00
Occupational Therapy	£	217,503.57	Occupational Therapy	£	217,503.57
CAVS Befriending Service	£	18,500.00	CAVS Befriending Service	£	18,500.00
Carers	£	50,000.00	Carers	£	50,000.00
Totals	**£**	**11,541,476.16**	**Totals**	**£**	**11,096,358.07**

5 LOCAL MEASURES

Outcome Framework Domain	Outcome Framework Improvement Area	Castle Point and Rochford CCG Priority	Quality Indicator	Baseline 2013/14	Target 2014/15	Action	Deadline
Local Measures	Quality Premium	Reduction in people with dementia taking anti-psychotic medication	8.1% reduction in people with dementia taking anti-psychotic medication by March 2014 (*12.5% of Quality Premium)*	1625	2442	Build on existing medicines management QIPP scheme relating to reduction in anti-psychotic medication in people with dementia.	April 2013
		Reduction in emergency admissions from care homes	7.1% reduction in emergency admissions from care homes by March 2014 *(12.5% of Quality Premium)*			Implement care homes QIPP scheme GP Federation to submit bid to secure funding through £50M Primary Care Challenge Fund to pilot GP dedicated cover Care Homes Pilot scheme funded through winter monies targeting care homes with highest use of urgent care resources.	April 2013
		Reduction in first appointments for acute dermatology services	20% reduction in first appointments for acute dermatology services *(12.5% of Quality Premium)*			Implement Dermatology QIPP scheme	April 2013
	Primary Care Strategy	Individual GP practices will move towards having a minimum list size of 4,500 patients serviced by the equivalent of 2.5WTE GPs	Quality Indicator still to be defined for CPR CCG	TBC	TBC	Some of our single-handed practices may find it difficult to meet the growing demands of general practice and we wish to support them to work as part of an integrated health care team, through federation, where the practice and its patient participation group agree this is the right model for them.	April 2015
		Number of GPs working in CP&R will increase through the establishment of more training practices and enhanced roles within hubs that attract professionals	Quality Indicator for the number of increased training practices still to be defined for CPR CCG	TBC	TBC	Working with NHSE identify opportunities for additional training practice in CPR CCG	April 2015

Outcome Framework Domain	Outcome Framework Improvement Area	Castle Point and Rochford CCG Priority	Quality Indicator	Baseline	Target	Action	Deadline
Local Measures	Primary Care Strategy	Number of nurses working in CP&R will increase through the enhancement of nurse practitioner training and enhanced roles within hubs	Quality Indicator for the number of increase enhancement of nurse training practitioner still to be defined for CPR CCG Ultimately, model will see • Nurse Practitioners taking on increased roles and operating from every hub • Nurse Practitioners managing lists of patients with GP support • Nurse practitioners operating from within hubs	TBC	TBC	Working with NHSE identify opportunities enhanced nurse training in CPR CCG	April 2015
		Practices who are unable to evidence they are delivering high quality care will be decommissioned and patients will be distributed to practices operating in the defined hub.	No CPR practices identified as being unable to evidence they are delivering high quality care	TBC	Nil	• In partnership with NHSE identify if any CPR Practices are operating below standard • CPR Practices identified as being unable to evidence that they are delivering high quality care will be to supported by CCG to improve in the first instance • Through access to training and education programme, support for the QOF and support for individual practices experiencing difficulty we will ensure that we continue to improve services for patients.	April 2015 Sept 2015
		Increase the % of GPs using text messaging service to remind patients of their appointments	Increase the % of CPR GPs using text messaging service to remind patients of their appointments	TBC	100%	• Using Locality Group engagement to support and encourage practices to introduce and use text messaging service that already available on primary care systems (SystemOne)	April 2015
		GP practices Federated forming a virtual hub covering populations of between 20,000 and 70,000 or GP practices merging forming a legal hub covering populations of between 20,000 and 70,000	By 1st April 2014 it is anticipated that there will be one federation in CPR with approx. 14 practices serving circa 80,000 population By 1st April 2015 it anticipated that CPR will have one large (170,000) federation.	Nil federation	Single federation	• CCG will promote the 'federation' model of general practice	April 2014

Outcome Framework Domain	Outcome Framework Improvement Area	Castle Point and Rochford CCG Priority	Quality Indicator	Baseline 2013/14	Target 2014/15	Action	Deadline
		Integrated Nursing Hub aligned to individual practices/hubs	Creation of 4 Hubs across CPR	Nil Hubs	4 Hubs	• Working with NHSE the CCG will To facilitate the establishment of hubs and the delivery of consistent high quality primary care services	April 2015
		% shift from acute to primary care.	CPR aspires to see a shift of up to 5% in resources from hospital providers into primary care over next 5 years equating to a transfer of £10m within the SEE system (£5M for CPR)		5% shift	• We will optimise the use of existing primary care estates • We will work to minimise or eliminate empty space and "void" costs and close premises that are not up to standard • We will work with health and wider partners to optimise use of all publically owned (or leased) estate. • Deliver BCF and system plans for reducing elective and non-elective care at acute trust	

Outcome Framework Domain	Outcome Framework Improvement Area	Castle Point and Rochford CCG Priority	Quality Indicator	Baseline	Target	Action	Deadline
Local Measures	Primary Care Strategy	Patients with LTC to have a named clinician/managed by a specialist within a hub or hub created as specialist practice for patients with LTC.	To be developed alongside Primary Care Strategy	TBC	TBC		
		Commuter clinics provided by GP practices / within a hub/hub delivering clinics in evenings and at weekends.	To be developed alongside Primary Care Strategy	TBC	TBC		
		Undertake triage, diagnosis and treatment of minor illness in a pharmacy setting / write prescriptions for a limited list of medications from pharmacy or as part of primary care team in general practice / fully integrated into primary care team delivering consultations, prescribing, immunisations	To be developed alongside Primary Care Strategy	TBC	TBC		
		Pharmacists take on a greater role in managing supplies of repeat medicines enabled by batch prescribing and electronic prescriptions / pharmacists will request or carry out appropriate routine monitoring e.g. blood tests and be able to re-authorise repeat medicines. This will be integrated with face to face discussions with the patient about their medicines / A holistic patient centred medicines service focussed on patient wellbeing, enablement and joint decision making, working closely with the patients GP.	To be developed alongside Primary Care Strategy	TBC	TBC		

Outcome Framework Domain	Outcome Framework Improvement Area	Castle Point and Rochford CCG Priority	Quality Indicator	Baseline	Target	Action	Deadline
Local Measures	Primary Care Strategy	Pharmacists managing straightforward conditions such as allergic rhinitis, hayfever, dry and itchy skin / management of long term conditions such as asthma or chronic pain, in the pharmacy, linked to and supported by GP hubs / specialist pharmacists will be employed within hubs to be part of specialist teams caring for patients with LTC.	To be developed alongside Primary Care Strategy	TBC	TBC		
		Establish local primary care network to facilitate integrated working.	To be developed alongside Primary Care Strategy	TBC	TBC		

6.1 SPECIALISED SERVICES

As part of *A Call to Action,* NHS Castle Point and Rochford CCG is to participate in a systematic market review of all services to ensure that the right capacity is available, consolidating services where appropriate, to address clinical or financial sustainability issues.

The CCG has agreed that Basildon and Brentwood CCG is to lead the scoping exercise to review current models of care locally and the potential for developing specialist centres of expertise.

The scoping exercise is to review all appropriate areas prioritising:

- Stroke
- Paediatrics
- Vascular
- Renal
- Cancer

The timeframe for the initial scoping exercise has been identified as May 2014 and the CCG will provide clinical and non clinical support to the lead CCG in this process.

6.2 PUBLIC HEALTH

The CCG will continue to support NHS England Essex Area Team to implement the following ambitions in 2014/15:

- roll out of the Family Nurse Partnership and the Health Visitor Programmes;
- a revised specification for Pneumococcal Vaccination;
- introduction of HPV testing in women with mild/borderline changes in their cervical screening;
- bowel and diabetic eye screening;
- extension of the bowel screening programme for men and women up to 75;
- a minor change to the service specification for seasonal flu;
- a meningitis C catch up programme for university entrants;
- continuation of a time limited MMR campaign for people over 16 and a catch-up campaign for teenagers;
- continuation of the temporary programme for pertussis for pregnant women;
- implementation of DNA testing for sickle cell and thalassemia screening;
- a shingles catch up programme planned for 71-79 year olds, starting with 78 and 79 year olds; and
- a number of developments for Sexual Assault Referral Centres to develop the service and make it more equitable.

6.3 ARMED FORCES COVENANT

The Armed Forces Covenant Commitment sets out the relationship between the national, the state and the armed forces. It recognised that the whole nation has a moral obligation to members of the armed forces and their families and it establishes how they should expect to be treated.

The CCG's identified lead to support the delivery of the Armed Forces Covenant is Kevin McKenny, Chief Operating Officer. Although the CCG does not have any military bases in the locality, it is recognised that the military and veteran community may well be registered with GP practices in south Essex and will be accessing services through providers. To that end, it is recognised that there is a need to build strong mechanisms within services commissioned to ensure access routes into mental health and other health services are available.

- Ensure NHS employers are supportive towards those staff who volunteer for reserve duties.
- Ensure primary care is provided with information and signposting for military and veterans who access services
- To ensure veterans‟ prosthetic needs are met.

We will continue to work with South Essex University Partnership NHS Foundation Trust to implement a plan for managing military and veterans cases referred by GPs or other agencies, this plan will include:

- Follow-up protocols for regulars and reserves leaving the forces.
- Access arrangements for crisis services
- Specification of outreach and early intervention services.

6.4 SERVICES FOR PEOPLE IN THE JUSTICE SYSTEM

NHS Castle Point and Rochford CCG will continue to support our stakeholders in the delivery of the following key priorities for 2014/15:

- to ensure that commissioning is informed by an up-to-date health needs assessment, taking account of the reconfiguration of the custodial estate, including the creation of Resettlement Prisons;
- to support sustainable recovery from addiction to drugs and alcohol and improved mental health services;
- promotion of continuity of care from custody to community and between establishments, working closely with Probation Services, Local Authorities and CCGs;
- development of a full understanding of the healthcare needs of children and young people accommodated in the secure estate and work collaboratively to commission services to meet these needs;
- continued close collaboration with our partners in the successful implementation of the Liaison and Diversion Programme; and
- to ensure timely and effective transition of commissioning responsibility for healthcare in immigration and removal centres.