Mid Essex Clinical Commissioning Group

Mid Essex CCG Integrated Plan

2013/14 and beyond

CONTENTS

FOREWORD: Mid Essex Clinical Commissioning Group Strategic Direction for 2013-16

Mid Essex Clinical Commissioning Group (CCG) has set five strategic objectives for 2013/14 which build upon those it established in 2012/13. These are as follows;

Transformation and integration
Practice engagement
Public confidence
Improving quality and outcomes for all
Meeting the financial challenge through responsible use of resources

Transformation and integration

Mid Essex Clinical Commissioning Group (CCG) recognises that all organisations within the mid Essex health and social care economy have a role in improving the health of our local communities. The current health system faces significant challenges to ensure that services are sustainable against a backdrop of limited resources and growing demand. The health and social care landscape will need to change significantly over the coming years to meet these challenges.

The Primary Care Trust (PCT) and the CCG identified three areas for transformation in last year's integrated plan. These were; care of older people, urgent care and care of people with long term conditions. However, after a series of public engagement events the feedback given showed that not all older people are reliant on health and/or social care and that many younger people and children are frail. As a result the priorities were revised to care of frail people, urgent care and care of people with long term conditions of all ages. Working with its partners, the CCG aims to simplify the urgent care system and transform community services so that the public can access the most appropriate service at the right time. It aims to make local services much more proactive in delivering care in the community for frail people and those with long term conditions, resulting in fewer severe exacerbations and crises and fewer hospital admissions.

The CCG is committed to collaborative working and a shared-system vision. Its high-level plans for transformation of urgent care and care of frail people have been informed by two whole system workshops. The CCG has consulted widely to further inform its detailed plans and it is confident its national and local priorities are fully supported by strong, locally owned plans. The plans are being taken

forward through multi-disciplinary programme boards and the whole system leadership group, which includes senior representatives from health providers, social care, the voluntary sector and tier one and tier two councils. This maintains a whole-system oversight of the transformation process.

Transformation of services also requires greater collaboration between those delivering care. Consequently, the CCG will be exploring how it can enhance the multi-disciplinary care team at locality, sub-locality and, where appropriate, at practice level to bring more co-ordinated care closer to the patient and promote better working relationships between the different health professionals, and with partners in social care.

The CCG's commitment to collaborative working extends to all levels within organisations that contribute to the delivery of health and wellbeing services. The CCG will embrace the opportunities that arise from membership of the Health and Wellbeing Board and it is committed to ensuring its strategic direction and Integrated Plan is consistent with the strategy of the Essex Health and Wellbeing Board. We are also working with Essex County Council to develop a joint approach to commissioning for mental health, learning disability and children's services.

In partnership with West Essex CCG and North East Essex CCG, the CCG has developed, and is committed to, a 'Collaborative Compact' agreement that sets out how the three North Essex CCGs, and possibly over time the wider Essex CCGs, will work together in a formal arrangement. The compact includes detail on governance arrangements.

These good system relationships, strong clinical engagement from GPs, consultants and wider health care professionals and the CCGs burgeoning public engagement provide key enablers to make the CCG's transformation plans a reality. The redevelopment of health services in Maldon and District presents another opportunity to deliver modern, transformed community services. The CCG has undertaken to complete a thorough review of the health need requirements of the local population to inform this development and it is anticipated that its plans will be available for review during July and August 2013, with CCG Board and NHS Commissioning Board (NCB) approval being sought in September 2013.

2. Practice engagement

The CCG will continue to develop and fully embed our GP membership arrangements. We will continue to support the development of the GP practices, sub-locality and locality groups to input into local pathway redesign, service feedback, collaboration with local partners, and peer support to drive up quality. We aim to encourage more GPs to become directly involved with the CCG through building on our model of distributed leadership.

The CCG will explore with localities and sub-localities the potential for different ways of delivering primary care, for example a federated approach across practices.

We will improve the data that is provided to practices so that it includes activity carried out under block contracts. We would envisage that practices take responsibility for indicative practice budgets during 2013/14 with a view to developing formally delegated budgets where information sources are adequate and delegation is appropriate. We will support practices and sub-localities through our service delivery managers and practice support managers to embrace this as a method of enabling GPs to ensure that they are fulfilling the General Medical Council 'Good Medical Practice' requirements to use resources effectively and take financial responsibility for delivering their service.

3. Public confidence

The CCG will maintain credibility with the public through delivery of high quality services, good two way communication and a culture of honesty, transparency and openness. We will reach out to the seldom heard groups through many different mechanisms described in our public engagement strategy.

We also aim to empower patient self-management where appropriate. This will require public education, supportive resource and confidence. Increasing education will require a multi-faceted approach to be successful including engaging with schools, working with community groups, including practice participation groups and local charities, in addition to broader communication strategies.

We aim to make the most of our community's assets and help to build greater community cohesion and resilience through working with our many different and varied communities and partners throughout Mid Essex.

4. Improving quality and outcomes for all

The outcomes that the CCG will commission for will be informed by the Essex and Mid Essex Joint Strategic Needs Assessments (JSNAs), the Health and Wellbeing Strategy, national and local NHS priorities and other important sources of information and insight such as from patients, the public and health care professionals. We will implement outcome based commissioning of pathways and use hard and soft intelligence to drive up quality and reduce inequalities.

As a CCG we are keen to ensure that we optimise our partnerships with the third sector. However, we recognise the potential for them being in a position of disadvantage due to their scale, and the need for certainty of commitment and their capacity to respond to tenders. Consequently we intend to devise a mechanism of support to help overcome these barriers.

In order to achieve true transformation, we will need different, and often more generic, skill sets with staff working as integrated and multi-disciplinary teams. This potential to work differently and more effectively with greater collaboration extends across all components of our health and social care system including acute hospital teams, community staff, primary care and social care. Integration and close working between these components may influence and facilitate changes to the workforce.

The CCG will improve methods of communication between providers and social care to enable more joined up care and better informed risk profiling of the population, whilst continuing to ensure that information governance responsibilities are upheld. This will include exploring the potential for a joint strategic approach to commissioning for IT system compatibility across all partners involved in delivering health and social care services to our population.

5. Meeting the financial challenge through responsible use of resources

The CCG will be involved in system-wide discussions regarding whether the current hospital configuration will continue to be the best model to meet the population's increasing health care needs in the most effective way.

The CCG is committed to supporting MEHT achieve foundation status.

The CCG recognises the need to undertake a formal system review of the plurality of providers within Mid Essex to ensure continued patient choice whilst supporting on going provider sustainability.

It will continue to promote the values that guide its work ethic; drive, passion, commitment and inclusive arrangements with all its stakeholders to develop and deliver QIPP schemes that drive up quality, improve equity of provision and help ensure the financial sustainability of our local NHS.

Chapter One:

Introduction

The Mid Essex Clinical Commissioning Group is aligned to the historical Mid Essex PCT boundary. The CCG has established a robust governance structure to support its shadow form since April 2012. The CCG submitted its application for authorisation as a Statutory Body in wave four of the formal authorisation programme and provided its evidence to a panel on 14th December 2012. The CCG is due to become a Statutory Body on 1st April 2013 and will take full responsibility for Mid Essex Quality, Improvement, Productivity and Prevention programme (QIPP), performance, financial budgets and commissioning decisions.

The Mid Essex Clinical Commissioning Group (the CCG) and its professional and public communities, stakeholders and partners, have worked together over the past year to progress a shared vision. Healthcare over the next three years will transform and improve for its local residents, in particular in terms of:

- *Looking after its frail population*
- *Managing long term conditions and anticipating a future increase in prevalence of long terms conditions*
- *People getting access to highly efficient, streamlined urgent care – right time right care, right place.*

The CCG has put people, systems and processes in place to deliver real benefits from clinicians taking the lead (this includes the CCG's membership and professional partners) and involving themselves in listening to patients and public, collaborating with partners and getting the most out of wider scale planning.

Financial context

The CCG recognises that its financial position presents a significant challenge to achieving its vision. It is this vision that articulates its commitment to delivering high quality care in a financially sustainable way. The scale and nature of the financial challenge facing the NHS is escalating. The NHS is required to make up to £20 billion of efficiency savings by 2014/15 while continuing to meet demand and improve quality. The CCG's demographic profile, national waiting list targets, advances in technology and NICE guidance will mean that those areas of spend which have traditionally represented cost pressures will remain so. These cost increases will be against a back-drop of smaller annual increases in resources than have recently been the case for the NHS.

For most of its existence, Mid Essex PCT was a financially challenged organisation. The Department of Health funding allocation deems that the Mid Essex population is relatively healthy and therefore funding was amongst the lowest for PCTs per head of population and recurrent funding was 4.7% below the Department of Health funding formula – a shortfall of £24.2m p.a. The 2013/14 CCG funding allocation does not seek to reapportion funding across individual areas. In 2013/14 the CCG is the ninth lowest funded CCG per head of total population in the country – with a healthcare funding allocation of £990 per head compared to the Essex average of £1,107. Every £10 per head equates to £3.7m of funding.

The CCG's providers and partners also face significant financial challenges. The main health providers have been required to deliver 4% efficiency savings for a number of years as part of the national tariff arrangements and in many cases, internal cost pressures have resulted in the annual efficiencies savings target being substantially higher.

Essex County Council also faces financial challenge and is forecast to shrink from being a £930m organisation in 2012/13 to an £850m by 2016/17 (excluding new responsibilities and funding arrangements around Public Health and Learning Disability Grant). The County Council forecasts that the gap between available budget and demand for services will be £200m by 2016/17.

Leadership

Mid Essex CCG continues to make steady and sustained progress in building the organisation capacity and competency. The success of that progress, and the self-awareness demonstrated in terms of what still needed to happen, was confirmed by the NHS Commissioning Board authorisation panel conclusion that the CCG had provided it with the confidence that it had the skills and capability, as well as the enthusiasm and drive, to be a competent clinical commissioning group. The appointment in December 2012 of a substantive Accountable Officer compliments the other substantive posts already appointed – the Director of Strategy and Primary Care (Deputy Accountable Officer), Chief Finance Officer, the Director of Nursing and Quality and Director of Clinical Transformation.

Together with selected and elected GP clinical leads and the appointed secondary care consultant and lay members, Mid Essex CCG has a strong Board to provide the leadership for clinical commissioning. Details of the continuing organisational development programme for the board, member practices and staff can be found in our Organisational Development plan in Appendix two.

Our vision is of strong clinically-led commissioning delivered through the CCG which will be the focal point for partnership working on health and wellbeing in geographic localities. The CCG will be engaging very effectively with patients and the wider public to drive up service quality, and will be using its clinical expertise to improve outcomes and to challenge colleagues to do the same. Through the

Essex Health and Wellbeing Board, and other mechanisms, we will be seeking complete integration between commissioners and service providers. These will ensure that the Essex Health and Wellbeing Strategy is relevant, effective and being delivered in Mid Essex to improve people's lives.

The local health and social care infrastructure will ensure the continued delivery of high quality services and improved outcomes for patients. In 2013/14 and beyond, the leaders of the local health and social care system together have recognised that the scale of our ambition for service transformation needs to take a significant step forward; we need to match this with a step change in how we organise ourselves as a system to deliver system transformation and to embrace an integrated approach to commissioning whilst maintaining high quality services and achieving the nationally set financial targets.

The CCG recognises the wide range of stakeholders with a key role in delivering this agenda. It is important to recognise how a wide range of decisions made by other organisations around issues including regeneration, housing, transport and leisure facilities can have an indirect but profound impact on public health. To this effect the CCG has established a strategic group of key stakeholders (the mid Essex System Leadership Group) which includes senior representation from Essex County Council, Braintree District Council, Chelmsford City Council and Maldon District Council as well as the Chief Executives of our main local providers and the voluntary sector. Chaired by Mid Essex CCG Chair, the role of the System Leadership Group is to ensure that plans fit strategically with all partners, gain a system approach to delivery of plans within Mid Essex and thereby maximise the optimisation of health and social care provision.

Since May 2012, this group has overseen urgent care and frailty system workshops, which have set out a programme of changes needed over coming years to increase quality and sustainability of services. The group has been involved in the development of the integrated plan and over 50 participants from across all sectors participated in a further workshop in November 2012, the outputs of which were used to develop the integrated plan. Additionally, joint workshops have been facilitated by Essex County Council with CCGs and other local authorities on children's and young people, mental health, vulnerable adults, families with complex need and a frailty workshop. The work and outcomes of these groups have informed this plan as well as being the basis of projects within a wider programme of joint and integrated work, development and commissioning which will be implemented during 2013/14. Appendix three demonstrates the various work streams within ECC in which the CCG is included.

Engagement with Primary Care / Primary Care Forum

Considerable work has been undertaken by the CCG to develop GP and practice engagement. Several CCG wide Practice shutdown afternoons have been held with excellent GP and practice manager attendance. Practice Shutdowns and locality meetings have provided mechanisms to update on the development of the CCG and consult on how GPs and CCG could best communicate, what both parties could offer and what the key priorities for transformation should be. The most recent shutdown focused on getting Primary Care support for addressing the financial challenge for the CCG and input into the plans and support for the recovery actions that need to be taken.

By agreement with our 50 GP practices, the CCG has established three locality forums for constituent practices in Chelmsford, Braintree and Maldon and each of the three localities has three sub localities, shown below. These have been shaped by the practices and are designed to fit with local needs and patient flows. Through this mechanism each practice is engaged in commissioning with the CCG and has the ability to directly affect priority areas of work and the development of local pathways. These localities are also geographically coterminous with the city council and two district councils.

Chelmsford	**Maldon**	**Braintree Witham & Halstead**
EGPC:	Maldon,	Braintree
Chelmsford 1	Dengie	Colne Valley
Chelmsford 2	South Woodham Ferrers	Witham
Sub-locality & GP Lead	**Sub-locality & GP Lead**	**Sub-locality & GP Lead**
Dr Caroline Dollery, Dr Les Brann	Dr Ahmed Mayet, Dr Amit Sinha	Dr Bryan Spencer, Dr Iain Tweedlie

The CCG Primary Care Forum has been established as a vehicle to ensure that our membership practices are positively and proactively involved in our decision making. It meets bi-monthly and includes GP representatives from the sub-localities, elected practice managers and representatives of the wider primary care team. The main emphasis is placed on ensuring that primary care and sub-localities are significantly involved in the annual commissioning cycle. The forum interacts with the CCG's planning groups to support work streams for service improvements and redesign. The Primary Care Forum will also lead the development of primary care and work in partnership with the CCG Board and the NCB to deliver the transformation and relevant commitments and initiatives of the CCG's Integrated Plan for Mid Essex.

The three locality groups offer the opportunity to not only involve a multi-disciplinary group of practice staff, but also to engage with other partners across the Mid Essex system. The CCG is developing strong relationships with Mid Essex partners including district and borough councils, providers, social care and the voluntary sector, and the locality groups provide a forum for these relationships to

also develop at a locality level. This provides opportunity to strengthen communication, integration and collaboration in service planning and implementation to meet the different population needs of the three locality areas and help to reduce inequalities.

The three locality forum meetings will be facilitated by the CCG on a minimum of a bi annual basis, with the input from the CCG Chairman, CCG nominated Board GP, locality Practice Support Managers and dedicated Service Delivery Managers.

In addition to the allocated Board GP and service delivery manager, other members of the CCG will also develop strong locality links so that they can also act as first point of contact for individual localities and sub-localities.

The smaller sub-locality groups provide a supportive learning environment that promotes peer support and constructive challenge to improve primary care quality, reduce variability and drive up clinical outcomes. They also allow an environment to explore QIPP pathway re-design that may bring care closer to home if appropriate such as tier 2 services and enable a proactive rather than reactive approach to patient care such as innovative provision of care to care homes.

The CCG has inherited an established pattern of practice based services and tier 2 services. This year there is a formal review underway of these services, with a view to ensuring equity of access, value for money and linkage to the CCG's priorities.

Health and Social Care landscape

Mid Essex has 50 member GP practices in its three localities, 48 dental practices, 61 pharmacies and 60 opticians.

The provider landscape in Mid Essex is mixed and diverse with NHS providers, social enterprises and private providers delivering care to our population. The provider landscape has been going through significant changes with a new independent sector community provider and some new entrants to the provider landscape through Any Qualified Provider (AQP) procurements. Our three key providers are:

Mid Essex Hospital Services Trust (MEHT)

The CCG's main provider of urgent, emergency, maternity and planned secondary care services. The Trust also provides a plastics service to a wider population. In 2011/12 the Trust had a turnover of £263million and employed almost 4000 staff. 2012/13 has proven to be challenging for the Trust with £10m transitional financial support provided to assist with estate rationalisation and implementing key service redesign. Performance has improved in many areas and MEHT is seeking to gain Foundation Trust status.

North Essex Partnership Foundation Trust (NEPFT)

NEPFT is the CCG's main provider of mental health services. With a turnover of just over £100million, around one third of the income is derived from delivering services to Mid Essex, although all three north Essex CCGs jointly commission these services.

Central Essex Community Services Community Interest Company (CECS)

Provides community health services primarily to the population of mid Essex through a block contract. Established as an independent social enterprise in 2012, CECS is exploring with the CCG opportunities to innovate delivery of its services.

The CCG also has a Section 75 agreement for adult social care with Essex County Council and works with its local City and district councils and a diverse range of independent and other NHS providers and voluntary organisations.

ntral Essex Community Services
Mid Essex Hospital Services NHS Trust
Colchester Hospital University NHS FT
Braintree Clinical Services Ltd
Ramsay Healthcare (Springfield Hospital)
North Essex Partnership NHS FT
Cambridgeshire & Peterborough NHS FT
East of England Ambulance Service NHS Trust
Essex Commissioning Support Unit
NHS Commissioning Board

Public Health Resource

The CCG is working with colleagues in Essex County Council to secure the optimal level of public health resource once this function transfers to the council from April 2013. The CCG will be involved in designing a future operating model for public health that will support us to deliver this Integrated Plan and our Health and Wellbeing Strategy.

It has been agreed by all parties that the CCG and Essex County Council will share a Consultant in Public Health and a specialist public health function, although the local authority will retain a separate public health commissioning resource. The CCG began to operate under these arrangements in shadow form from October 2012 ahead of the transfer of public health to the local authority in April 2013. The named Consultant in Public Health is currently a non-voting member of the CCG Board.

Primary Care

While primary care commissioning is the responsibility of the NCB, the CCG recognises that there is a strong interdependency between primary care services and other CCG commissioned services. Success of the wider system transformation programme is also reliant on provision of high quality primary care services. The CCG will work closely with, and support, the NCB Essex Area Team in this.

The CCG aims to support GPs to provide increased levels of closer to home services at practice level where appropriate and possible. Currently, not all practices are able to offer the same level of service to their patients (such as minor injuries) due to constraints such as premises etc. A sub-locality / locality service provision model could help to improve local access and the CCG will explore this further with GPs. The CCG is expecting that the capacity in primary care will increase as a result of the work facilitated by the Primary Care Foundation (detailed in chapter five under urgent care programme board).

Currently, there is a lack of consistency across the contracts for GP provided Local Enhanced Services (LES). Work is currently taking place as part of contract transition to establish a baseline. Once this is completed, a CCG review will be carried out to ensure that any LES commissioned going forward, offer value for money.

Voluntary Sector

The CCG and the voluntary sector share a great deal of common ground around striving to reduce inequalities and improving health outcomes, improving access, providing value for money and placing the needs of the individual at the centre. Third sector organisations provide a broad range of opportunities for all residents to access activities and services in their local community. For those people who are frail, disabled or suffering from illness, extra support may be needed to help them have the lifestyle that the rest of the community have access to.

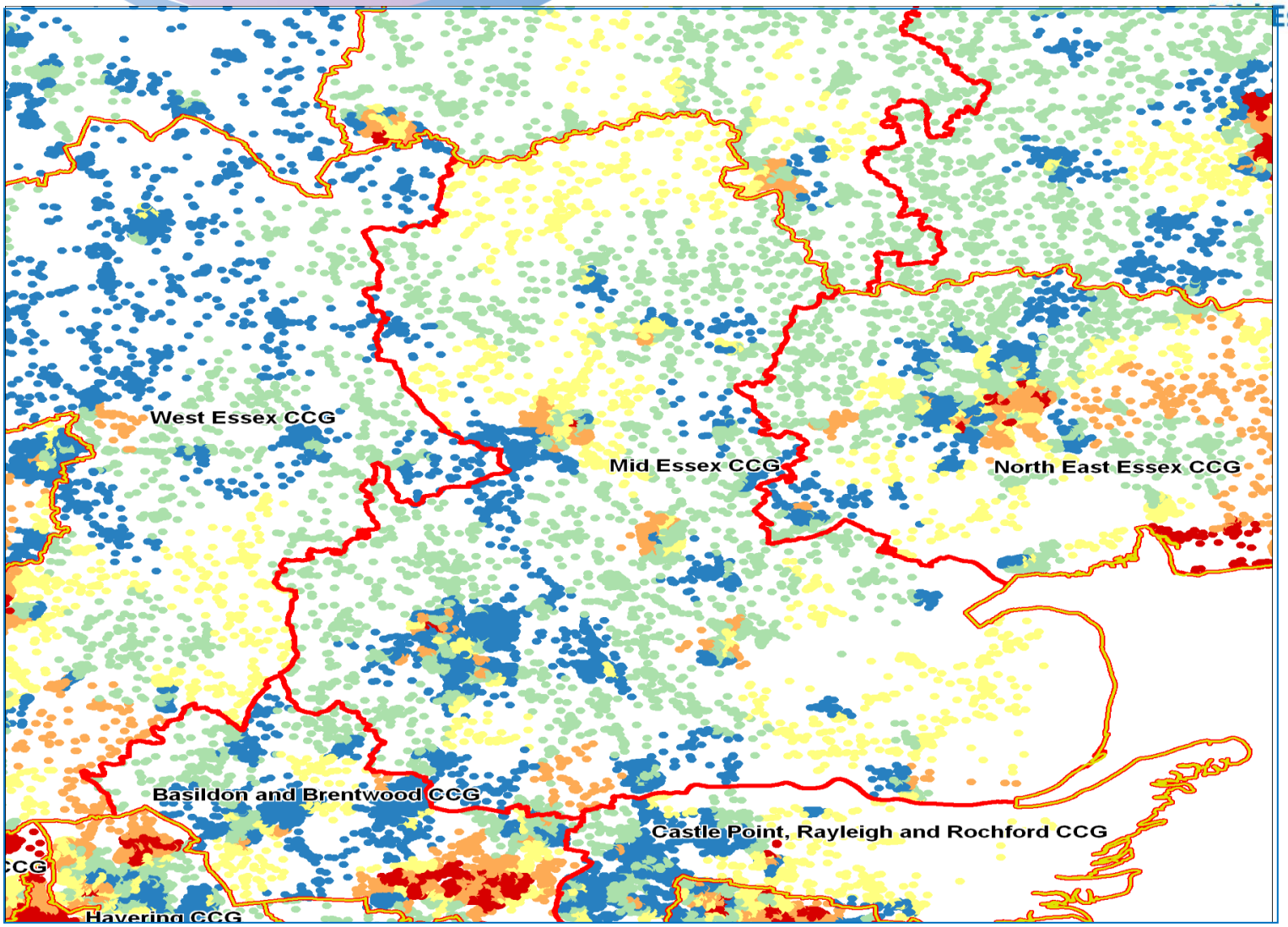
Where community and social capital can be increased, the quality of life for people will improve and less reliance will be placed on more expensive care and support provision. The CCG and its partners will endeavour to work with third sector organisations to fulfil the local ambitions. Representatives from third sector organisations are members of the System Leadership Group as described on page 11.

Mid Essex Demographics

Mid Essex covers an area of 520 square miles. Mid Essex is a two tier local authority area within the boundary of Essex County Council with Chelmsford City Council and Maldon and Braintree District Councils. With a GP registered population of around 371,807 (Department of Health) people, the majority of the population of Mid Essex are in the Chelmsford area (177,000 people). Maldon is the smallest of the three local authorities in mid Essex.

The recent Marmot strategic review of health inequalities[1], suggests that people with less access to money, power and resources face the risk conditions and life circumstances that will make their journey to wellbeing and health more difficult. Mid Essex is generally a less deprived place than most other parts of the country. However there are communities experiencing deprivation to a far greater extent than their neighbours. This disparity is driving an increasing gap in health inequalities between the least and most deprived in the area. The map below shows the levels of deprivation in and around Mid Essex, based on the Index of Multiple Deprivation 2010 (IMD21010). This is calculated at Local Super Output Area (LSOA) level[2].

[1] Fair Society, Healthy Lives (Marmot 2011)
[2] *(Source: NCB CCG outcomes benchmarking support pack Mid Essex, December 2012)*

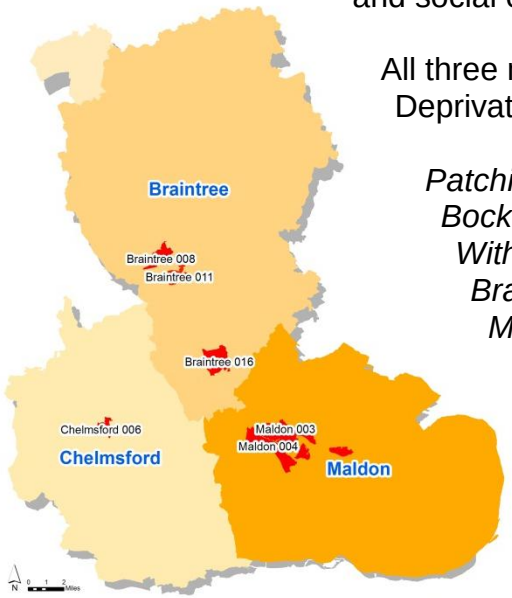

West Essex CCG
Mid Essex CCG
North East Essex CCG
Basildon and Brentwood CCG
Castle Point, Rayleigh and Rochford CCG
Havering CCG
IMD score by quintile
Quintile 5 (lowest)
Quintile 4
Quintile 3
Quintile 2
Quintile 1 (highest)

Population

It is predicted that by 2033 the population served by Mid Essex CCG will have risen to 440,900, a rise of over 70,000 people on 2010, a 19% increase. (2010 based PCT population projections – ONS)

All three areas of mid Essex are predicted to increase in the size of their populations with the Maldon district predicted to have the largest increase in the older age brackets and the Chelmsford City Council area predicted to have the largest increase in the younger age brackets.
The female population in mid Essex aged 85+ is expected to rise from 5,800 in 2010 to 14,200 by 2033. (2010 based PCT population projections – ONS)

Over the last six years, the number of births in mid Essex has been steadily increasing. In 2011 there were over 4,300 births to women aged 15 to 44, a birth rate of 61 per 1,000 women. (Source: The NHS Information Centre for health and social care - https://indicators.ic.nhs.uk)



All three mid Essex areas have lower deprivation levels, as measured by the Indices of Multiple Deprivation 2010, than the Essex average. Some of the most deprived areas in Mid Essex are:

Patching Hall Ward – Chelmsford
Bocking South Ward - Braintree
Witham West Ward - Braintree
Braintree South Ward - Braintree
Maldon town area and Heybridge

There has been a distinct rise in life expectancy across the area, however the gap between the worst and the best in life expectancy is increasing and now stands at 5.9 years. The 20% most deprived communities in mid Essex experience a significantly lower life expectancy at birth of 79.2 years compared to their peers in the rest of mid Essex of 82.4 years. (Source: http://fingertips.erpho.org.uk 2008-10)

Health related choices

The CCG is committed to ensuring that children born locally have the best start and development in early years and this includes improving the uptake of childhood immunisation. Our efforts have contributed to an increase in the uptake of Measles, Mumps Rubella (MMR) vaccine locally with uptake rates of both dose one and two MMR continuing to rise, with annual uptake at 88.3% and 85.4% respectively.(Source: http://fingertips.erpho.org.uk 2010-11)

The uptake rate of the seasonal flu vaccination fell slightly during 2011/12 to 72.1%. Uptake for the 20% most deprived practices was lower than the rest of the PCT and more concerted effort will be required. (Source: www.inform.nhs.uk)

73% of Mid Essex women attempt to breastfeed their new born. This is in line with regional averages (73%) but lower than the national (74%). (Source: www.dh.gov.uk). The breastfeeding rate at 6-8 weeks (which contributes to a number of health benefits) is improving.

Health Outcomes

The CCG rate for all-cause mortality is significantly better than that of the East of England at 502 deaths per 100,000, compared with 515 per 100,000 in the region. (Source: The NHS Information Centre for health and social care - https://indicators.ic.nhs.uk)

The area average for mortality from all cancers (in those aged under 75) has remained relatively stable over the last few years at around 100 deaths per 100,000 and remains similar to the East of England average however, there is much variation within the area. (Source: The NHS Information Centre for health and social care - https://indicators.ic.nhs.uk)

Due to the ageing population, long term conditions are expected to increase over the next 25 years from 16% to 24%.

The number of people with dementia is expected to almost double by 2030 to include over 4,200 people aged 65 and over. (Source: Projecting Older People Population Information System - www.poppi.org.uk)

The mortality gap is increasing between the most deprived and the least deprived areas in the CCG area for nearly all conditions. (Source: http://fingertips.erpho.org.uk)

Lifestyle Choices and Outcomes

Only around one in ten mid Essex adults meets all four of the recommended healthy lifestyle behaviours of not smoking, moderate alcohol intake, being physically active and eating 5-a-day fruit and vegetables. (2008/2009 Lifestyle Survey summary – www.erpho.org.uk/lsr/lsr.aspx)

Around a fifth of the mid Essex population smoke with a disproportionate number residing in the most deprived communities in the area. (2008/2009 Lifestyle Survey summary – www.erpho.org.uk/lsr/lsr.aspx)

The smoking attributable mortality rate for mid Essex stands at 167/100,000 and is significantly better than that of the East of England average of 185/100,000. (Source: http://fingertips.erpho.org.uk)

4% of females and 8% of males in mid Essex are drinking alcohol at levels harmful to their health. This is higher than the eastern region average for males. (2008/2009 Lifestyle Survey summary – www.erpho.org.uk/lsr/lsr.aspx)

5.5% of the adult population in mid Essex is living with either type 1 or type 2 diabetes. Each year in mid Essex, diabetes claims over 128 years of life from those aged under 75. (Source: Quality and Outcomes Framework (QOF) for April 2011 - March 2012 - www.ic.nhs.uk/qof and The NHS Information Centre for health and social care - https://indicators.ic.nhs.uk)

Around 13.5% of the mid Essex population have high blood pressure diagnosed and are on the disease register - although the expected prevalence is closer to 30%. (Source: Quality and Outcomes Framework (QOF) for April 2011 - March 2012 and apho hypertension prevalence estimates Dec 2011 - www.apho.org.uk/DISEASEPREVALENCEMODELS)

Just fewer than 10% of mid Essex patients are registered as having a BMI of 30 or more (over 29,000 patients). However, around 15% of mid Essex adults self-report a BMI that would classify them as obese. (Source: Quality and Outcomes Framework (QOF) for April 2011 - March 2012 - www.ic.nhs.uk/qof and 2008/2009 Lifestyle Survey summary – www.erpho.org.uk/lsr/lsr.aspx)
Around 17% of year 6 pupils and around 9% of reception year children are classified as obese. (NCMP 2010-11 – www.noo.org)
Less than half of the adult population in mid Essex are eating enough fruit and vegetables to benefit their health. (2008/2009 Lifestyle Survey summary – www.erpho.org.uk/lsr/lsr.aspx)

There are just over 12,000 people on the Coronary Heart disease register, 3.2% of people registered with a mid Essex GP Practice. (Source: Quality and Outcomes Framework (QOF) for April 2011 - March 2012 – www.ic.nhs.uk/qof.

estimates that the number of individuals in Mid Essex suffering from domestic abuse in a year are Maldon - 2029, Braintree - 5,102 and Chelmsford 5,966. Actual Police recorded domestic abuse incidents in 2011/12 were Maldon – 645, Braintree - 1,765 and Chelmsford - 1,974. This has a natural impact on urgent care services as domestic abuse victims will often seek help in a healthcare setting.

Addressing inequalities

The health of the population in mid Essex varies considerably with an unacceptable geographical variation in life expectancy of nearly five years. There are vulnerable groups throughout Essex who suffer health inequality, including carers, children in care and young people leaving care, children with Special Educational Needs and/ or a disability, people with mental health issues, people with learning difficulties, people with physical and sensory impairments, domestic abuse victims, Gypsy and Traveller groups and people who misuse drugs and alcohol.

Often these groups with the greatest need are those least likely to access help. We will need to develop tailored services to help those whose needs are greatest and those with additional health needs requiring specific focus (e.g. families with complex needs). The CCG Board gives an absolute commitment to equality and diversity in respect of the services that it commissions for the population of our local area and to its staff and has identified an executive lead, a GP lead and a lay member Equality and Diversity champion who is also the Champion for patient and public engagement.

The Board has set out its Equality and Diversity Strategy and is preparing to receive equality and diversity training. This will improve the awareness of members and will enable them to more ably challenge and scrutinise the content of equality impact assessments which are to be completed for all strategies, policies and business decisions where the impact on equality and diversity needs to be assessed and mitigating actions fully considered and determined. Each Board report is required to have an entry as to whether an equality impact assessment has been undertaken.

There is an established North Essex Equality and Diversity Steering Group and a to be re-established Essex wide Equality and Diversity Group which provides the current focus for the CCG on promoting and developing equality and diversity and is complemented by the Health and Wellbeing Group.

Under the Equality Act 2010, the CCG will exercise its functions and have due regard to:

- *The need to eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the 2010 Act*
- *Advancing equality of opportunity between people who share a protected characteristic and those who do not*
- *Fostering good relations between people who share a protected characteristic and those who do not*

The CCG will do this by:

- *Publishing annually sufficient information to demonstrate compliance with this general duty across all our functions.*
- *Preparing and publishing specific and measurable equality objectives, and reviewing and revising these every four years, by the end of April 2013.*
- *Adopting and implementing the Equality and Diversity System as the framework to review compliance with the Equality Act 2010; The CCG will be updating the relevant proportionate information that had been published for the locality in January 2013.*

Actions to reduce inequalities are taking place by:-

- *Having a named clinical lead and Consultant in Public Health responsible on behalf of the CCG Board to review, implement and monitor the CCG's strategy in tackling inequalities, in partnership with other agencies*
- *Maintaining the Mid Essex System Leadership Group, consisting of senior representatives from the City, Districts and County Councils and key stakeholders will provide a forum for agreeing local priorities in addressing local inequalities*
- *Developing local Joint Strategic Needs Assessments both at CCG and District levels, and listening to interest group research and evidence on where inequalities exist and on evidence based approaches to tackling the gap in opportunities*
- *Actively working with partners to explore opportunities to engage with hard to reach communities*
- *Innovating in ways of engaging and communicating with disadvantaged groups by working in partnership with other service commissioners, providers, voluntary sector and resource*
- *Enhancing patient choice as part of the CCG's Public and Patient Engagement Strategy in the selection of tailored services they receive thereby improving access, communication and health outcomes.*
- *Further action planning for stakeholder engagement to review the current equality objectives and to inform equality objectives for 2013/14.*

Chapter Two: Mid Essex CCG Priorities

With the changing demographics of the mid Essex population, the financial challenge across the health and social care economy and the acknowledgement that the current model of service provision is unsustainable, the CCG recognised that it was imperative to consider different approaches to commissioning and provision. The CCG aims to provide a proactive local healthy system to support the health and well-being of people in mid Essex, enabling individuals and communities to make informed lifestyle choices and take better control of their own health. Major transformation programmes will be implemented in key service areas (detailed in chapter five of this document) to move away from a reactive and largely hospital based model. More care will be provided in community settings where this is clinically appropriate and cost effective and patients will be supported to maintain independence as long as possible.

The key information feeding into this plan has been derived from the Essex Joint Health and Wellbeing Strategy (informed by the Essex JSNA), Mid Essex's JSNA and the outcomes of stakeholders' engagement. The CCG is supporting the development of the Essex Integrated Outcomes Framework which will enable us to specify how the CCG will contribute to the delivery of the Joint HWB strategy.

Delivery of these transformational changes and the priorities of the Essex Health and Wellbeing Strategy, have driven the CCG's strategic and clinical priority setting and the CCG has a clear vision to see:

'Our communities working together to create innovative and sustainable local services delivering first class healthcare for all'.

The CCG's mission is to **commission better care** and this is enabled by our values, the way we all work with our patients, our primary care members, our health and social care partners and our wider population.

- *We care about our communities*
- *We work together*
- *We act with integrity and honesty*
- *We deliver.*

The CCG will support the provider landscape to evolve in order to deliver our vision and mission. Over the next few years we would expect that a diverse market will develop from all sectors where patients and users are largely in control of which services they

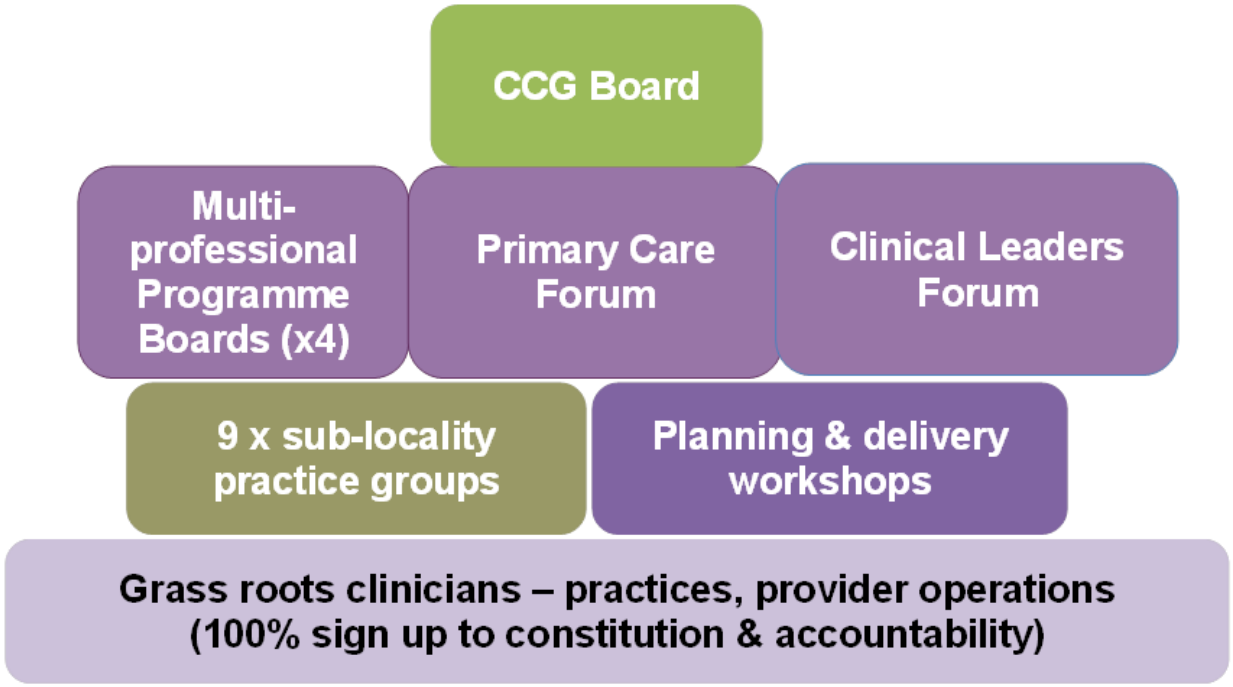
receive; provision will be based on pathways rather than the fragmented diversity that patients may currently experience. There will be a high degree of collaboration and integration between service providers to enable them to respond to the single integrated services that will be commissioned.

Clinically driven and Clinical Priorities

The CCG recognises that service transformation is critical to achieving sustainable improvements in terms of quality and affordability. Clinicians at the heart of commissioning, decision making and monitoring of transformation and reform is one of the under-pinning principles of Mid Essex CCG.

Key clinicians will continue to be closely involved in contract negotiations and continuing service and performance review, influenced by our constituent practices.

The diagram demonstrates how clinicians are included at all levels.



The CCG has set its three clinical priorities at the heart of its vision and mission. The clinical priorities identified and their agreed strategic aims are:

Urgent Care:

- *To provide an accessible, responsive, seamless and cost effective service to people of all ages through pathway redesign integration of provision and public education and engagement. There will be a focus on prevention and proactive management of vulnerable patients.*

Frailty:

- *To develop a pro-active, coordinated and integrated health and social care service focussing on realising a person's full potential for independence and mobility. Through maximising the potential of advances in assistive technology, medicine and pharmacology to reduce, as much as possible, the risk of dependency and reliance on institutional and hospital care.*
- *To improve out of hospital care for frail people and reduce the number of hospital attendances and admissions and enable a significant shift in resource from acute to community care settings.*
- *To establish a new dedicated frailty care pathway and develop a frailty register in primary care.*

Long Term conditions:

- *To ensure that patients with long term conditions will be in control of accessing a range of health and social care services that fit their own personal circumstances, are customised to meet their particular needs and helps them maintain independence and take care of themselves as much as possible to prevent their conditions deteriorating. Where patients are children or young people, we will also work closely with the family or guardians.*

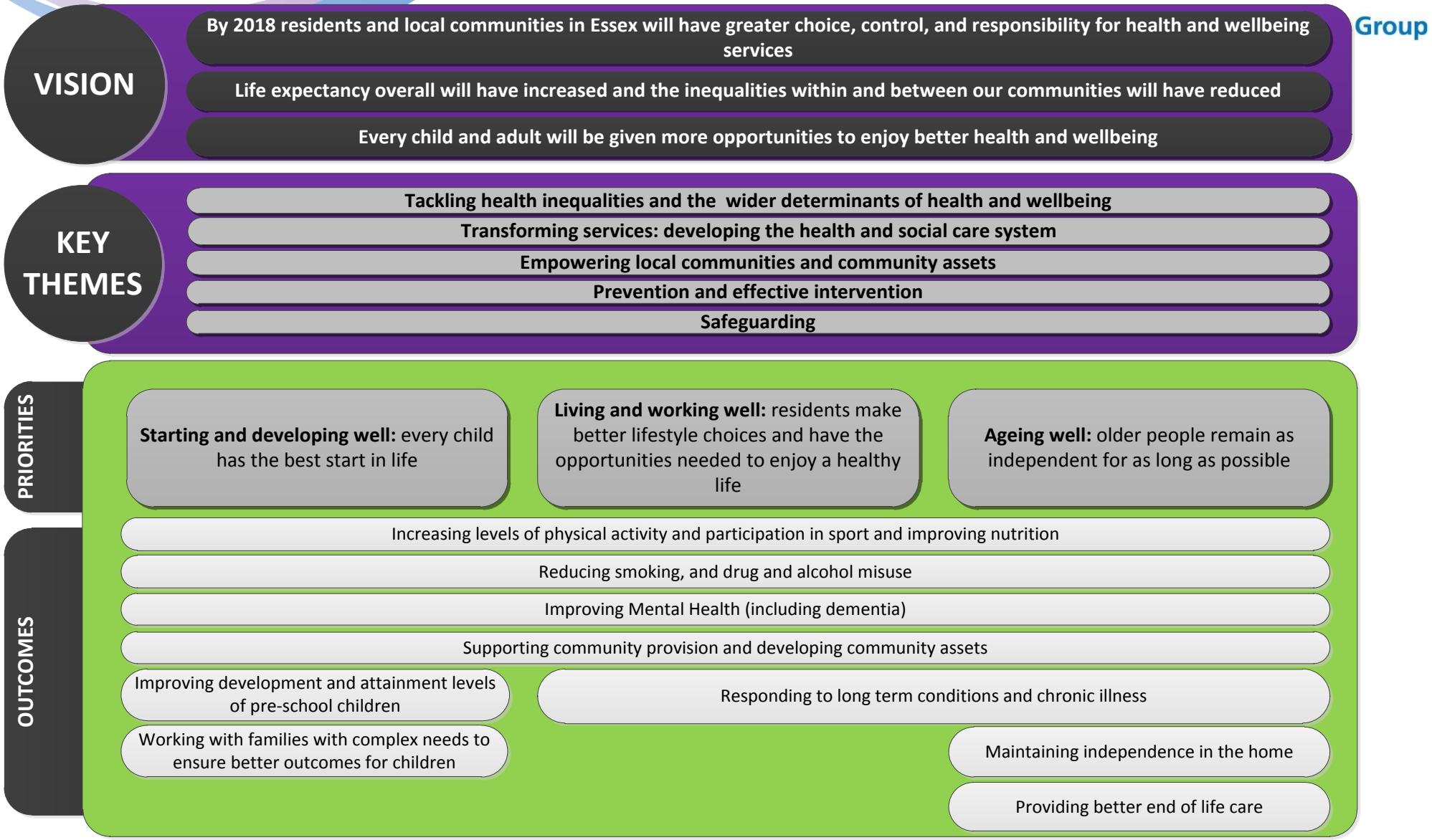
The CCG has arranged its clinical leadership around these three priorities and each has an assigned clinical lead. The clinical priorities are managed and monitored through four multi-professional programme boards: Unplanned care, Planned care, Children's & Maternity and Mental Health and Learning Disabilities. The Planned and Unplanned Care Programme Boards are local Mid Essex boards. Thus the frailty and unplanned care clinical priorities work report into the Unplanned Care Programme Board and long terms conditions reports into the Planned Care Programme Board. We have cluster-wide Children's and Maternity and Mental Health and Learning Disabilities. All programme boards report to the CCG Clinical Commissioning Committee and the priorities and plans from the programme boards are agreed by that committee

The four programme boards are the means of generating new ideas for improving quality, driving innovation, increasing productivity and focussing on prevention, so are the mechanism for delivering QIPP within Mid Essex. Each of the programme boards has representatives from the wider health and social care system.

The Health and Wellbeing Board will be the focal point within Essex for our partners involved in improving the health and wellbeing of our communities. It will be providing leadership and the right level of challenge to CCGs in the delivery of the Essex Health and Wellbeing Strategy. It will be recognised by all as an effective leadership group for the local system.

The Joint Health and Wellbeing Strategy for Essex provides the 'vision for better health and wellbeing in Essex 2013-18
By 2018 residents and local communities in Essex will have greater choice, control, and responsibility for health and wellbeing services. Life expectancy overall will have increased and the inequalities within and between our communities will have reduced. Every child and adult will be given more opportunities to enjoy better health and wellbeing.' The three high level priorities have been agreed as follows:

- *Starting and developing well: ensuring every child in Essex has the best start in life.*
- *Living and working well: ensuring that residents make better lifestyle choices and have the opportunities needed to enjoy a healthy life.*
- *Ageing well – older people remain as independent for as long as possible.*


VISION
By 2018 residents and local communities in Essex will have greater choice, control, and responsibility for health and wellbeing services
Life expectancy overall will have increased and the inequalities within and between our communities will have reduced
Every child and adult will be given more opportunities to enjoy better health and wellbeing
KEY THEMES
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 intervention
Safeguarding
PRIORITIES
Starting and developing well: every child has the best start in life
Living and working well: residents make better lifestyle choices and have the opportunities needed to enjoy a healthy life
Ageing well: older people remain as independent for as long as possible
OUTCOMES
Increasing levels of physical activity and participation in sport and improving nutrition
Reducing smoking, and drug and alcohol misuse
Improving Mental Health (including dementia)
Supporting community provision and developing community assets
Improving development and attainment levels of pre-school children
Responding to long term conditions and chronic illness
Working with families with complex needs to ensure better outcomes for children
Maintaining independence in the home
Providing better end of life care

Essex Joint Strategic Needs Assessment

The Essex Joint Strategic Needs Assessment (JSNA) provides the bedrock of information on the population of Essex; the wider determinants of health and the information needed to assess the quality of life in the county. It suggests the key areas that need addressing and has been used to assess how resources can be deployed to make the greatest improvements in health and wellbeing. Additionally, a CCG JSNA and three tier 2 local authority profiles were produced to provide some clinical and local granularity to the Essex-wide information and the development of the Essex HWB Strategy and this Integrated Plan. Some of the key pieces of evidence that have informed local priorities include:

- *High levels of limiting long-term illness*
- *Low levels of disease ascertainment*
- *High utilisation rates of urgent care services*
- *Growth in ageing population*
- *Carers' health and wellbeing*
- *5-year gap in life expectancy between communities.*

The CCG also recognises the need to respond to other key areas such as safeguarding of children, young people and vulnerable adults, domestic abuse and substance misuse.

At a locality level, the following is a brief summary of key challenges:

Braintree has the second lowest life expectancy rate for women in Essex, and a high level of hip fractures in those aged 65 or older. GCSE attainment in Braintree is poor compared to most parts of Essex. The number of obese adults is also relatively high.

Chelmsford has a low level of physically active children and high levels of adults with increasing and higher risk drinking. It has the highest level of hospital stays for self-harm in Essex and a high level of excess winter deaths.

Maldon has the second highest incidence of hospital stays for self-harm, low life expectancy for men, and relatively high incidence of road injuries and deaths.

Strategic objectives

The CCG has identified its five strategic objectives which are focussed on building and sustaining a competent and sound organisation fit to commission safe, quality services, and in particular improving our member practices' confidence and engagement in the CCG. The CCG also demonstrated through its authorisation panel outcome in December 2012 that it had successfully achieved an impressive start against those objectives, but was not complacent about the work ahead and intended to expand on them for the coming year to ensure that as a CCG it had firmly built upon those things established last year.

Transformation including integration

The CCG is very clear that to deliver sustainable high quality health care to our population we need to ensure that we seek to transform services and work in a more integrated manner with our partners

Practice engagement

This is pivotal success as a CCG. As a membership organisation the CCG aspires to ensure that its member practices recognise their status and are actively involved in both informing and supporting the commissioning arrangements of the future

Public confidence

The CCG must ensure that those it seeks to commission services for are confident that it is a listening organisation that seeks to reflect their needs. The CCG will embed transparency and openness in what it does.

Improving quality and outcomes for all

This is a crucial element of commitment for the CCG. Although it is currently working in a period of unprecedented change, it is seeking to ensure that the services it commissions strive not only to improve the quality of care experienced by our population but also improves outcomes.

Meeting the financial challenge through responsible use of resources

The CCG has a significant financial challenge that it needs to address as part of a wider system. It is not alone in this and therefore aims to ensure that it works with its member practices, staff, public and stakeholders to optimise the resources available to it both individually and collectively. The CCG's investments going forward, need to be those that guarantee a positive return. Chapters 3 and 4 provide more detail on the CCG's 2012/13 financial position and its medium term financial plans.

Managing the risk

The CCG strategic objectives and clinical priorities are all underpinned by a set of principles in order to ensure that we are doing the right things in the right way that will deliver positive benefits and outcomes for the CCG's population:

- *Tackling health inequalities*
- *Transforming Services*
- *Protecting the public (safeguarding)*
- *Ensuring interventions are evidence based*
- *Ensuring the safety & quality of services*
- *Empowering communities and*
- *Engaging our public and diverse groups and communities.*

The CCG has a Risk Management Policy that sets out a corporate and systematic process for identifying, evaluating and mitigating the impact and likelihood of all known and reasonably foreseeable clinical, non-clinical, organisational, financial and strategic risks. The Executive lead for risk management is the Director of Nursing and Quality.

The Executive team regularly consider these risks and the effectiveness of mitigating actions and the position is regularly reported to the sub committees of the Board. The Audit Committee is responsible for ensuring that the CCG establishes and maintains effective systems for integrated governance, risk management and internal controls across all activities.

Communications and Engagement

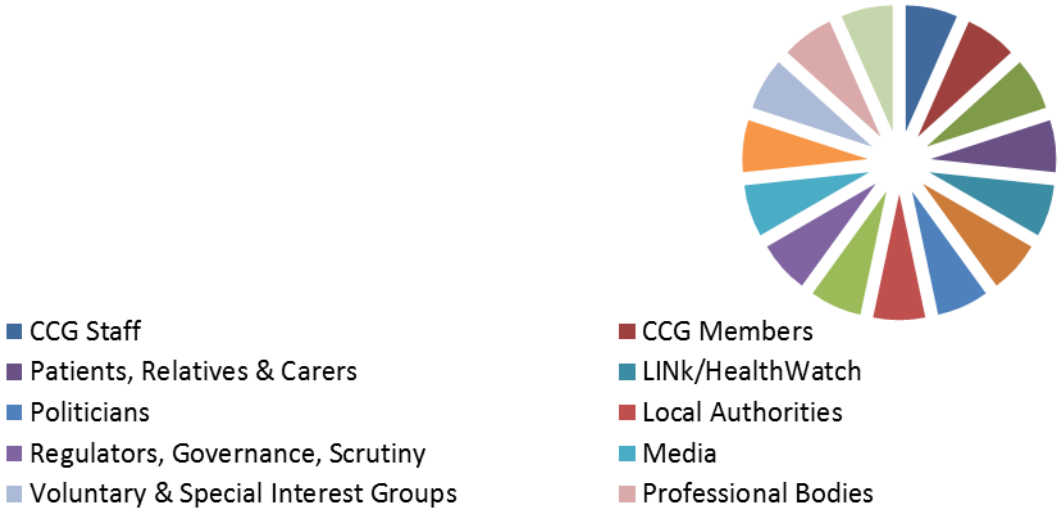
The CCG has a Communication and Engagement Strategy and as a CCG is committed to being open and transparent in everything it does.

Principles of the strategy: Effective communication and engagement is about getting the right messages to patients, communities and key stakeholders through the most appropriate channels at the most appropriate times. This two-way process must inform, share information and insight and actively seek views from individuals and patient groups, to gain insight, to listen and respond to feedback.

The CCG believes that communication and engagement should be a core competency of all staff. By embedding the principles of a constant, two-way process, using the appropriate channels at the appropriate time, the CCG will put in place the foundations of a culture that will bring stakeholders along with it on the this journey.

The CCG acknowledges that its stakeholders don't necessarily belong to one group constantly. They wear many hats and can easily change 'group' or can represent more than one group at any given time. It is vital that we adopt an integrated approach to engaging with the public, seek their views about experiences and use this information in commissioning improved, client-centred services.

Integral to each group are levels of 'seldom heard' (or 'hard-to-reach') people. Embedding a communications and engagement approach that specifically considers these seldom heard groups in each of our stakeholder groupings allows us to address those needs as part of any communication process.



Our approach to public engagement

The CCG has developed a model of public engagement which seeks the views of the public, patients and carers to inform decision making and shape services for the people of Mid Essex. The CCG will build on the work already completed and seek to develop innovative ways of reaching individuals and communities and ensure those voices are heard all the way to Board level, including those voices that are heard less frequently.

Leadership and champions

The Mid Essex Locality Membership is supported by patient and public engagement (PPE) champions, including the Director of Strategy as executive lead, a Board Lay Member and the Chairman as clinical lead.

The PPE champions have responsibility for embedded communications and engagement at the heart of the CCG's governance. They will assure transparency and accountability, as well as ensuring that patient and public perspectives inform major decisions.

Patient Reference Group

At the centre of the locality membership network is a Patient Reference Group, which has a responsibility to ensure effective engagement and will report directly to the CCG Board. The group is selected from volunteers representing a cross-section of our communities drawn from our locality membership, including representatives of younger people. It maintains a connection to the network of patient groups associated with GP practices and provides a coordinating channel for patient and public feedback. This group works alongside the CCG Board to ensure that the Board is aware of the patient and public perspective at all times.

GP Practice Participation Groups

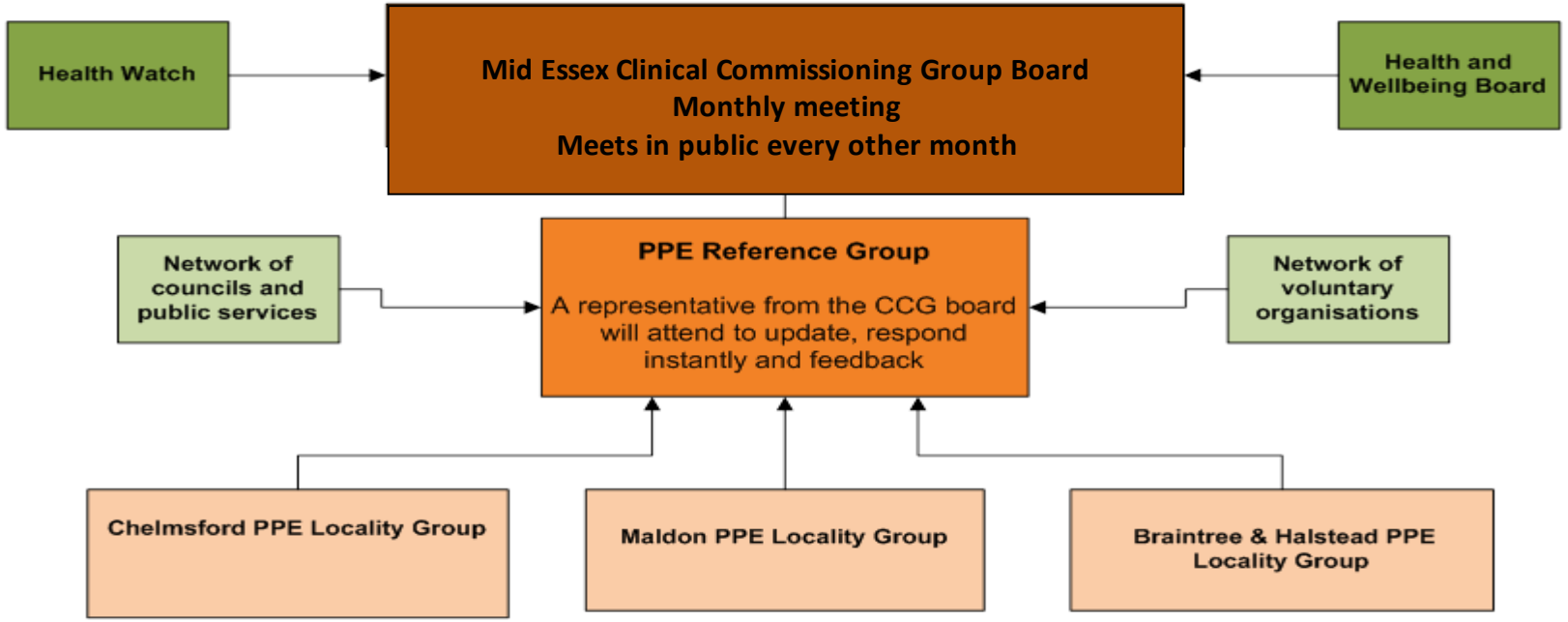
A significant part of the CCG's membership network is a network of GP practice-based patient groups. These groups provide a grass roots source of feedback and engagement in commissioning. We are encouraging the groups to collect feedback on services and patient issues and to get involved in commissioning through the range of opportunities on offer.

Close working relationships with representatives

Through the CCG's membership network, it is envisaged that there will be close working relationships with statutory representative bodies and other patient representative forums. The CCG will continue to build its relationships with the excellent voluntary sector networks coordinated by local voluntary sector support services in each of our three localities; and with democratically elected local authority partners at county, city/district and town/parish levels. It will also continue with well-established relationships with the county Health Overview and Scrutiny Committee.

New relationships are being forged with the Essex Health and Wellbeing Board and the Health & Wellbeing Groups in our area. Essex Healthwatch, the new statutory 'watchdog' body set up as part of NHS reforms, will also play an important role in representing the public and patient voice.

Ensuring voices are heard at board level



There are also many additional routes to gain more local engagement and it is important to continually identify opportunities afforded by working with the CCG partners in local authorities, the voluntary sector, the charitable sector, local faith groups and a variety of community groups. This will enable the CCG to ensure that the public voice is heard and reflected throughout the commissioning process.

Chapter Three: 2012/13 Performance

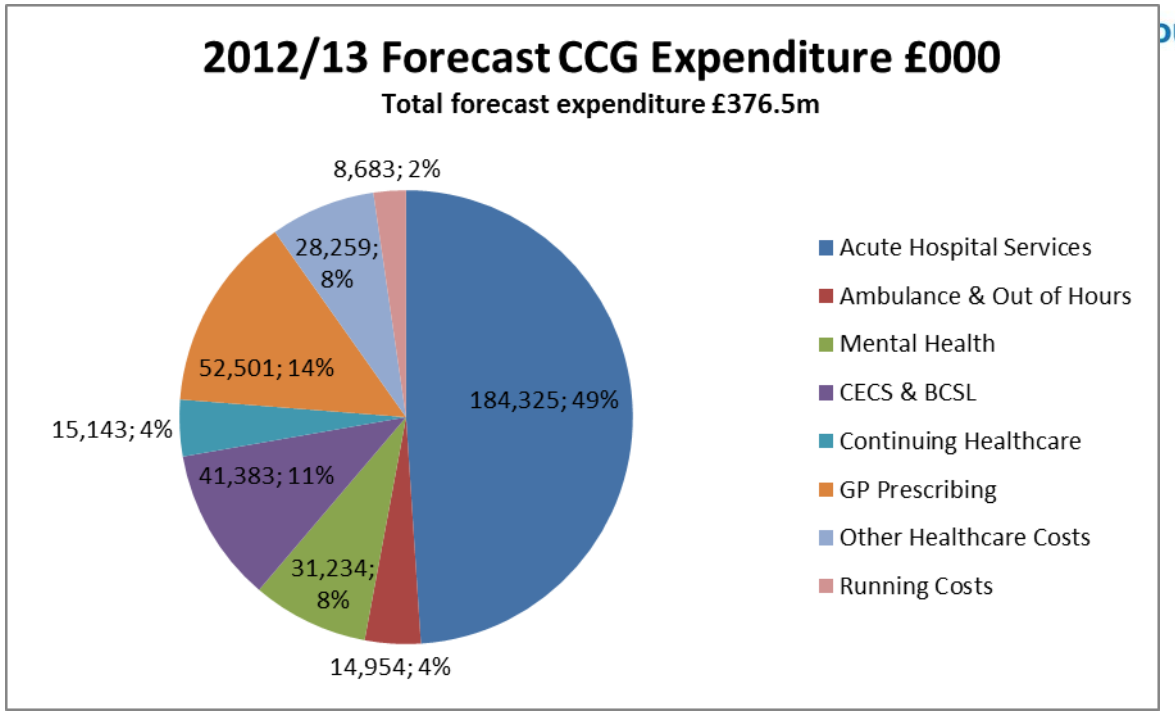
Mid Essex Clinical Commissioning Group

Context and finance

For most of its existence, Mid Essex PCT was a financially challenged organisation. The Department of Health funding allocation deems that the Mid Essex population is relatively healthy and therefore funding was amongst the lowest for PCTs per head of population. In 2011/12 (the last year for which comparisons are available) recurrent funding was 4.7% below the Department of Health funding formula – a shortfall of £24.2m p.a. Achievement of nationally mandated service targets has therefore required a significantly higher QIPP programme in Mid Essex in order to maintain financial balance.

The PCT/CCG commenced 2012/13 with a QIPP target of £24.7m gross. A significant element of this target arose from the use of £11.2m of non-recurrent resources to balance the 2011/12 financial position. The size of the target was such that at the start of the year the PCT/CCG did not have robust plans to deliver the full £24.7m in-year. The NHS organisational changes and some vacancies in key CCG posts contributed to slippage on delivering the formulated plans and delayed the identification and development of plans to close the remaining gap.

At month four of 2012/13 the CCG identified that the scale of the risk to balancing the 2012/13 financial position was £12.8m. The CCG decided to adopt formal Financial Recovery mode in order to generate the organisational attention and commitment to ensure that the 2012/13 financial position could be balanced and that robust and credible plans were identified for 2013/14. The Financial Recovery Plan was approved in November and the CCG is on trajectory to deliver the recovery plan in 2012/13.



The Financial Recovery Plan uses a number of non-recurrent solutions to achieve the 2012/13 target surplus. These solutions must be replaced by recurrent QIPP schemes by the end of 2012/13 to avoid increasing the size of the 2013/14 QIPP challenge by legacy issues.

Quality has been at the heart of Mid Essex CCG throughout its transition and will remain so. Services commissioned by the CCG are quality assured from inception and throughout the procurement process. Quality is an integral part of the contract with all service providers, including special agreements to fund innovation and improvement, via CQUINS (Commissioning Quality and Innovation).

The CCG formally monitors all providers for care quality and standards monthly or weekly in some situations, via the Clinical Quality Review Groups (CQRG), where performance is monitored against a number of national, regional and local quality indicators and targets. Quality is also monitored informally using soft intelligence gathered through walk rounds and PALS contacts.
Key successes to date are that no falls resulting in moderate or severe harm have occurred within our community hospitals, which is excellent performance.

The percentage of eligible patients assessed for venous thromboembolism (VTE) across all providers has been very good and above the national target of 90%.

Awareness and reduction of pressure ulcers has increased with the introduction of the pressure ulcer pathway and the introduction of Pressure Ulcer Panels to get to root of pressure damage.

Collection of data for the Safety Thermometer is well underway and providers are now looking at the impact of that information.
Patient Experience has improved at the local acute provider; addressing issues raised by patients. For example, the SShh campaign in particular is a direct response to concerns about noise at night. Results for the Friends and Family test are improving month on month indicating local providers are working hard to deliver an excellent experience for patients using their services.
2012/13 has seen the formation of the CCG Quality and Governance Committee where all aspects of quality are discussed. Particularly notable is the predominately clinical membership, which will inform the CCG Board of any quality issues.

Learning from Mid Staffordshire failings, Essex has developed and implemented a Quality Surveillance Group for the purpose of sharing quality intelligence and identifying areas of concern by sharing early warning systems. The CCG is a key member of this group with attendance by the Accountable Officer and Director of Nursing.

The CCG will continue to strive for excellence in Patient Safety and Quality. Key priorities will include:

- *The continued programme to eliminate all grade 3 and 4 health acquired pressure ulcers*
- *Working with partners such as the local authority to identify and manage non health acquired pressure ulcers particularly in care homes*
- *Continue to deliver low numbers of Health Care Acquired Infections, with a zero tolerance for MRSA Bacteraemia*
- *To ensure the Chief Nurse Vision of compassion is delivered by all providers*
- *Ensure the learning from the Francis 2 report is achieved across the health system*
- *Reporting and learning from serious incidents across all Providers*
- *Reporting and learning from the findings of Sudden and Unexplained Injury, Child Death and Serious Case Reviews and implementing the recommendations*

Continued improvements in patient experience

Since publication of the Francis 2 report in February 2013, the CCG has agreed with providers that 10% of CQUIN money will be used to achieve the relevant points from Francis. Ward managers will lead this work. The CCG is committed to ensuring quality through its values, its priorities and its targets and measures.

Regulators: Care Quality Commission and Healthwatch

In addition to the nine health and social care professional regulatory bodies (e.g. General Medical Council, Nursing & Midwifery Council, General Dental Council), the Care Quality Commission (CQC) is the statutory regulator for the quality of health and social care in England. It is responsible for registering and monitoring compliance of NHS and social care providers with the essential standards of quality and safety. Healthwatch England, the national body providing leadership and support to local Healthwatch is a committee of CQC. Healthwatch replaces the existing Local Involvement Networks (LINk) in April as part of the Health and Social Care reforms.

Healthwatch will work in local teams to provide advocacy and advice services to its local population and ensure that the views of patients, carers and the public are represented to local commissioners. Its key role is to focus on quality, dignity, safety of services and safeguarding and will work closely with local authorities, the Health and Wellbeing Board, providers, CCGs and GPs. The CCG

has made clear its intent to support Local Healthwatch and build a strong and constructive relationship to ensure the quality and safety of services by its providers.

Review of 2012/13 delivery against national standards

Across the health economy the CCG faces a number of challenges to ensure that all its key national standards are achieved, in particular during 2012/13 it has faced challenges in achieving sustainable performance against the four-hour A&E standard, 18 weeks in all specialities, stroke care for scanning TIA patients and the cancer services.

During 2012/13 the CCG agreed with Mid Essex Hospital Services Trust 66 Quality standards within the contract. These are monitored through the monthly Service Performance Review Group, Clinical Quality Review Group, Technical and Activity Groups. Remedial action plans are applied as consequences of any breach on 43 of the quality standards as these are considered to be more beneficial than financial penalties and seek to encourage the trust to seek remedies. Contractual penalties are applied should the trust fail to deliver on promises within remedial action plans.

23 of the Quality standards have financial consequences. Of these standards, some are local, some SHA mandated (for example Choose & Book) and others are Department of Health contract requirements (for examples MRSA, C.Difficile).

The CCG's approach to managing provider contracts is to work in partnership wherever possible and support providers to deliver the highest standard possible. Breaches of standards do not therefore always necessarily result in the issue of Formal Contract Query Notices, the CQRG or SPRG review the breaches and agree remedial action plans where appropriate and necessary. The Trust reports formally on progress to these monthly Groups or the appropriate body.

Target	What we have done in 2012/13	What we will do in 2013/14
18 Week Standard 18 week aggregate not met in 11/12 for admitted ; non -admitted pathway was met In 2012/13 standards have been met at aggregate level and met as required at specialty level by Qtr.2 . MEHT is treating patients in turn and backlog is also reducing.	Monitored performance weekly	Monitor compliance weekly/monthly and ensure compliance to aggregate and speciality level. Plan to continue to reduce backlog and continue to ensure patients get treated 'in turn'.

Stroke Care To meet the targets for 90% stay on a stroke unit and achieve high risk and low risk TIA consistently month on month.	Monitored performance monthly Performance has improved and MEHT is consistently meeting the targets Implemented an Early Supported Discharge Team Undertook review of the psychological support needed for the stroke unit A&E staff training and reinforcement of urgent need to transfer to stroke unit on arrival Concerns raised about the regional strategic stroke model, costs and impact on quality measures.	Continue to monitor performance monthly. Continue to influence the regional stroke model to ensure improvements for Mid Essex patients.
Cancer Services MEHT has met all cancer standards MEHT needed to improve on the national cancer survey 2010/11 outcomes.	Consultants were very concerned about the ratings in the survey and introduced local in-house surveys to change this. The 2011/12 survey showed substantial improvements but the Trust recognises there was still work to be done and always room for improvement. MEHT has worked with the Essex Cancer Network to continue to improve access and treatment to cancer services	Monitor compliance and improve outcomes
Accident and Emergency After a challenging year in 2011/12 MEHT has met the 4hr wait in A&E target consistently	Consistent performance in exceeding the standard helped the Trust focus on improving patient flows through the hospital. Working with MEHT and the community provider to introduce an Integrated Discharge Team to help move patients out of the acute to community setting with the support they need.	Ensure performance continues to meet 95% standard. Monitor performance daily Ensure patient's discharge is timely and with the support needed
Reducing healthcare acquired infections	The CCG/PCT has made improvements on last year on reducing the number of incidents but meeting the (DoH set) very low ceilings in 12/13 has been challenging.	A North Essex action plan to continue to improve in both community and acute settings will be monitored and actions implemented to secure patient safety as a priority.

Mid Essex – Performance in 2012/13

Our performance in 2012/13 is monitored against the requirements of the Annual National Operating Framework and the Regional Strategic Health Authority Commissioning Framework. These include all national and local targets which are used to measure how we are improving health and healthcare year on year for our local population.

In 2012/13, the national priorities continued to focus on improving access to hospital treatment, faster access to cancer services and reducing healthcare associated infections. An increased focus was placed on mental health with the requirement to meet national indicators for 'access to psychological therapies' services.

One of the most challenging targets was to continue to ensure that the number of healthcare infections in a hospital was dropping year on year. Mid Essex Hospitals Trust has made great strides in improving their infection control processes and procedures and continue to improve year on year, Current performance is showing that they are keeping within ceiling for the number of Cdiff incidents.

The Trust has also made enormous strides to improving performance in Stroke services and meeting both of the stroke national targets, 90% time spent on a stroke unit and TIA scan within 24 hrs, as well as improving the A&E performance and the Cancer standards.

Mid Essex PCT commissioned an IAPT service in 2012/13 following its successful pilot. This is providing a gap in mental health services.

A major part of delivering improved healthcare is to commission services where evidence has proven that it will impact on better health outcomes. Performance has improved in 2012/13 with the increase in the number of people quitting smoking and the number of people having a health check.

The tables below show how we performed in terms of the national priorities for 20012/13 and how our performance compared with 2011/12.

Performance measures	Target / plan	Actual performance	
		2012/13	2011/12
Maximum time from referral to treatment			
% People treated with a stay in hospital within 18 weeks of referral by their GP	90%	95.1%	93%
% People treated (non-admitted) within 18 weeks of referral by their GP	95%	98.5%	98%
Reducing healthcare associated infections (PCT)			
Number of *C Difficile* infections	61	70	77
Number of MRSA infections	2	5	0
Cancer treatment waiting times			
% People attending a first appointment within two weeks of an urgent referral by their GP for suspected cancer	93%	97.0%	95%
% People attending a first appointment within two weeks of an urgent referral by their GP for breast symptoms	93%	97.6%	98%
% People receiving treatment within 62 days of an urgent referral by their GP for suspected cancer	85%	84.2%	87%
% People receiving treatment within 31 days of a cancer diagnosis	96%	98.8%	99%
Improving care for strokes			
% People spending 90% of their treatment time on a special stroke unit	80%	86.1%	70%
Patients with a suspected transient ischaemic attack (TIA) seen and treated within 24 hours	60%	66.2%	69%
Performance measures	**Target / plan**	**Actual performance**	

		2012/13	2011/12
Reducing blood clots in the vein (VTE)			
% People admitted to hospital who are assessed for risk of VTE	90%	96.5%	95%
Accident & emergency department waiting times			
95% Patients seen in A&E within 4 hours	95%		96%
Ambulance response times			
% Calls for life-threatening incidents resulting in a response within 8 minutes	75%	74.0%	75%
% Calls for life-threatening incidents resulting in a response within 19 minutes	95%	93.9%	95%
Improving mental health			
% People who have depression and/or anxiety disorders who receive psychological therapies	9.8%	6.0%	8.9%
% People who complete treatment who are moving to recovery	50.5%	50.8%	47.0%
Choice about where to die			
% Deaths at home, or place of residence (as opposed to in hospital)		42.6%	40%
Improving maternity care			
% Women of women who are smoking at time of delivery	<10%	%	%
% Women breastfeeding their babies at 6-8 weeks after birth		46.5%	47.6%
Performance measures	**Target / plan**	**Actual performance**	

		2012/13	2011/12
Improving support for children and families			
Increasing number of Health Visitors	Increase to 72 HVs by March 2015		45
Reducing smoking			
Number of people who quit smoking for more than 4 weeks after using NHS Stop Smoking Services	2,850	2,001	2,906
NHS Health Checks			
% People who are eligible being offered a health check	20,568	18,099	14,498
% People who are eligible who received a health check	13,310	9,740	9,313
***This data is provisional for 2012/13**			

Provider performance

Mid Essex Hospital Services NHS Trust

Mid Essex PCT (as Co-ordinating Commissioner) and Mid Essex Hospital Services Trust signed the new NHS 2012/13 Standard Contract, with a one year duration, in April 2012. Valued at £192m there are 13 Associates to the contract who have activity plans ranging from £230k to £15m.

The CCG is forecasting to over perform by £1.2m at contract / financial year end. The over performance is mainly the result of emergency activity exceeding commissioner's indicative plans. Electives are underperforming against plan, with the local Ramsay Hospital benefitting from increased elective/day case referrals/activity.

Headline Performance

In summary, despite the capacity and financial pressures faced by the Trust, MEHT has performed well against most performance and quality standards in 2012/13, the trust is consistently in the top ten performers list of the Midlands and East SHA.

There are, however, areas of performance where commissioners require significant improvement and these remain a key priority for 2013/14. This includes communications (discharge letters including A&E), medical records, ambulance turnaround times and clearance of the 18 week Refer to Treat admitted backlog.

Performance against key standards/targets

Infection Control - The Trust has an excellent infection control record and their Board has reaffirmed the Trust's focus on eliminating all Hospital Acquired Infections. Health Care Associated Infections (HCAIs) pose a serious risk to patients, staff and visitors and can incur significant costs to the NHS and cause significant morbidity to those infected. As a result, infection prevention and control is a key priority for the Trust, evidenced by 2012/13 performance against key targets where, as at the 31st December 2012, the Trust had reported one case of MRSA and 15 cases of Clostridium Difficile, against agreed targets of one and 22 respectively, for the year.

Patient safety and quality improvement - The Trust commissioned, and acted upon, an external review of patient safety and governance arrangements. Patient safety, quality issues and patient stories are discussed at every Board meeting; at directorate level

governance reports are provided for monthly meetings and a programme to increase awareness and shared learning from serious incidents and complaints has been established.

Patient surveys - During 2012/13 there have been several patient surveys both national and internal across inpatient and outpatient areas. The common themes for improvement include the need for improved communication, better information relating to medication and information relating to discharge home. The Trust's patients had a positive experience in relation to privacy and dignity, cleanliness, pain management and involvement in care.

Cancer targets- MEHT performance in respect of the nine cancer targets is in the top ten trusts monitored by Midlands and East SHA.

A&E 4 hour wait - MEHT has achieved the main four hour wait target, for each of the first three quarters and cumulatively for the year to date, with 96.1%, despite service pressures.

Ambulance turnaround times –Performance issues remain, with the agreed 80% target for clinical handovers within 15 minutes not being achieved and performance deteriorating against the trust trajectory of improvement.

18 weeks RTT – MEHT continue to report achievement of the aggregate national targets of 90% for admitted, 95% for non-admitted and 92% for incompletes. At specialty level they have breached the targets on eight occasions (one admitted and seven non-admitted) to the 31st December. Fifty per cent of the breaches were in Trauma and Orthopaedics and penalties as required by the contract have been imposed for the breaches. As part of the 2013/14 contract discussions, trust capacity plans will be requested for problematic specialties.

The reduction of the 18 week backlog has been a key priority for the trust and CCG in 2012/13, with a remedial action plan and clearance trajectory having been implemented. Whilst the non-admitted backlog has reduced to be just over 100 by January 2013, the admitted backlog has been the subject of a revised trajectory, the 400 in February 2012 has reduced to 330 by the end of January 2013, having risen in the last two months as a result of service pressures. The trust has successfully reduced the backlog for the most problematic specialty, Plastic Surgery.

Medical records – Clinicians undertaking audits or reviews have identified the state of patients notes to be a patient safety issue, the trust has implemented an action plan, and reports progress to the Clinical Quality Review Group.

Standards of communication - this relates to the contract requirement for discharge letters/summaries or other communications to be issued to GPs, other providers or patients, on a timely basis. Despite an improvement in performance and the implementation of a

remedial action plan this is still considered to be a significant patient safety issue by the CCG, and a significant improvement will be required in 2013/14.

North Essex Partnership NHS Foundation Trust (NEPFT)

The NEPFT contract is a north Essex cluster block contract (value £75m) which is apportioned over the three north Essex CCGs on a 'per capitation basis' as set out in the current inter-PCT agreement:

North East Essex	0.372
Mid Essex	0.350
West Essex	0.278

Headline performance issues

Overall the performance of the Trust is high. However the two acute adult mental health wards in mid Essex have been operating at very high occupancy levels with the risk share arrangements being invoked two or three times a month. This is in a context of an increasing use of the Mental Health Act nationally as well as locally. Crisis resolution and home treatment services are also under increasing pressure. Targets are being met on gatekeeping by these teams (98% performance) and seven day follow up is being achieved 100% of the time.

Memory assessment services are coping well with increased demand. The Trust is on target to meet its CQUIN requirements. A contract query relating to the non-production of Serious Incident reports within nationally established timetables has been issued. The Trust continues to meet the 18 week Referral to Treatment target for consultant outpatient services.

There has been a national patient survey during 2012/13. The majority of the results were similar when compared to the national benchmarking. Better results were achieved in out of hours contact, being given a care plan and understanding the care plan. The worst results appeared in the section on day-to-day living and in particular on support with accommodation and help with benefits. The action plan has been altered accordingly.

The Infection Prevention and Control Team continue to encourage the reporting of all infections and infestations from all clinical teams and staff to provide a degree of surveillance. The Trust has not produced any MRSA bacteraemia and has very few cases of Clostridium Difficile – only one case in the year to date.

NEPFT has been working since December 2012 to deliver a £3.5million reduction from within the block contract. Whilst that work is still on-going it is yet to go through the appropriate governance and quality assurance processes, however NEPFT has advised that the indicative CIP proposal include the following:

- *Whole Service reconfiguration, including Community Team reorganisation which will include reduction in clinical, HCA posts and administration posts*
- *Drug spend reductions*
- *Functional model on inpatient wards*
- *Estate reconfiguration (rates/ utilities, capital charge valuations) and energy efficiencies*
- *'Margin/income' from new services outside of Essex*
- *Procurement and tendering contracts.*

NEPFT has assured the CCG that none of the savings proposals involve reductions in minimum inpatient ward staff levels.

Central Essex Community Services (CECS)

The opening contract value for 2012/13, which is year two of the contract, was agreed at a value of £36.8m.

CECS is on track to deliver its financial targets in 2012/13. The total potential CQUIN payment for 2012/13 is £925k.

Headline Contract Performance

Performance across the range of key performance and measured clinical quality standards for the first seven months of the year is per expectations and CECS continues to report adherence with all applicable national quality requirements and nationally specified event thresholds. There have been no nationally reportable 'never events' although this position may change as a result of an on-going Root Cause Analysis ('RCA') in relation to a recent incident at the St Peters ward.

Compliance against 18 week performance targets remains good with only 0.8% of patients with clocks still running reported as waiting for more than 18 weeks. There are however a small number of breaches reported for the Wheelchair service, Adult Speech & Language Therapy and Scheduled Physiotherapy and these are being investigated.

In addition, the following areas are those that show red or amber lights:

18 weeks referral to treatment times for all non-consultant led services – Performance in October shows 99.60% compliance compared with a target of 100% and 99.20% when last reported (October). CECS continues to work with commissioners on services where capacity is cited as the reason for breaches, and the organisation has committed additional resources to ensure breaches are minimised. The focus of discussions is now around the 2013/14 financial year and the introduction of appropriate mechanisms (e.g. cost per case tariffs) to ensure that the appropriate resource is available to meet demand. To put this year's performance into perspective, the number of breaches has been on average around 3 patients per thousand

Smoking Cessation – Performance was below target but there is increasing confidence that the full year target will be met.

Chlamydia Screening – Performance is below plan and efforts are being made to make up the shortfall.
All other mid Essex key performance indicators are being met.

Compliance with mandatory training remains poor. The CCG, as Commissioner, has raised a Contract Query Notice which will require a suitable Remedial Action Plan to be put into place, monitored and reported against.

CECS has identified a number of key issues and priorities in 2013/14 that could affect the CCG and health and social care system. They include:

- *Retaining service quality and effectiveness whilst implementing cost savings (including 4% CRES)*
- *Securing a new IT provider*
- *Securing lease agreements in fit for purpose estate*
- *Reviewing productivity across business units through LEAN methodology and zero based budgeting approach*
- *Producing quality information reports from our community services following agreement with commissioners in contracting negotiations.*

CECS has identified areas of potential impact on its activity and costs in 2013/14 of proposed CCG QIPP projects. These include: Carry forward QIPP of £1.2m, added to 2013/14 target of £0.7m and CRES of £1.4m requires and overall savings requirement in CECS of £3.3m

This could result in a potential reduction in staffing where efficiencies cannot be delivered by increased activity/productivity in the block contract.

Contract negotiation 2013/14

As an extant contract, complete renegotiation of terms and conditions is not required. Subject to notice being served on part or all of the contract, the key assumption is that services will continue to be delivered on the same basis in 2013/14 unless specific changes are made and negotiated by the CCG. The CCG therefore intends to agree a number of changes from 1st April 2013 in order to align with its priorities and QIPP transformation delivery projects (see Chapter five). Key service areas have been identified and are under discussion with CECS. This includes Integrated Care, community hospitals and the Central Referral Service.

Essex Commissioning Support Unit

The CCG has commissioned Essex CSU to provide a range of services from the full suite of services that the CSU offers. The service level agreement is for delivery of services until September 2014. Most of the SLA charge will score against the CCG's running cost allowance – resulting in a cost of £8.52 p.a. per head of population against the CCG's total allowable expenditure of £25.00 per head.

The CCG manages the service level agreement through a formal performance management framework. The CSU has allocated a Key Account Manager (KAM) whose role is to manage the relationship with Mid Essex CCG and ensure that services are meeting the CCG's needs.

On a quarterly basis all Essex CCGs meet with the CSU senior team to review Essex wide KPIs and address strategic issues.

Chapter Four:

Operating Frameworks

As a statutory body, the CCG will be required to operate through statutory frameworks which determine not only how it can operate but the things it has to achieve as well as exploring areas where the CCG could achieve better efficiencies. A summary of these operational parameters, dependencies and requirements are included in this chapter. In addition, the CCG is committed to operating under the Nolan principles of public life.

NHS Mandate & NHS Constitution

The Department of Health issued the first Mandate to the NHS Commissioning Boards (NCB) in December 2012. The NHS Mandate sets out the Government's ambitions to improve health care by looking to provide routine NHS services seven days a week, more transparency, more choice, more patient participation, better data and informed commissioning, improved outcomes and higher safer standards and in the first instance to uphold and promote the NHS Constitution. The CCG will actively promote the constitution as part of its cycle of public involvement.

NHS Mandate & NHS Outcomes Framework

The Mandate renews the focus on improving patient outcomes and reducing health inequalities. The NHS will be measured against a number of areas including whether a patient's treatment was successful, whether they were looked after well by NHS staff and whether they recovered quickly after treatment. The Mandate uses the five parts of the NHS Outcomes Framework which sets out indicators to help the health and social care system work in partnership to focus more on measuring outcomes. It will be used to hold the NHS Commissioning Board to account for improvements in health gain/outcomes as part of the government's mandate to the NHS Commissioning Board.

Indicators in the NHS Outcomes Framework are grouped around five domains:

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.

For each domain, there are a small number of overarching indicators followed by a number of improvement areas.

The Secretary of State, the NHS Commissioning Board and Clinical Commissioning Groups have a duty, for the first time, to have regard to the need to reduce inequalities between the people of England.

NHS Commissioning Board Planning Framework – Everyone Counts 2013/14

The NCB has set out its priorities in its planning framework, Everyone Counts 2013/14 to deliver the Mandate as set out by the Government which priorities the CCGs to deliver the NHS Constitution Pledges as listed above and maximise through its planning in partnership with Public Health and Social Care improved health gain for its population.

To this effect, working through the Health & Wellbeing Board aiming to contribute to the delivery of the Essex HWB Strategy, the CCG will also collaborate in defined areas where there is a cross-over with the Public Health and Social Care Outcomes Frameworks. The CCG is collaborating on the development of an Integrated Outcomes Framework for Essex.

From the NHS Outcomes Framework and each of the five domains, the NCB has identified measures where CCG data exists and a baseline can be determined and therefore will be used to inform CCGs and the NCB of progress being made through the CCG assurance framework process to improve health for its local population. The CCG indicators are shown in the following Indicator Set for 2013/14 below and have been chosen on the basis that they will help contribute to better outcomes across the system working with the Health and Wellbeing Boards and Local Authorities to deliver together better outcomes.

The CCG is also required to determine three local priorities based on the NHS Outcomes Framework and linked to the JHWBS as measures which will be monitored to reflect the quality of the health services commissioned in 2013/14 and the associated improvements in health and wellbeing outcomes and reducing inequalities.

The three local priorities selected by the CCG are:

	Indicator Definition (please specify the local measures chosen) max 4000 characters	**Numerator**	**Denominator**	**Measure**
Local Priority 1	To reduce the number of delayed transfers of care in the acute setting. Measure -the reduction in the number of patients recorded as hospital delays validated as DTOC to 17 or less.	17		Reduce to 17
Local Priority 2	Improve the percentage of people registered with diabetes who receive the nine key processes of diabetes care. Measure - NDA audit.	9838	17887	55%
Local Priority 3	Reduce the number of 999 calls from Care Homes (to aid reduction in A&E and non-elective admissions).Measure- Number of calls saved.	426		

Priority 1: Delayed Transfer of Care – better management of this area will support optimal use of NHS resources, reduce length of stay in hospital, promote independence and enhance patient satisfaction.

Priority 2: Diabetes Care – better management of diabetes, including the provision of self-care education, will reduce health complications and ensure people have a healthier life.

Priority 3: 999 calls reduction from care homes – this will support preventable hospital admissions, reduce the need for people being discharged into care homes, empower and up-skill care home staff and improve quality of life.

To secure an additional premium payment in 2014/15, the CCG will also need to achieve four national measures identified by the NCB:

- *reducing potential years of life lost through amenable mortality (12.5% of premium): the overarching objective of Domain1 of the NHS Outcomes Framework*
- *reducing avoidable emergency admissions (25% of premium): a composite measure drawn from four measures in Domains 2 and 3 of the NHS Outcomes Framework*
- *ensuring the roll out of the family and friends test and improving patient experience of hospital services (12.5% of premium) based on one of the overarching objectives for Domain 4 of the NHS Outcome Framework*
- *preventing healthcare associated infections (12.5% of premium) based on one of the objectives for Domain 5 of the NHS Outcomes Framework*

Total payment for a CCG (based on its performance against the above three local priorities and the four national priorities) will be reduced if its providers do not meet the NHS Constitution pledges.

National NHS and locally determined priorities (measures)

In addition to achieving the CCG's clinical priorities and strategic objectives, the National Commissioning Board measures its performance on a number of other performance measures:

- *Eliminating long waiting times – zero tolerance on 52+ week waits*
- *Urgent & emergency care – better turnaround times for ambulances*
- *Reducing cancellations*
- *Mental health – completion of improving access to psychological therapies (IAPT) rollout.*

Mid Essex CCG Authorisation

In order to achieve full authorisation from the NHS Commissioning Board to operate as a formal and statutory body, the shadow CCG underwent its formal authorisation process as a 'Wave 4' applicant body in December 2012.
The CCG agreed with the outstanding issues (Key Lines of Enquiry) noted by the Authorisation Panel and responded to those with a full action plan to the NCB, led by the Director of Strategy and Primary Care and monitored by the Executive Team and CCG Board.

The CCG was advised by the NCB that with effect from the 6th March 2013 it is fully authorised as a formal and statutory body with just three conditions as set out in this excerpt from the CCGs official letter:

ANNEX B – CONDITIONS OF AUTHORISATION FOR NHS MID ESSEX CCG

Criteria	14C(2) Ref.	Proposed condition	Support level
3.1.1B	E	CCG must have a clear and credible integrated plan that meets authorisation requirements	II
3.1.1C	E	CCG must have detailed financial plan that delivers financial balance, sets out how it will manage within its management allowance, and is integrated with the commissioning plan	II
4.2.1G	E	Provide evidence that the CCG has appropriate and effective financial reporting, management and governance in order to meet its statutory financial reporting duties and in year financial reporting requirements. In particular, provide evidence that the CCG has appropriate risk-sharing arrangements with other CCGs in place and clearly understood by all parties	II

The CCG is required to develop an action plan for how it will discharge these conditions that must be agreed by the NCB Area Director by 28th March 2013.

The NCB will review the status of these conditions on a quarterly basis, commencing June 2013.

Chapter Five: Transition and Reform of the Mid Essex Health & Social Care Economy (in context of north Essex wide system)

Collaborative and joint commissioning

The three north Essex CCGs (Mid Essex, North East Essex, and West Essex) have a strong history of working together particularly the adult safeguarding and Essex Safeguarding Children's Clinical network which will both continue, as will the quality collaborative and the collaborative work in infection prevention and control.

Essex County Council and the CCGs have a shared agenda in respect of commissioning for Mental Health, Learning Disability, Children's and Maternity services and have agreed that this will be a joint arrangement from April 2013. The CCGs have developed and are committed to a 'Collaborative Compact' agreement that sets out how the three CCGs will work together in a formal arrangement including detail on working arrangements and governance arrangements and also defines a dispute resolution process that could be used if circumstances arise where this is necessary.

The CCG anticipates working closely with West Essex and North East Essex CCGs in particular to ensure that a coherent approach to commissioning is maintained. It is expected that all contracts that have historically been hosted by NHS Mid Essex will be retained, as will arrangements that were in place for associate commissioning.

In most cases the CCG will seek to enter into associate agreements with other CCGs outside of Mid Essex where other CCGs geographically host the service in question e.g. East Anglia Ambulance Services Trust Contract. The exception to this is the contract with North Essex Partnership Foundation Trust which is being jointly commissioned by Mid, West and North East Essex CCGs.

Essex County Council has long been a partner of the NHS and has worked closely with the shadow north Essex CCGs. Over the last four years Essex County Council has embarked on an ambitious transformation programme and will have achieved savings of £300m per annum by 2013. The county council faces pressures in demand in adult, health and wellbeing including learning disability, physical and sensory impairment, Older People and Mental Health services. These services represent close to half of ECC's controllable budget. Both health and the local authority recognise that it will be imperative to work together and build on the whole Essex community budgets work.

In order to deliver efficiencies of £200m by 2016/17 the county council has embarked upon a Transformation Mark II programme to transform into a commissioning-led council, separating strategy and commissioning from operations. In re-structuring the council, the statutory roles of the Director for Children's Services and Director for Adults Social Services have been combined into the principal Commissioner for People Services.

The planned phased activity of the ECC Transformation Mark II programme includes having integrated commissioning in place with partners by March 2016. The council aims to secure lock-in to integrated commissioning arrangements with CCGs through joint appointments and joint contracts for services and is committed to reviewing jointly its procurement pipeline and CCG contestability plans to identify opportunities for joint commissioning. These should lead to the development of joint specifications followed by joint procurement and contract management, with deliverable savings for the partners.

The county council is committed to devolving and co-locating commissioning capability and resources to CCG areas to support integrated commissioning development with CCG partners during the course of 2013/14.

The initial proposals for the use of sustainability funds (under section 256) transferring from the NHS to Essex County Council which have yet to be agreed between the NCB area team, ECC and CCG lead Commissioners, are:

- *Provide CSU and Project Management capacity for the development of integrated specifications and the delivery of plans;*
- *Fund, on a CCG population basis in alignment with CCG transformation funds, resource for mutually beneficial demand management schemes and provider transformation.*

During 2011/12 Essex was successful in being one of the four national sites for piloting community budgets. Reducing health inequalities is a strategic aim set out in the Joint Health & Wellbeing Strategy for Essex 2013-2018. The key interventions incorporated in the whole Essex community budgets programme will also contribute to tackling local inequalities whilst improving health and wellbeing outcomes.

The scheme has three key work streams, as follows:

- *Families with complex needs*
- *Domestic Abuse*
- *Strengthening communities*

Families with Complex needs

Families with Complex Needs are families that can be the subject of multiple problems, such as alcohol and drug misuse, mental health issues, involvement in crime and anti-social behaviour, poor parenting, child protection issues, homelessness, economic crises and dependence, low attainment at school, school absence and exclusions and domestic abuse.

The problems faced by the individuals in these family units are often interdependent, therefore an integrated and holistic approach is required that will address the needs of the family and not just the individuals within it. The CCG is committed to improving health and wellbeing outcomes for its resident population and will collaborate with Essex County Council over the next three years to support the development of effective early interventions in locally identified areas to negate the need for more costly actions in the future.

Domestic Abuse

People who are affected by domestic abuse will require more than just the support of the police service and the criminal justice system. They will also, among other services, have a call on housing, social services as well as health services (GPs, hospitals and mental health). It is estimated that over 3% (c. £1.22b) of the NHS funding is as a direct cost of healthcare treatment resulting from domestic abuse; mainly incurred as hospital and ambulance costs.

The CCG is committed to explore the development of prevention and early intervention services with ECC and local partners from 2013-14, including working with schools. The development of an effective model of intervention would see better cross-agency referrals, a higher rate in cessation of abuse and a reduction in A&E attendances and prescription costs.

Strengthening Communities

Fundamental to the success of the programme, the strengthening communities work stream aims to build a comprehensive approach to strengthening communities, working at individual, group, community and organisational levels across Essex.
The aim of the programme is to shift expectations and create different relationships across public, commercial, voluntary and community sectors – managing demand and reducing dependency on services. Initial development of the programme has been formed around the following areas of activity and the CCG will be engaging in relevant activities and commissioning to maximise gains for its local population:

Community connectors - Creating connections between individuals and across communities; supporting people to own and solve their own problems and encouraging people to get involved in volunteering or local action and acting as a support resource, such as the development of community health champions.

Targeted volunteering – Working through local partners and the third sector in stimulating individual and reciprocal activity and increasing shared understanding about the incentives, rewards and barriers to volunteering. Such a resource can support primary and community care (including pharmacies) services with responsive signposting.

Community Commissioning - Creating a different relationship between public, private, voluntary and community sectors to enable sustainable community-led activity. Building social capital and providing grant-funding to provide an opportunity for community-led commissioning.

Securing partnership commitment is key to the on-going development of the programme as to be effective it needs to draw on the skills, knowledge and the experience of a range of public sector professionals, as well as our communities across Essex.

The community budgets project presents a strategic case for change and seeks the commitment of partners to business case development and testing the models, including alignment with other key partner work streams so that the shift towards integrated approaches to commissioning can be progressed through binding commitments between partners during the course of 2013/14.
Since the start of the community budgets programme, the business case has evolved significantly and has had to adapt to the rapidly changing aspirations of the greater Essex CCGs. The original proposition was to develop specifications for integrated service provision for older people with long term conditions, learning disabilities provision and dementia care. This was quickly superseded by the realisation that, whilst important, simply adding to an already well furnished catalogue of integrated service design would yield

limited benefits. Focus shifted to considering what conditions needed to be created (technical, financial and organisational) to ensure that collaborative planning and commissioning was adopted on a systemic basis and benefits maximised across Essex.

The journey towards integrated commissioning requires the development of a shared plan across partners, with agreement on how risks and benefits are shared, and how they will jointly produce service specifications which they will then commission together. Not every area of Essex will elect to move to the same degree of integration, or at the same pace.

The strategy recognises that communities within greater Essex differ widely, as do each of the constituent public bodies and therefore the proposed strategic framework is sufficiently flexible to enable local progress towards common goals. One-size-fits-all solutions will not work.

The resulting proposition is to develop a greater Essex Integrated Planning and Commissioning Framework, based on a partnership concordat, which allows local flexibility within a strategically consistent model. It describes a staged journey to integrated public service commissioning for health and wellbeing through levels of integration, based on what works well for local people and local places, working on a CCG footprint. It also explores how the framework can be embedded early in the new governance structures created by the Health and Social Care Act so that it becomes 'business as usual' as quickly as possible.

The business case described an integrated commissioning implementation journey that allows partners to travel along as far and as fast as they are able.

System transition and reform – planning the future

In recognition of the need to respond to the demographic and financial challenges, the three north Essex CCGs - Mid Essex CCG, North East Essex CCG, and West Essex CCG - co-commissioned Matrix to undertake a review of system demand and capacity for future service delivery. The overarching purpose of this review was to assess and quantify the impacts of the proposed system transformations on the North Essex health and social care system over the next five years and beyond.

Methodology and approach

Matrix was provided with patient level data on all admitted patient care purchased by the three CCGs from the three main acute providers, namely Colchester Hospitals University NHS Foundation Trust (CHUFT), Mid Essex Hospital Service NHS Trust (MEHT), and Princess Alexander Hospital NHS Trust (PAH). This activity was modelled at HRG chapter level, by CCG, and by acute provider. Patient level data for outpatients and A&E attendances were modelled at specialty level. Primary and social care data were modelled using nationally published data.

In consultation with the project Technical Advisory Board and the CCG Steering Group, Matrix developed a series of assumptions to inform estimates of future activity for each activity type. Informed by a review of clinical guidelines and literature, these assumptions were used to generate estimates of shifts from admitted patient care to other settings. Four scenarios were modelled to estimate reductions in the volume of admitted patient care resulting from efficiency savings and an increased focus on prevention and management of ill health in other care settings.

Findings from the model

Analysis undertaken by Matrix to inform this system review indicated that with the assumption of constant levels of activity per capita, projected changes to population and disease prevalence will lead to a 9% increase in admitted patient care and a requirement for an additional 150 beds by 2016/7.

Demographic projections (i.e. analysis of Office for National Statistics assumptions of changes in demography) indicate a 5% increase in GP practice list size and an expected increase in primary care consultations of 7% (or 12% if historical trends are taken into

account). The age profile of the current GP workforce suggests that approximately 20% of currently employed GPs will have retired or be working reduced hours by 2017.

Demographic assumptions indicate a 12% increase in the number of adult recipients of social care.

There are opportunities for efficiency improvements across the system. Moving to benchmarked good practice levels using data published by the NHS provides opportunities to each of the CCGs to reduce admitted patient care per capita without impacting on quality. Many of these initiatives are already built into the CCG QIPP plans. Applying a selection of these efficiency improvements would, by 2016, halve the growth in admitted patient care across North Essex; the overall growth would fall from 9% to 4% by combining changes in demography and disease prevalence with efficiency improvements.

The only way of reversing the trend for increased admitted patient care would be to transform the system and focus on the prevention and management of care in non-acute settings, particularly for chronic conditions where prevalence increases with age. If the North Essex system could develop care pathways in line with those envisaged by NHS London's 'A Framework for Action' they could potentially achieve a total reduction of admitted patient care of 9,000 admitted patients compared with 2011, and the potential to avoid the equivalent of 17,000 spells of admitted patient care which would otherwise be needed by 2016.

An assessment of resource implications

If the three CCGs can enable all of the changes in models of care assumed in the analysis, the findings indicate the potential to shift approximately 9,000 admissions to non-acute settings. This will require additional spend on care delivered in primary and community settings and a collaborative working relationship with Essex County Council, in particular the Health and Wellbeing Board. This will need to be considered in the context of the requirements of the local authority needing to realise savings of at least £49m by 2016, demographic pressures driving an increased demand for both social and primary care, and the high predicted rate of retirement of GPs by 2016 as stated above.

Following handover of the Matrix Health System model, the CCG will have a sophisticated tool for modelling growth in health demands over the next five years and to assess the potential impact of both strategic macro-transformation of the health system as well as specific individual QIPP programmes. The CCG initially plans to input the current service redesign proposals into the Matrix model to fully understand the impact of current redesign on service demand and activity over the next 5 years. The outputs from this work can be shared with provider organisations and Local Education and Training Boards (LETBs) to ensure that providers are adequately able

to plan for the impacts of redesign both from activity and finance, and from workforce perspectives. Providers and wider stakeholder groups have already been party to the early outputs from this work and are using the modelling assumptions to feed into their own internal medium term financial plans.

The challenge facing mid Essex into the future is undoubtedly significant. As such the CCG views itself as a key player in leading the discussions on wider strategic transformation of the NHS in Essex. The planning model will allow us to profile the impacts of provider integration on the health demands of our population.

Proposals for how CCGs can enable change

Achieving these types of transformational changes through planned reconfiguration has proved challenging in the NHS and in other health care systems. Increasingly, commissioners of healthcare are looking instead to different ways of contracting and paying for services to provide greater incentives for providers to work together to deliver integrated services focused on prevention and improved management.

Value-based purchasing offers a compelling approach as a model to enable the CCGs to develop a health and social care system focused on the prevention and management of ill-health in non-acute settings. Although this is not a quick fix, it is anticipated that the CCGs will begin the preparatory work that is required to implement value-based commissioning, namely:

- *Agree definitions of 'medical conditions' to provide a framework within which providers can organise into Integrated Practice Units;*
- *Establish universal measurement of outcomes and cost for every patient;*
- *Move to bundled prices for care cycles;*
- *Integration of care across separate facilities (provider-led); and*
- *Create an enabling information technology platform.*

These potential transformational changes in service models will impact on the provider landscape. It will be important to ensure that any changes do not unduly de-stabilise the system and inadvertently undermine the quality of patient care. A review of the implications will need to be done as part of a wider Essex system review involving all stakeholders with the support of the NCB Area Teams.

Programme Boards

The CCG has put in place clear lines for accountability, management and monitoring of its transformation work programmes and clinical priorities through its multi-professional programme boards. Unplanned Care and Planned care are local Mid Essex Boards that align the CCGs clinical priorities and the planned clinical transformation work with the contractual changes. For example, currently Frailty has no clear pathway and so is very much a reactive service with patients presenting through the urgent care route and using hospital services. The CCG plans to develop the frailty pathway (see below) to become a much more proactive service with care delivery shifted into the community. Thus the frailty and unplanned care clinical priorities work report into the unplanned care programme board and long terms conditions reports into the Planned Care programme board.

Essex County Council has a representative on these Boards and is also represented on the relevant working groups. The CCG and Essex County Council are also working closely in other areas to develop joint or collaborative commissioning across health and social care services, for example a joint Carer's strategy.

The proposed transformation work programmes for the clinical priorities are described below through their respective programme board.

Unplanned Care Programme Board

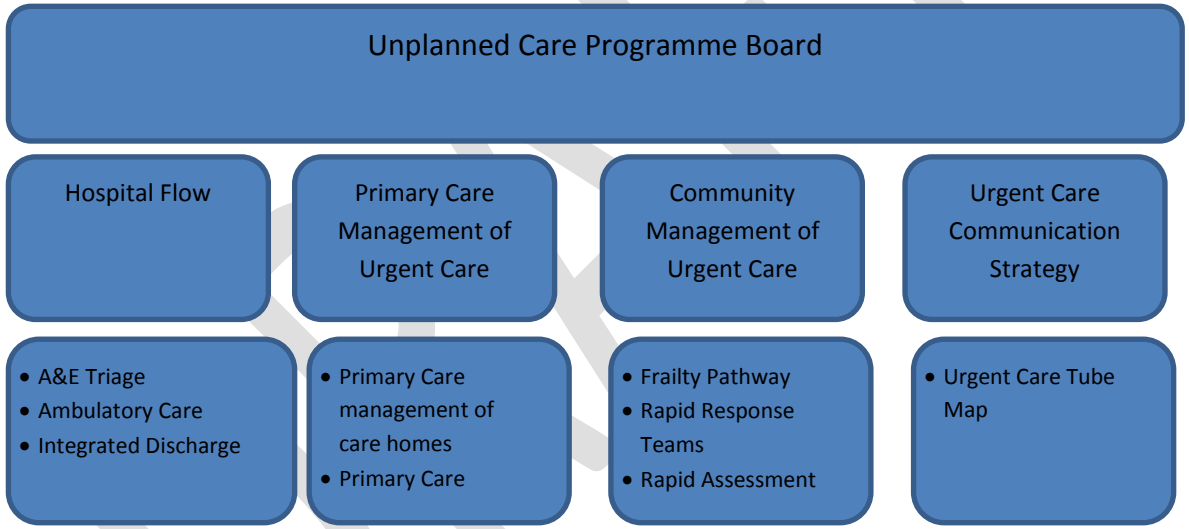
As laid out in chapter two, the CCG worked with its stakeholders to identify three key themes as priorities for the health and social care system in mid Essex. Urgent Care was identified as one of these priorities with the CCG committing to provide accessible, responsive and cost effective services for patients needing urgent care, through pathway redesign, including exploring the potential for radical redesign of A&E and education of the public in better use of key services.
Urgent care is the range of responses that health and social care services provide to people who require urgent advice, care, support, treatment or diagnosis. People using urgent care services should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate, proportional and prompt response to need[3].

[3] Mason et al,(2011) Reconfiguring health Services, The Kings Fund

Following extensive stakeholder engagement with all our partner organisations, member practices and public, the CCG developed an urgent care plan setting out the proposed transformation of urgent care services for Mid Essex over the next three years. The plan has been shared with our stakeholders and the public.

The CCG Unplanned Care Programme board oversees and is accountable for the delivery of the urgent care plan. The Director of Clinical Transformation is the director accountable for delivery with support from the clinical lead and chair of the programme board.

The Unplanned Care Programme board has four primary work programmes, indicated in the diagram below and described in detail further:



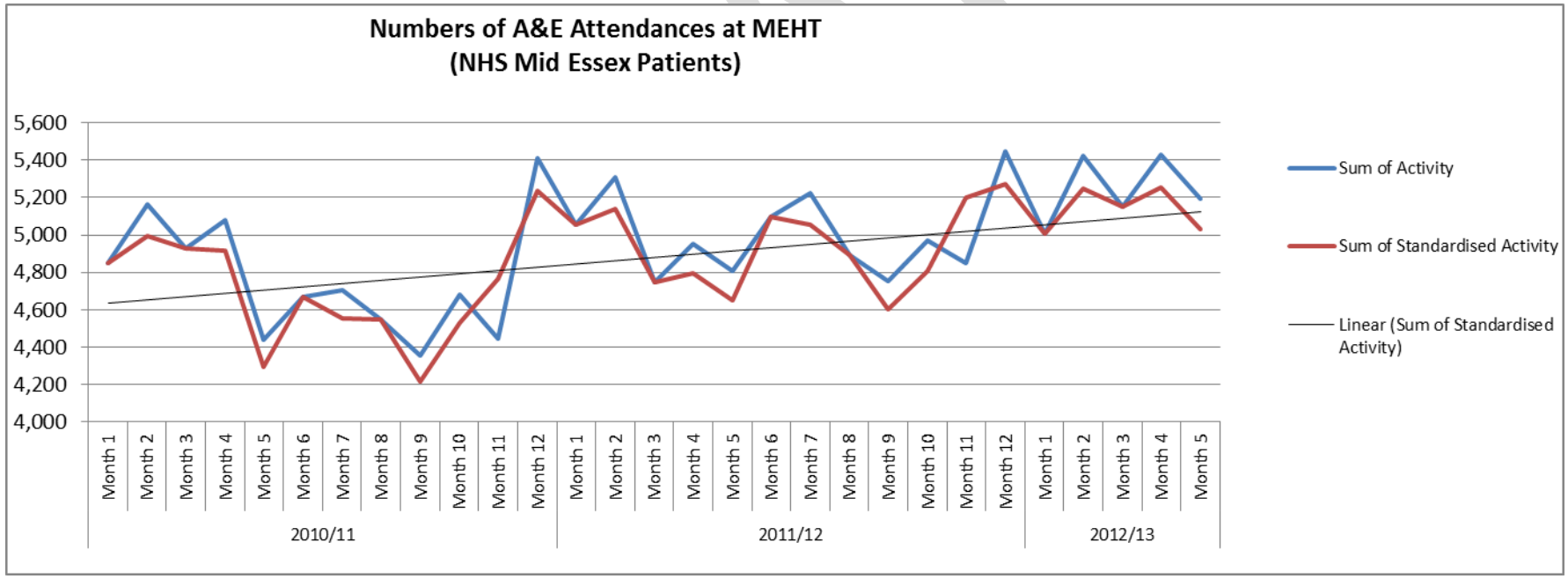
Programmes

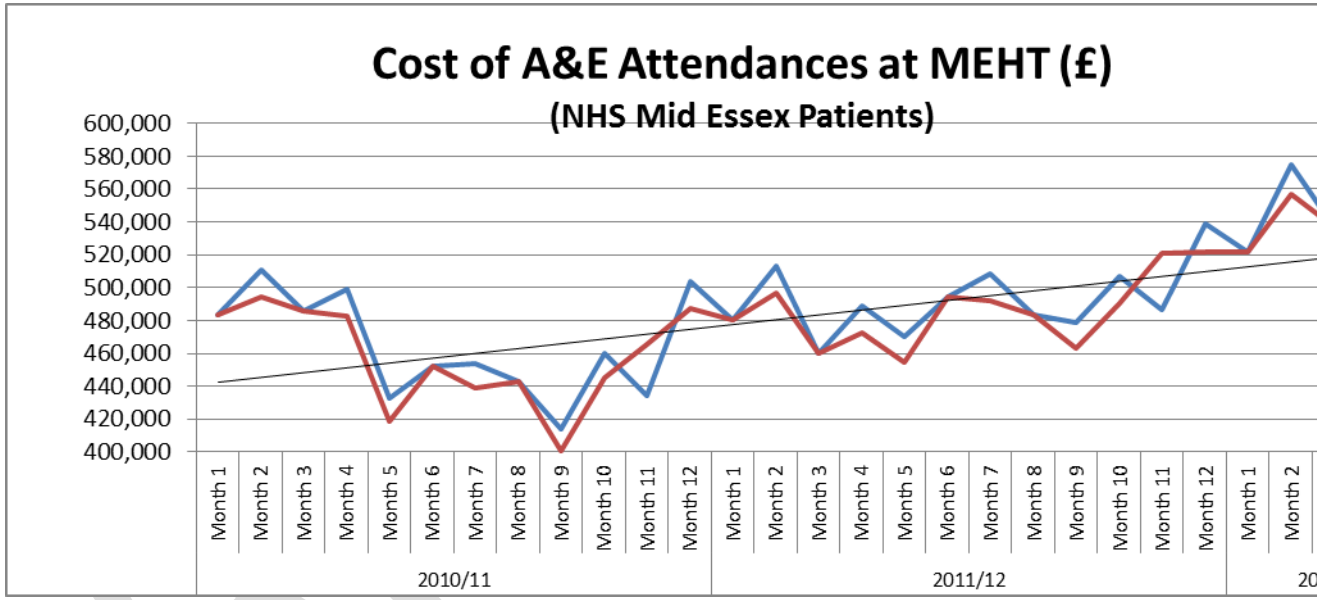
Hospital Flow

This work programme focuses on the flow of non-elective emergency patients through our local acute hospital (MEHT). It has three sub-streams:

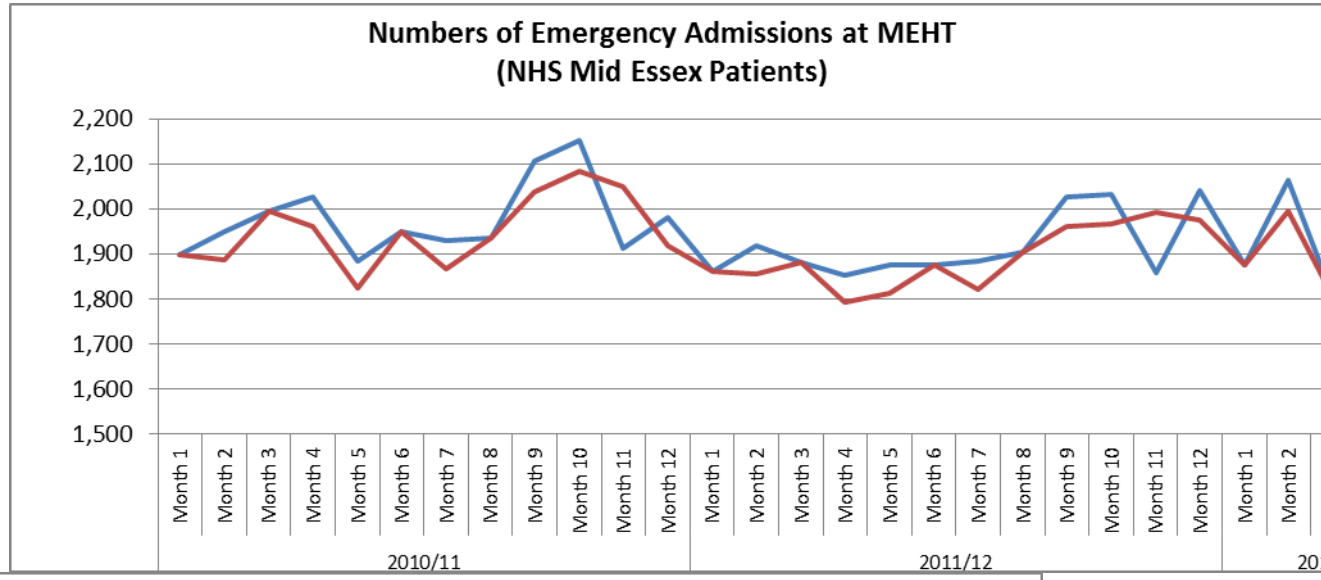
Hospital Flow: A&E Triage

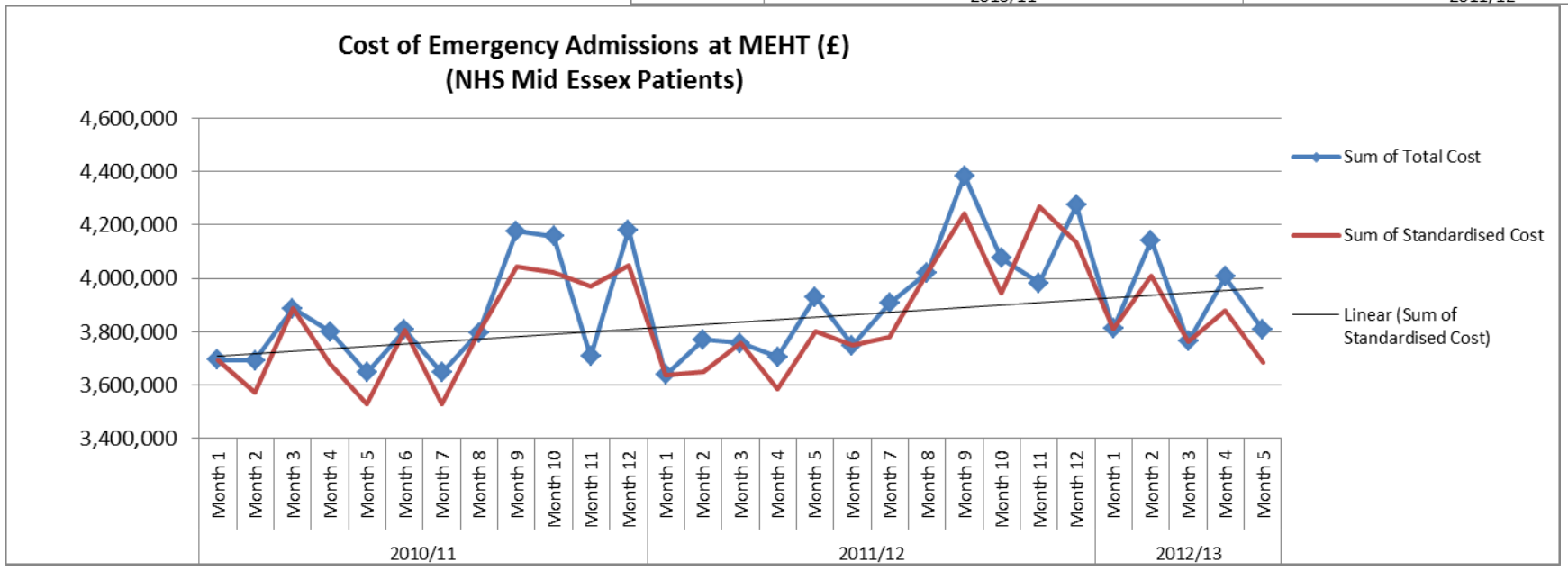
Attendances to A&E in mid Essex are seen to be rising, although this is in line with the national picture on A&E attendances, the cost of attendances is also rising in line with the increased number of attendances.





Non-elective admissions, and associated costs of these admissions, is also rising in Mid Essex.


Numbers of Emergency Admissions at MEHT
(NHS Mid Essex Patients)
2,200
2,100
2,000
1,900
1,800
1,700
1,600
1,500
Month 1
Month 2
Month 3
Month 4
Month 5
Month 6
Month 7
Month 8
Month 9
Month 10
Month 11
Month 12
2010/11
2011/12


Cost of Emergency Admissions at MEHT (£)
(NHS Mid Essex Patients)
4,600,000
4,400,000
4,200,000
4,000,000
3,800,000
3,600,000
3,400,000
Sum of Total Cost
Sum of Standardised Cost
Linear (Sum of Standardised Cost)
2010/11
2011/12
2012/13

The CCG plan to set up a primary care led service to triage all A&E attenders. This service will be staffed by GPs and/or appropriately trained Nurse Practitioners. The aim of this service is to triage all patients attending the Broomfield A&E department other than those deemed to be 'blue light' emergencies. Patients will be either deemed suitable for A&E management or suitable for primary care management.

In addition to triage functions the CCG plan to set up a primary care urgent treatment centre on the Broomfield site. Those patients triaged as suitable for primary care management will be directed to the primary care urgent treatment centre for treatment without an A&E attendance.

It is likely this service will be required 24/7 although the staffing arrangements required between 8am – 8pm will differ from those required overnight.

Hospital Flow: Ambulatory Care

The CCG has worked with the Mid Essex Hospital Trust to redesign the front door urgent care service at Broomfield Hospital to introduce Ambulatory Care Model and improved pathways for elderly patients. Patients urgently referred from primary care, and patients attending A&E that meet the current ambulatory care best practice tariff requirements will now be guided through an ambulatory care service that ensures they receive the correct treatment promptly through a defined pathway for specific conditions.

This will be a consultant delivered service supported by dedicated diagnostics, therapeutics and nursing resources. This proposal will also allow the hospital to schedule GP urgent assessment requests collaboratively with the ambulance service to smooth patient flow throughout the day, reducing activity peaks and delays for patients.

This will create a significantly improved experience for patients who will receive care along a dedicated pathway which is clearly defined for the individual and the carers. We will introduce a dedicated multi-disciplinary rapid response team within the emergency department to support patients in returning to the community. This team (known as a FAST team) consists of therapy, nursing and social care staff who will ensure safe support upon return to the community and will ensure a reduced re-admission rate as well as shortening length of stay and avoidance of admissions where acute intervention is not required.

Hospital Flow: Integrated Discharge & Delayed Transfer of Care

of an Integrated Discharge Team. It is proposed that all partner organisations work together to establish an Integrated Discharge Team, in pilot form for six months, to confirm configuration success and agree the lead provider for permanent establishment.

The aim of the pilot is to explore ways in which the current workforce within multi organisational teams can be integrated to provide a cohesive integrated discharge planning service to support and achieve clear and effective outcomes for patients. It is recognised that sometimes barriers and challenges are in existence that impede this aim. The pilot will examine these barriers; develop solutions to test ideas for future improved ways of ensuring that discharge planning is most effectively delivered.

The integrated discharge team will work across the local health economy to drive down length of stay, reduce excess bed days and avoid readmissions within 30 days in addition to improving timely and effective discharge. This will be achieved through establishing joint pathways and protocols.

Primary Care Management of Urgent Care

This work programme focuses on how GP practices can manage urgent care demand by innovative working within primary care. It has two sub-streams**.**

Primary care management of Care Homes

It is well recognised that care homes are high users of urgent care services, which at times may not be the best care pathway. Care home staff often cite lack of access to primary care, confusion over the availability of community service, plus an increasingly risk averse care sector as reasons for potential over dependence on acute emergency services (999).

Historically, primary GP care to care homes has been provided by our constituent GP practices. In some instances, a particular practice provides all the GP input to a specific care home whereas in other areas patients in a care home may be served by GPs from multiple practices. The outputs from various GP shutdown events combined with analysis of care home utilisation of urgent care services suggest that the current means of managing primary care (GP) services within care homes are inefficient and have significant potential for redesign.

There is no single model best practice model for primary care provision to care homes. The CCG is committed to empowering its constituent practices to take an active role in shaping the future provision of care. As such, the CCG is supporting its constituent practices at locality and sub-locality level to evaluate a number of innovative service redesign projects designed to improve the quality and efficiency of GP led care provision within care homes.

The CCG has selected reducing the number of 999 calls from care homes as one of its key local priorities as described in Chapter four, which will support this important work in the best interests of nursing and residential home residents.

Urgent Care: Primary Care Foundation toolkit

The Primary Care Foundation (PCF) undertook a review and developed a series of recommendations to improve the management of patients with urgent care needs in general practice across England. The report was published in April 2009 with the support of the Department of Health, The Royal College of General Practitioners, and the General Practitioners Committee of the BMA. The report focussed on the actions practices need to take to ensure all patients including those with urgent care needs can access care effectively and rapidly.

Around 90% of unscheduled and urgent care for our population is provided through primary care services, primarily via general practice but also via community pharmacies, dental surgeries and opticians. The main focus of this work program is therefore to seek to improve the access and appropriate use of primary care services for urgent care. Patients seeking urgent care from primary care services usually seek same day appointments. Whilst patients give importance to continuity of care for long term conditions they are less concerned with regard to the practitioner they see for urgent care, access being the overriding issue
The primary care foundation work addresses three fundamental questions patients ask when contacting their practice with urgent care demands:

- *Will they get through?*
- *Will they be identified?*
- *Will they be seen rapidly?*

The PCF recommend that practices should be able to answer all of these questions with an emphatic yes and make the following recommendations as to how practices can achieve this. They suggest that practices should:

- *Address the urgent needs of a patient, whether they choose to access the service by phone or in person.*
- *Match capacity to demand – both in responding to the initial call or visit from a patient and in recognising the different demand patterns for same day and advance appointments.*
- *Ensure that the full range of cases that might need urgent attention will be reliably recognised by staff when the patient rings or presents in person and that the process is understood.*
- *Set deadlines for assessment and intervention and measure performance against these, paying particular attention to the needs of those requesting home visits where the chances are that the case may be more acute or complex.*

- *Review and audit the processes to refine the way that they operate.*

The CCG intends to work with GP practices to enhance their ability to manage the urgent care demands of patients. The demands on primary care are growing with increasingly complex patients. Many GPs share the view that the historical model of primary care provision is no longer fit for purpose. Some Practices are already trialling innovative models of primary care delivery. For example, a GP surgery in Halstead has demonstrated how total telephone triage of GP appointment requests can improve the flow of patients through general practice and allow 'urgent' patients to be seen on the day whilst ensuring there is sufficient primary care provision for patients requiring management of long term conditions and more transactional patients.

To support practices to continue to meet the increasing demand, we have commissioned the Primary Care Foundation toolkit to review current provision and appointment processes within practices and make recommendations to practices regarding alternative more effective and sustainable ways of working.

Use of the PCF toolkit in other regions has delivered significant reductions in acute admissions which have been estimated as between 20 and 40% as a result of good management of urgent care in general practice. Although this benefit will not be achievable in every practice the aim is to fill the gap in capability of practices to undertake regular and on-going capacity planning to ensure their response to urgent care is as effective as possible. The QOF (Quality Outcomes Framework) provides incentives to practices to reduce their emergency admissions.

NHS 111

NHS 111 is due to Go Live for Mid Essex on 14th April 2013. This is a fundamental opportunity to signpost the residents of Mid Essex to the most appropriate care that they might need. As a CCG we will be working closely with the 111 team to ensure that this service remains safe and responsive to need.

Community Management of

Urgent Care

In addition to urgent care, the CCG also identified management of the frail patient as a specific strategic priority for the next three years. With an increasingly elderly population prevalence of frail patients within Mid Essex communities is increasing. The CCG is intending to use an innovative form of commissioning known as the accountable lead provider model to commission services to proactively identify and manage frail patients within Mid Essex.

This work programme focuses on how community services can respond to the urgent care needs as well as encompassing the work on frailty. It has three sub streams.

Community management of urgent care: Frailty Pathway

Despite its changing demographic and rapidly increasing elderly population, as a result of public consultation, the CCG agreed that the term Frailty was preferred to the previously used 'Frail Elderly'. This was on the basis that elderly person may not necessarily be frail and that frail elderly did not cover others who may be frail but not elderly (e.g. children and adults with long term conditions).

The concept of 'Frailty' as a syndrome in its own right is fairly new; frailty can be defined as a combination of factors that reduce an individual's functional reserve to cope with inter-current illness or change in social circumstances. The syndrome may consist of one or more long term conditions, a degree of cognitive impairment and functional performance limitations such as mobility and continence problems as well as social circumstances such as housing and isolation. Frailty can be assessed and measured on a variety of scales or tools some of which are evidence based internationally.

Frailty is a risk factor for unplanned hospital admission, longer lengths of stay, poorer outcomes and higher mortality. As an example, the CCG spends in the region of £1.3m on admissions to the acute hospital with a primary diagnosis of urinary tract infections (UTI) and the mortality is 8%. Clearly this is not just due to the UTI itself but as a result of the individual being frail and at high risk.

In addition, as people become more frail they inevitably rely more heavily on care and support either informal, voluntary care or on statutory Social Services support with associated costs. The processes for continuing health care arrangements will be reviewed with all partners across Essex.

This is the rationale for developing a pathway and systematic care for people identified as 'Frail'.

Developing the pathway and systematic care for people identified as Frail

As with any Long Term Condition the first step in the pathway is identification or diagnosis of the condition. The CCG will develop a Frailty Register in Primary Care based on other LTC registers on the GP clinical systems. A simple to use Frailty assessment tool and scale will be identified, able to be used by Primary Care, community teams, acute and social services to build up the register.

The aim would be for primary care teams to re-assess those on the register opportunistically in order to identify deterioration and the cause. Once a certain level of frailty is reached, the individual would be referred into services to more pro-actively manage their care and reduce the risk of unplanned hospital admission and deterioration. Such an approach can also contribute significantly to reduce risks linked to safeguarding issues for all concerned.

The provider of this support service would be commissioned using the 'Lead Provider Model', also known as prime vendor. This model is currently being used as a vehicle for integrated pathway delivery such as for Long Term Conditions. This is an effective model because it aligns incentives across the system both financially and for outcomes. The lead provider is responsible and accountable for the whole integrated pathway of care and, in this model, would be commissioned on the basis of a tariff that includes the costs of care in both acute and community as well as potentially also in part for Primary Care. In addition, in a truly integrated model it would potentially include the costs of social care and elements of voluntary sector investment.

The CCG plans to commission the pathway applying a 'Year of Care' tariff for the accountable lead provider based on the degree of Frailty of the individual referred into the pathway. The expected outcome would be more proactive and integrated care with reduced unplanned activity and costs and potentially reduced social care costs.

This approach also shifts resources up front to the lead provider from acute care costs. The model would incentivise the lead provider to invest in community and other services to prevent unplanned hospital admission and manage with the tariff based budget. The risk of costs of unplanned admission up to an agreed level rests with lead provider and not the Commissioner.

Programme delivery: A Frailty working group has been established and reported to the Unplanned Care programme board. The working group consists of clinical commissioners, delivery manager, finance and contracting leads as well as representatives of CECS, MEHT and Social Services.

At its first meeting the Working Group agreed the Frailty Pathway and the Lead Provider Model of delivery. An outline three year implementation plan was as follows:

In year one the Frailty register in primary care will be developed and implemented, it is acknowledged that a Local Enhanced Service (LES) may be required. Developing the register and identifying individuals at risk due to high Frailty scores would support case finding for the integrated care teams (ICT) and potentially lead to increased QIPP savings through the consequently more effective and targeted use of this service.

A database of activity related to this population including, community, Acute and Social Care costs would be implemented. There are tools already available that could be utilised for this. The database would enable the development of the year of care tariff based on the costs associated with a particular degree of Frailty.

Outcome Based Indicators will be developed and agreed that will monitor the quality and performance of the service provider.

In Year 2, the model will be tested by commissioning the pathway and associated costs in 'shadow' form. This should deliver the cost benefits to the system but with some protection to both parties against some of the risks in implementing the pathway.

In Year 3 will be full 'go live' using a year of care tariff with elements of acute care costs stripped out from the Acute providers and included in the tariff with a built in element of cost reduction based on the expectation of the Lead provider reducing unplanned care.

True integration of commissioning and delivery would mean that the social care element of the costs for a frail individual would be included in the tariff and this element would therefore also be managed by the lead provider.

The joint Frailty workshop held on 16th January 2013 established that Essex County Council's priorities for integration are aligned to this model and the three year action plan to deliver this integration was agreed. It also resulted in agreement between the CCG and Essex County Council to develop a Frailty register and jointly commission a service to support persons identified as 'Frail' in the

community through a truly integrated 'Accountable Lead Provider' or Prime Vendor model, combining health and social care interventions and basing the year of care tariff on both NHS and social care costs.

Next steps: The working group has agreed the above outline plan and identified a number of sub working teams to move actions forward each with identified tasks. A Clinical Reference Group will be convened to engage with a wider range of clinicians and professionals and public consultation will be on-going as the pathway is developed and implemented. The working group will meet at least on a monthly basis to oversee the delivery of this project and will continue to report to the Unplanned Care programme board.

Community management of urgent care: Rapid response teams

A high proportion of attendances at A&E are as a consequence of 999 calls from Residential care Homes, Nursing Homes and Domiciliary homes. The purpose of this project is to set up a rapid response team either to 'see and treat' this cohort of patients in their location rather than conveying them to A&E, or telephone triage with the EAU to establish whether the patient can be treated in location or has to be conveyed or some combination of the two.

There are 4,500 patients in care homes and countless patients in domiciliary settings. The geographical spread and the variability of call volumes and frequencies favours the use of existing service providers but commissioned in a new way that provides a degree of in situ consultation before conveyance to EAU. The exact method of delivery of this project is being developed. Options are:

- *Commissioned through the East of England Ambulance service*
- *Commissioned through Primary Care*
- *Commissioned through a third party*

Community management of urgent care: Rapid Assessment Unit

The purpose of the Braintree Community Hospital Rapid Assessment Unit (RAU) is to provide a community based, rapid access assessment service, for predominantly frail mid Essex residents experiencing an exacerbation or decline in health. The service provides assessment and diagnostics to support clinical decision making and provides an alternative pathway to inappropriate acute hospital admission, enabling the provision of care closer to home and is therefore an integral component of urgent care work streams of the CCG.

The current service model is a nurse led/GP supported multidisciplinary clinical assessment for patients who are at risk of unplanned hospital admission, and who are likely to experience further deterioration without prompt and timely intervention.
The service aims to provide a credible, safe, high quality alternative to secondary care intervention by preventing unnecessary acute admissions, signposting, and facilitating the transfer of patients to a more appropriate community setting or service.

Urgent Care Communications

Numerous stakeholder workshops have highlighted the complexities of the urgent care system and the lack of public understanding over what constitutes urgent care, accidents and emergencies. The Mid Essex health economy has overwhelming support for a sustained public communications strategy aimed at educating the public about the availability of urgent care services and most importantly, appropriate usage of the different urgent care services. There is support for the creation of a ‘roadmap’ or ‘tube map’ of urgent care services for public distribution to inform the public of what services are available and when and how to access them.
It is likely this project would link closely with the NHS ‘111’ project and it directory of urgent care health services.

Current use, based on NHS comparators in mid Essex indicates high levels of effective and appropriate utilisation of new outpatient, day case and elective in patient referrals.

The focus for further service improvement and development during this planning period is aligned to the key themes of the Planned Care Strategy which are to:

- *Bring appropriate care closer to home with access which supports optimum health*
- *Enhance and develop the range of locality services with secondary on community and primary care providers to achieve value for money and clinical excellence*
- *Continue to develop an evidence based best practice culture: by 2014, funding for lower clinical value procedures will be reduced significantly with focus on high clinical value interventions*
- *Ensure that all providers of continuing care are operating to the same quality standards. Our patients deserve the highest standards of care and there should be equity of access to high quality placements.*
- *Develop and implement guidance to support appropriate service use and optimum health benefit to service users*
- *Critically review traditional ways of Commissioning and Providing services and introduce systems, process and technology which removed duplication and smooth patient pathways*

The major schemes for service change and development through commissioning, which are linked to both locality service need and QIPP principles are:

- *The development of a truly integrated musculoskeletal service which encompasses orthopaedics, Rheumatology, Pain Management and Physiotherapy Services. The business case and pathway specification are being developed*
- *Review of the current range of tier 2 services and expand those which are effective, to other localities. Further expansion of the range of existing tier 2 services is anticipated to provide an equitable and comprehensive access to a range of outpatient services and minor procedures in each locality. Ophthalmology, Dermatology, Cardiology, Gynaecology, Urology, ENT, and long term conditions are particular priorities for the programme implementation of which it is envisaged will span 2013 to 2015 and again link directly with both locality service need and QIPP Principles*

In creating alternative options for new outpatient referrals and treatment it is essential that individual GP Practices are aware of all services available. However, the Central Referral Service will continue to play a vital part in ensuring that referrals are assessed and directed to the most appropriate service.

Long term conditions

More than 20% of residents in mid Essex report having a long term condition, including long term limiting illness, health problem and/or disability. The management of long term conditions is fragmented, reactive and poorly coordinated. The emphasis for patients with long term conditions will be on encouraging preventative lifestyles, and supported self-care education. To achieve this requires a combination of improved prevention and rehabilitation services, strong community and primary care services and the ability for the whole system to work effectively together to meet the needs of patients and carers. Patients will work with a primary or community care professional to provide any expert advice or support they might need, and this person will provide continuity of care. They will be used to using technology to help them monitor their condition and to make informed decisions about when they might need to contact a health professional.

There will be opportunities for patients with long term conditions to hold a personal budget to enable flexible access to a range of local health and social care services that are customised to meet their own needs and wants, and that help them to maintain independence, take care of themselves as much as possible and prevent their condition deteriorating.

The key focus areas for 2013/14 are as follows:

- *Ensure clear pathways*
- *Develop clear pathways based on outcomes for a range of long term conditions such as diabetes.*
- *Adopt best practice clinical settings*
- *Negotiate a best practice tariff model for diabetes*
- *Reduce variations in primary care support services for patients with COPD*
- *Improve and support self-management and education*
- *Develop key performance indicators for long term conditions with providers*

- *Improve self-management for patients with diabetes*
- *Support independence*

- *Develop a comprehensive falls strategy by 2013-14*

- *Prevent breakdown in carer's support & move to implement best practice and the Essex Carers strategy starting in 2013-14*
- *Early intervention and an integrated approach to the prevention of incontinence, joint commissioning in place by 2014-15.*

Mental Health

NHS and local authority social care commissioning for mental health social care is already aligned and well established across Essex and this includes a Mental Health Outcomes Framework that has been developed with all health commissioners, Essex County Council and the two south Essex unitary authorities (Southend and Thurrock), providers, service users and carers. This framework provides a common framework for commissioning both health and social care and incorporates both the national outcomes framework and 'No Health Without Mental Health' outcomes. There is already a single Essex wide dementia strategy in place and during 2012/13 a contract procurement to the value of circa £800k was led by Essex County Council.

At a joint workshop held on 16th January 2013, agreement was reached that that joint commissioning in Adult Mental Health should be on a north and south Essex systems basis. North East Essex CCG will be the coordinating commissioner on behalf of the three north Essex CCGs and will align with ECC to lead MH commissioning for the North System. The detail of this is still to be agreed but will be coherent with the collaborative compact.

The current north Essex mental health & learning disabilities joint commissioning forum will continue to work to the following agreed priorities.

Integrated Service Delivery and Joint Commissioning: In order to deliver integrated Health and Social Care services both Health and Social Care have to align commissioning intentions and have an integrated approach to commissioning. There are joint benefits to this approach and efficiencies and quality improvements (including more robust safeguarding parameters) can be jointly realised. In north Essex this includes joint commissioning of third sector providers with ECC leading and a Section256 agreement in place until end March 2014 (continuity currently being discussed by the three CCGs).

Improved crisis response: An integrated approach to crisis response, home treatment and enablement will mean that less people need to be in hospital and people can be supported better to remain in their own homes.

Access: Improved access into services and across primary and secondary services so that more people are directed to the right support at the right time.

Recovery orientated services that focus on achieving as much independence as possible with the least intervention. This would include support to achieve social inclusion, employment etc.

Implementation of the Mental Health accommodation strategy to achieve reduced dependency on residential care or long term hospital care and achieve step down through the accommodation pathways from supported living to independent living where possible. This is also a crucial aspect of delivering recovery orientated services.

Implementation of the joint carers strategy to support those caring for people with mental health. The CCG will move to endorse the Essex Carers Strategy and work in collaboration with ECC, local districts councils and the voluntary sector to build on the existing foundations.

Further discussion will take place in due course regarding Older Adults with functional mental health needs, so that irrespective of age people are able to access the appropriate services, to ensure quality outcomes mirror existing working age adult services.

In addition to the above, the CCG has defined its own additional local priorities:

- *Implementation of the Sandwell model (RAID)*
- *Review of older adults' community mental health teams, and*
- *Improved primary care management of mental health.*

The detailed outputs of the 16th January workshop including priorities to 2016, can be found in Appendix five

In collaboration, the north Essex CCGs will:

- *Determine how older adults with functional mental health needs will be supported jointly by ECC and the CCG's*
- *Identify older adults who are at risk of developing mental health issues; e.g. people who are socially isolated, those who are bereaved and ensuring older adults with mental health needs have access to 'mainstream' support for older people.*
- *Identify mental health factors (e.g. depression) which are specific to older people and the strategies to manage these.*
- *Develop support options for those at risk of developing mental health issues*

- *Ensure that older people have equal access to mental health*

Services for working age adults and ensure that reasonable adjustments to WAA services are made to ensure that these are accessible for older adults. Services may include: IAPT, Crisis intervention and Home Treatment

- *Continue review of the Older Adult Mental Health teams to develop an outcome model supported across health and social care economy*.

Dementia Strategy

Building on the successful local authority and health partnership and work in developing dementia services, the Essex, Southend and Thurrock Dementia Strategy was developed during 2011. Following the public consultation, the strategy was agreed and signed off by the North and South Essex cluster PCTs, Mental Health Trust providers and Essex, Southend and Thurrock local authorities in November 2012.

A key focus of the strategy is to increase uptake of early intervention services for people with dementia and their carers that support independence and ensure service pathways incorporate the appropriate range of interventions throughout the dementia journey. These include commissioning the voluntary sector to provide support to people in the community and at first diagnosis within Memory Assessment Services.

Learning Disabilities

In January 2013, agreement was reached between the three CCGs in the north of Essex to align the commissioning arrangements for specialist health and social care learning disability services with West Essex CCG as the coordinating commissioner for the three CCGs. The County Council has offered to take on lead commissioning responsibilities for the partnership.

The joint vision of the CCGs and county council is that people with learning disabilities and their carers will have improved health and wellbeing through

- *Making healthy choices and adopting healthy lifestyles*
- *Having equal access to primary care health services*
- *Maintaining and improving their physical and mental health and*
- *Learning to manage their own health and care needs*

North Essex CCGs and Essex County Council have agreed jointly to establish integrated commissioning of health and social care services to support adults with a learning disability. The strategic intent re-affirms the leadership and role of Essex County Council as the lead commissioner for learning disability services. To achieve this end, the North Essex CCG and Essex County Council will address the following key tasks and action areas:-

- *Establish an Integrated Commissioning Programme Board with representation from CCGs and ECC*
- *Agree the governance arrangements and delegated decision-making mandates*
- *Establish priorities for service transformation that reflect current local and national imperatives*
- *Agree and publish a joint health and social care strategy*
- *Set up a pooled financial arrangement with appropriate governance*
- *Establish genuine joint arrangements for commissioning and contracting with health & social care providers.*

The CCGs and Essex County Council have agreed jointly to complete these actions and tasks by 31st March 2014."

These integrated commissioning arrangements will help ensure that services reflect best value through:

- *reducing dependency by encouraging and supporting people to develop skills and capabilities to do as much as possible for themselves*
- *maximising use of low level interventions, equipment, technology and adaptations that increase independence and reduce the need for more intensive support*
- *maximising use of community and mainstream facilities and services that allow people to lead as fulfilled a life as possible*
- *closer integration of specialist health and social care services and integrated care and support pathways*
- *collaboration between agencies to better understand safeguarding referral and activities.*

The north Essex system CCGs have agreed that on draft priorities, as laid out below:

- *All age commissioning.*
  - *To ensure individual assessments / needs and treatment / support are identified as early as possible.*
  - *To ensure that services are in place at the point of transition into adult services.*
  - *An enablement model of support is in place at the earliest opportunity.*
  - *Implement a joint carers strategy*
- *Integrated pathway for people who challenge services.*
  - *To ensure an integrated Health and Social Care Pathway for this group.*
  - *To review the current services provided and re-commission on an Enhanced Community basis.*
  - *Reduce any possible duplication of services between health and social care interventions.*
- *Access to mainstream health services (e.g. health checks)*
  - *To address health inequalities, people with learning disabilities need Annual Health Checks and Health Action Plans.*
  - *People with learning disabilities need to be able to access health screening programmes.*
  - *Reasonable adjustment from mainstream health services –i.e. Appointment times; Easy Read Information*

Children's and Maternity Services Programme Board

Children's services, including Children's and Adolescent Mental Health Services (CAMHS), will be commissioned jointly by Essex County Council and the CCGs on either a CCG level (e.g. Families with Complex Needs, Maternity/Early Years), or at a system level (North Essex/South Essex system or Essex-wide basis)), informed by the JSNA and a strategic review of CAMHS. Mid Essex CCG will be the Coordinating Commissioner on behalf of the North system CCGs for CAMHS.

Examples of system level commissioning that we intend to develop and implement over the next three years are:

- *A Joint CAMHS & Behaviour Service across Tier 1-3 services, children with complex care needs and disabilities, safeguarding and provision/statutory duties for Children in Care and Care Leavers*
- *Safeguarding children and provision for Children In and Leaving Care is a priority and the CCG will ensure through mainstream contracts that Health providers recognise and deliver their role as active members of core groups and contribute to assessment, planning and review activities as required Health providers provide direct interventions to improve children's health and wellbeing and to support family parenting skills*
- *The quality, speed/priority and consistency of health and dental assessments and treatment for Children In and Leaving Care is improved through more timely information between corporate parents and health providers.*

There is good transition and support for care leavers over 18 as they begin using adult services.

There is improved CAMHS tier 3 provision for Children on a Protection Plan, Children in Care and Care Leavers.

A joint workshop held in January 2013 involving the County Council and North East Essex CCG and Mid Essex CCG identified the following as priorities for 2013/14 and we will work closely with the County Council and other CCGs across the system to:

- *Map current contract lengths and join contestability plans together*
- *Map savings needed + commissioning resources available*
- *Improve joint performance management of contracts*
- *Contribute to ensure coordinated work with Families with Complex Needs – first reviewing the business case articulation of outcomes and implementation plans and clarifying the impact on CCGs*

- *Plan integrated CAMHS and behaviour specification for tiers 1-3 (ensuring appropriate provision for children with continuing care needs, children in care and children with disability)*
- *Secure active CCG involvement in Essex and Local CYP Partnership Boards*
- *Maintain current commitment to County wide Safeguarding Children's Clinical network and work jointly to improve safeguarding and health and well-being of looked after children and care leavers*
- *Link up with Education to secure their engagement and enhance effectiveness in safeguarding, improving education outcomes for children in care, tackling obesity and improving children's wellbeing*
- *Map maternity and early years pathway from conception -> 5 years to identify scope for improving integration*
- *Alignment of referral thresholds.*
- *Continue to agree care for children with complex needs through the Joint Area Panel.*
- *Build on the All Age Disability Strategic Framework and in line with the new government legislation and guidance on SEN, commence planning to commission jointly services and care pathways for children and young people ensuring appropriate transition into adulthood.*
- *Work together on joint data, information and performance management systems and workforce training and development*

The following were identified as priorities for 2014/15, although planning for these will need to commence in 2013-14.

- *Start delivery of integrated CAMHS and behaviour interventions for tiers 1-3 and draw up service specifications for other priority areas, for example Children's Centres*.
-

The CCG has identified a number of QIPP work streams that will be carried out this year. This includes:

- *Outpatient redesign for paediatric services*
- *Frail children (as part of the frailty pathway)*
- *Autistic spectrum disorder pathway services*
- *Pathway review of top five paediatric presenting conditions – febrile seizures, gastro, respiratory, bronchiolitis and asthma*

South Essex has piloted a pathway that seeks to keep paediatric patients suffering from the top five presenting conditions in primary care. This pathway provides community paediatric nurse support in the home for patients who have been to the GP and have been

sent home, but do not seem to be improving; the intention is to provide the parent or guardian a means of accessing community nursing support rather than attending A&E. Mid Essex is intending to implement the same pathway.

In addition public health has mandated priorities which it must commission. For 2013/14 these are Health Checks, the National Child Measurement Programme and Sexual Health. The delivery of the Health Checks programme is dependent upon Primary Care and expectations of Primary Care will be strengthened through NHS Commissioning Board's Area Team Primary Care Commissioning.

In 2013/14 the public health priorities for review and development of plans/specifications for procurement in 2014/15 are:

- *Sexual Health Services*
- *School Health Services*
- *Drugs and Alcohol misuse*

Consultants in Public Health will work with CCGs to ensure that the public health commissioning is tailored to local needs. Local priorities to be agreed with CCG include atrial fibrillation management, Smoking Cessation services, Reach-out, Senior Health Checks, Falls Prevention pathways, Gypsy and travellers' health and wellbeing and Virtual wards. Some areas will require an agreement on joint investment, and or joint working, including:

  - *Essex County Travellers Unit: Early intervention and prevention service (ECC requesting joint funding from 2013-14 at circa £6,000*
  - *Senior Health Checks: Case finding for undiagnosed patients (diabetes, CVD risks, etc) aged between 75 and 84 years – ECC will collaborate with the CCG to launch this programme during 2013-14. A detailed business case will be required to agree the full impact of implementing this programme.*
  - *Alcohol Liaison Nurse Service: Provision in acute settings to support hospital staff to identify, manage and support problematic alcohol users – ECC will fund the Alcohol Liaison Service along with treatment services from 2013-14 and it is anticipated that the CCG will put in place Alcohol IBA (Intervention & Brief Advice) to identify people whose drinking may be adversely affecting their health*

A mix of commissioning models is proposed for Public Health across Essex:

- *Across Essex where this leads to optimal economies of scale*
- *Commission jointly with partners at a local level where it makes more sense (e.g. HIV/AIDS)*
- *Partner with Public Health England for specific programmes including screening and health protection response*

Enablers: During the integrated plan process, a number of common Essex-wide enablers were identified a as being likely to benefit from systemic development across the whole system. This includes enablers such as finance, human resources, technology, communications and procurement and contracting. The CCG and its partners will look to establishing agreed work streams.

Assistive Technology. The continuing development of technology provides possibilities to be able to meet people's health and social care needs in an innovative and less resource intensive way. The use of simple to use devices can play a major role in improving safety and quality of life for people so that they can lead their lives with greater choice, independence and personal control allowing people to have more choice and say in their own care arrangements. Assistive technology can offer an opportunity for transformational change in the way people 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.

The use of assistive technology will be reviewed in following three key areas:

- To maximise the opportunities for Assistive Technology to support independence, choice & control whilst reducing reliance on health and social care interventions
- To explore AT's contribution to the achievements of personalised health & social care outcomes for individuals, and
- To analyse the role of AT in supporting and contributing to the delivery of wider outcomes in areas such as shifting the balance of care and the management of long-term health condition.

Chapter Six: Financial Analysis, Activity and QIPP 2013/14 and Beyond

The Department of Health funding allocation deems that the mid Essex population is relatively healthy and therefore funding was amongst the lowest for PCTs per head of population. The 2013/14 CCG funding allocation does not seek to reapportion funding across individual areas – instead a flat rate increase of 2.3% was allocated to all CCGs. The CCG is the ninth lowest funded CCG per head of population in the country with a healthcare services funding level of £990 per head of population compared to an average of £1,107 per head for all Essex CCGs.

The CCG is expected to have three core financial targets which it is required to meet:

- *to contain revenue expenditure within allocated resources (the approved 'Resource Limit') and deliver a surplus*
- *to contain capital expenditure within allocated resources (the approved 'Capital Resource Limit')*
- *to contain cash payments within allocated resources (the approved 'Cash Limit')*

The 2013/14 CCG financial resources are comprised of:

- *an allocation to cover the local services (£369.7m including adjustments), representing 2.3% nominal growth or 0.3% real terms growth on 2012/13 plans*
- *a running costs allowance of £25 per head (£9.3m)*
- *£2.5m surplus / strategic reserve brought forward*

The 2013/14 national Operating Framework published in December 2012 outlines the financial framework requirements for 2013/14, key issues include:

- *all CCGs are required to deliver a 2013/14 surplus (an average of 1% of turnover for the Essex area) and an underlying 2% surplus (i.e. ensure that 2% of the funding is only ever committed on non-recurrent expenditure)*
- *a negative tariff uplift of -1.3% will be applied for NHS providers including a 4% efficiency assumption (expected net -1.1% impact on acute hospital tariff expenditure)*

- *CQUIN to remain at 2.5% of Service Level Agreement values but to be focused upon* high-impact innovations, as set out in 'Innovation, Health and Wealth'
- *potential new cost pressures from the commitments in 'Everyone Counts: Planning for Patients 2013/14' as the result of a seven days a week NHS (report to be published autumn 2013) and improving provider transparency and patient choice*
- *subject to Regulations, a Quality Premium will be paid in 2014/15 to CCGs that in 2013/14 improve or achieve high standards of quality in the four measures from the NHS Outcomes Framework and achieve appropriate standards across the whole range of service delivery – including delivering financial targets (up to £5 per head premium – potentially £1.9m)*
- *CCGs will inherit the retrospect continuing healthcare liabilities from PCTs.*

The Department of Health has previously provided PCTs, and will now provide the Area Team of the NCB, with funding for social care that is required to be transferred to the Local Authority responsible for social services (i.e. Essex County Council) to spend on agreed priorities with health care benefits – the 'Social Care Grant'.

In addition the CCG is expected to spend a prescribed amount each year on re-ablement services, which is to be jointly agreed with the local authority. The CCG is budgeting for total of £1.7million for re-ablement Funding for 2013/14, some of which will be paid to Essex County Council through a Section 256 grant agreement to deliver agreed outcomes.

In 2013/14 the CCG will still be in formal financial recovery mode. The challenge imposed by relatively low funding is exacerbated by the extent of non-recurrent measures which were used to deliver financial balance for 2012/13 and now need to be covered by recurrent solutions.

2013/14 contract expenditure requirements have been estimated from 2012/13 forecast outturns and then refined for other changes arising from operating framework requirements and QIPP schemes. The use of non-recurrent funding in 2012/13 to support additional expenditure and the 2013/14 requirement to deliver a surplus results in the funding for baseline healthcare service expenditure being less in 2013/14 than 2012/13.

No information on future years' funding is yet available and so the medium term plan is based upon local assumptions. The following tables set out some of the key facts from the financial plan. Detailed planning assumptions and opening 2013/14 budgets are set out in the 2013/14 Budget Book.

Mid Essex CCG £25 per head

running cost breakdown

Mid Essex CCG
Medium Term Financial Plan

	2013/14 - Year 1		2014/15 - Year 2		2015/16 - Year 3	
	Impact in year	Recurrent impact	Impact in year	Recurrent impact	Impact in year	Recurrent impact
	£'000	£'000	£'000	£'000	£'000	£'000
Recurrent deficit/(surplus) brought forward	5,125	5,125	(2,009)	(2,009)	(7,439)	(7,439)
Growth available	(8,275)	(8,275)	(8,703)	(8,703)	(8,902)	(8,902)
Inflation	683	683	4,420	4,420	3,168	3,168
(Available for investments and cost pressures)	(2,467)	(2,467)	(6,292)	(6,292)	(13,173)	(13,173)
Cost Pressures/Investments	16,458	16,458	12,958	12,958	12,812	12,812
Contingency	6,500	6,500	6,750	6,750	7,000	7,000
QIPP	(22,500)	(22,500)	(20,855)	(20,855)	(14,343)	(14,343)
2% Transformational Funding	7,396		7,570		7,659	0
Non-recurrent underspend	(3,587)		(3,207)			
In-Year (Surplus)/Deficit	1,800	(2,009)	(3,076)	(7,439)	(45)	(7,704)
Creation/(draw down) Reserves from SHA	(1,613)		0		0	
Closing (Surplus)/Deficit b/f	(896)		(709)		(3,785)	
Closing (Surplus)/Deficit	(709)		(3,785)		(3,830)	

In addition to healthcare funding, the CCG receives a funding allocation of £25 per head of population (£9.3m) to cover the running costs of the CCG in delivering its roles and responsibilities.

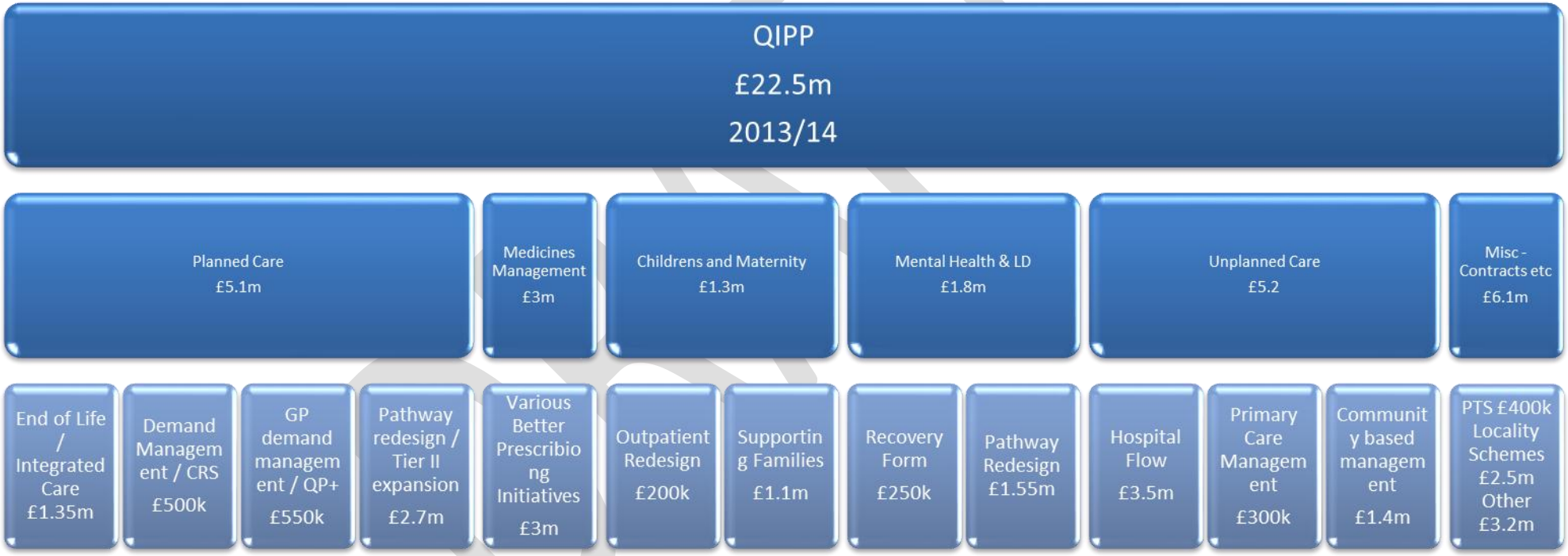
2013/14 Running Costs

	£000	£ per head
In house and shared posts	3,697	9.94
CSU SLA and pay as you go	3,669	9.87
External support services,fees & charges	432	1.16
Other	800	2.15
Project funding and uncommitted	702	1.88
	9,300	25.00

QIPP 20-13/14 and Beyond

Governance and delivery of QIPP

The CCG has a very clear QIPP programme, defined in specific areas as shown in the diagram below:



The four programme boards, described in Chapter five are the mechanism for delivering QIPP within Mid Essex. The CCG has established a Programme Management Office (PMO) to oversee the delivery of QIPP programmes. It does this via three key mechanisms:

The PMO Support and Develop QIPP ideas

By working closely with public health and the finance and information teams the PMO can analyse activity data and health trends and identify areas potentially fit for transformation. By bringing this information to the attention of the programme boards the PMO can stimulate the development of new QIPP schemes. Additionally, they can provide data analysis for embryonic QIPP ideas generated directly by the experiences of programme board members, the wider health care professional community and stakeholders. The PMO then help to develop viable QIPP schemes into robust business cases, challenging assumptions made and ensuring that the cases are resilient both from financial and quality perspectives.

The PMO monitor and challenge QIPP delivery

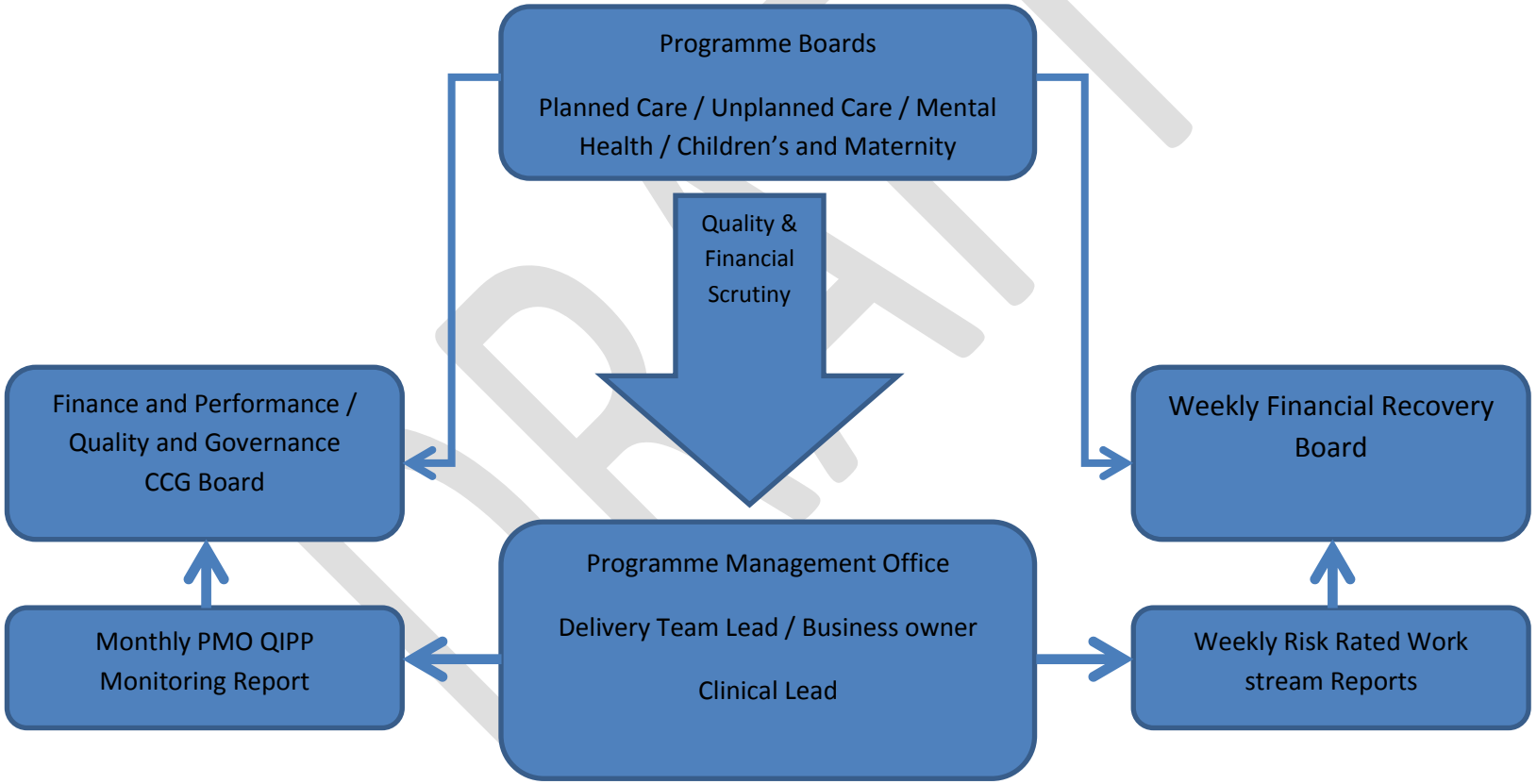
The PMO ensure that all QIPP business cases contain appropriate, measurable KPIs. They monitor performance of these KPIs against agreed trajectories reporting weekly to the Financial Recovery Board. Where particular schemes are failing to meet specific performance metrics or timelines, the PMO risk rate the projects and work with the project team to ensure mitigating actions and recovery trajectories are developed.

The PMO evaluate QIPP

Where particular QIPP schemes exist in pilot form the PMO ensure rigorous evaluation of schemes against pre-agreed delivery targets. Where schemes are deemed to deliver, the PMO support the roll out as business as usual. However, if schemes are found to fall short following evaluation then the PMO are able to recommend pilot termination.

The CCG has a clear line of sight for management, reporting and accountability for delivery of all its activities. As noted above, the PMO reports its functions to the weekly Financial Recovery Board and the monthly CCG Finance and Performance Committee that reports directly to the CCG Board. There is clear line of sight to and through to the Board.

The diagram below provides the arrangements for QIPP weekly & monthly project monitoring governance arrangements.



In addition to the financial impact of QIPP, there is likely to be a significant impact on the health and social care workforce across Essex. While it is not within the gift of the CCG to determine workforce matters for providers, the CCG is able and very willing to engage with and support providers in this matter. The system leadership group is one forum for this and the Local Education Training Board (LETB) is the body that will be responsible for the education and training of health and public health workers at a regional level. The LETB will have a number of core functions that have been defined and described in "Liberating the NHS: Developing the healthcare workforce from design to delivery". They include:

- *Develop a skills and development strategy for the local health workforce that meets employer requirements and responds to the plans of commissioners*
- *Aggregate workforce data and plans for the local health economy*
- *Commission education and training to deliver the local skills and development strategy and national priorities set out in the Education Operating Framework*

The East of England Local Education and Training Board (LETB) will develop a five-year Workforce Skills and Development Strategy which will set out how the existing workforce in East of England will be developed to deliver new models of health care and improved patient care. This provides a significant opportunity to improve the care of patients by bringing the immediate and long term needs of the service at a local level closer to the planning and commissioning of workforce development, education and training.

The strategy will support the transformation of patient care in the East of England and will improve excellence in the education, training and development of the whole workforce. Key work streams will focus on developing effective solutions to fill the gaps between the existing workforce and the required future workforce through high quality education and training aligned to robust newly qualified demand, skill mix design, new ways of working and partnership working.

In East of England there will be an integration of Deanery, workforce and education commissioning functions within the LETB.

There will also be four Workforce Partnership Groups chaired by local Chief Executives:

- *Bedfordshire and Hertfordshire*
- *Cambridgeshire and Peterborough*
- *Essex*
- *Norfolk and Suffolk*

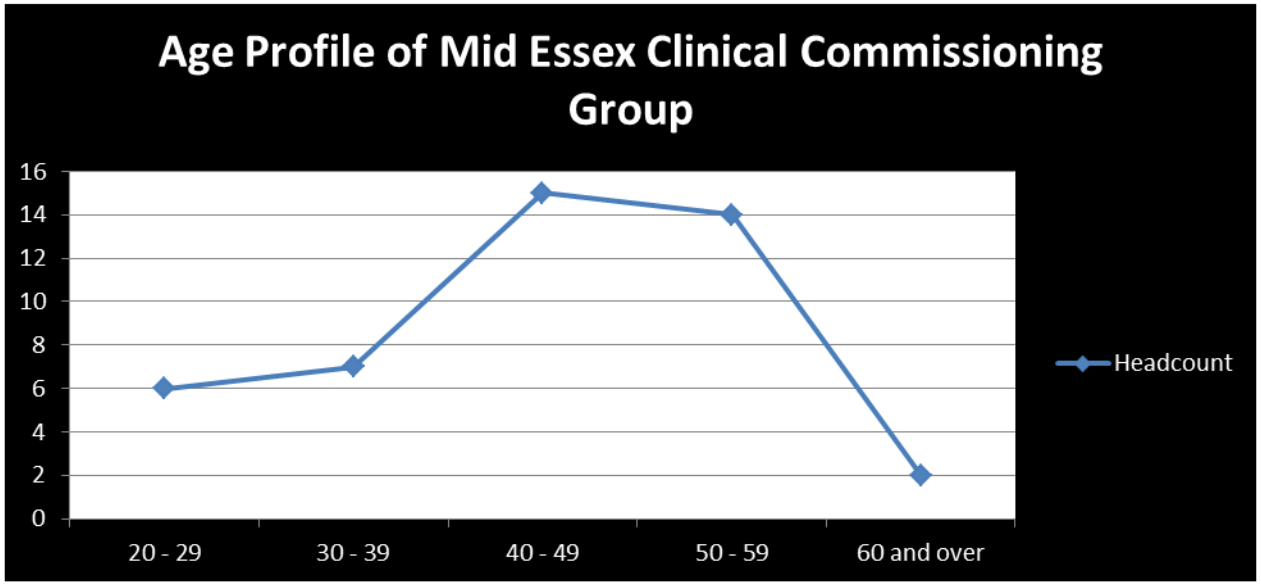
Essex Workforce Partnership

The Essex Workforce Partnership Executive Steering Group is chaired by the Chief Executive of South Essex Partnership University NHS Foundation Trust. In February 2013 it held a successful workshop with all Essex partners and stakeholders to understand their ideals and ideas for the future. This workshop will be followed up in coming months and will shape the work of the LETB to flex and fit with commissioner and provider requirements.

Discussions are taking place about patient, GP, CCG and primary care representation. Consideration is also being given to how Academic Health Science Network, Clinical Senate, Trade Union and Independent Sector views can be represented on the group.

The CCG will continue its engagement with the LETB through the Director of Nursing and Quality, who will ensure that the process for regular appraisal to both the executive team and Board is robust.

The CCG is itself a small organisation with a current work profile as shown below.



Age Band	Headcount
20 - 29	6
30 - 39	7
40 - 49	15
50 - 59	14
60 and over	2
Grand Total	**44**

At the current time not all posts have been recruited to, the detail above represents those currently in post

As a CCG we are committed to continuing to develop our organisational capacity and capability. The CCG Director of Strategy and Primary care, who has responsibility for the CCG's Organisational Development has overseen the commissioning of some additional OD professional support to refresh our OD plan for 2013/14 and to support our talent and succession plan going forward. Wider organisational development remains at the heart of our leadership agenda and will support us in our objective to build a capable and sustainable organisation (See Appendix 2).

The CCG has summarised its integrated plan into a 'Plan on a Page'

Mid Essex Clinical Commissioning Group

Vision	*Our communities working together to create innovative and sustainable local services delivering first class healthcare for all*			
Priorities	Three clinical priorities:	Urgent Care	Frailty	Long term conditions
Values	We care about our communities	We work together	We act with integrity & honesty	We deliver
Strategic context & challenges	• One CCG with three localities & nine sub-localities • Ageing population. Growth in over 65s, average 28% for Mid Essex, 50% Maldon • Increasing prevalence of LTC and frailty. Number of people with dementia expected to double by 2030		• Financial delivery - £22.5m QIPP challenge 2013/14 •The increasing mortality gap between the most & least deprived areas in Mid Essex • Providers: diverse market & multiple providers. • Acute hospital Foundation Trust status	
Objectives & targets	**Strategic priorities 2013-14** • Transformation including integration • Practice engagement • Public confidence • Improving quality and outcomes for all • Meeting the financial challenge through responsible use of resources	**Local priority measures** • Improve the percentage of people registered with diabetes who receive the nine key processes of diabetes care •Reduce the number of delayed transfers of care in the acute setting • Reduce the number of 999 calls from Care Homes (to aid reduction in A&E and admissions)	**National priority measures** • Eliminating 52 week wait • Better ambulance turnaround time • Reducing cancellations • Rollout of access to psychological therapies (IAPT) **Health & wellbeing strategy priorities** 1. Starting & developing well 2. Living & working well 3. Ageing Well	**QIPP savings £22.5m** Planned care £5.1m Unplanned care £5.2m medicines mngment £3m Children's & maternity £1.3m Mental health & LD £1.8m Misc & Contract efficiencies £6.1m
Programme boards: key areas of trans-formational change	**Unplanned care (Frailty & Urgent care)** • **Hospital flow:** Ambulatory care, A&E triage, integrated discharge • **Primary care management of UC:** Nursing homes (high impact & sustainable models of care), Primary Care Foundation • **Community management:** Frailty pathway, rapid response, rapid assessment unit (RAU)	**Planned care (Long term conditions)** • Demand management / Central Referral Service • Long term conditions work • End of life / integrated care • GP demand management /QP+ • Pathway redesign / tier II expansion • Musculoskeletal pathway redesign • Better Prescribing	**Mental Health & LD** • Primary Care Management • Implementation of Sandwell model (RAID) • Implementation of the mental health accommodation strategy • Review of older adults' community mental health teams	**Children's & maternity** • Outpatient redesign • Frail children (frailty pathway) • Autistic spectrum disorder pathway services • Pathway review on top five (paediatric) presenting conditions
Underpin-ning principles	• Tackling health inequalities • Transforming services • Protecting the public (safeguarding) • Ensuring interventions are evidence based • Ensuring safety & quality of services • Empowering communities • Engaging our public and diverse groups and communities			

Making this work

As an authorised and statutory organisation Mid Essex CCG looks forward to the opportunity to implement the commitments set out in this plan on behalf of the people it serves. The CCG is confident that through closer and more integrated working with those that are also committed to ensuring that the health needs of the Mid Essex population are addressed both collaboratively and competently; we will further improve the health outcomes for years to come.

END

Appendices

Appendix One	Mid Essex CCG Delivery Plan 2013-16  Delivery Plan Appendix for IP 1803
Appendix Two	Organisational Development Plan  Organisational Development Plan 20
Appendix Three	Essex County Council Vision and Outcomes framework programme  ECC Vision and Outcomes Framework
Appendix Four	North Essex CCG Collaborative Compact  N Essex CCGs collaborative agreem
Appendix Five	Outputs of 16th January Mental health Workshop with Mid Essex & West Essex CCG & Essex County  Appendix five.docx Council

Jargon Buster

A&E	Accident and Emergency		KAM	Key Account Manager
AHP	Allied Health Professional		KPI	Key Performance Indicator
AQP	Any Qualified Provider		LA	Local Authority
AT	Area Team (of the National Health Service Commissioning Board)		LES	Local Enhanced Scheme
CAMHS	Child and Adolescent Mental Health Services		LETB	Local Education and Training Board
CCG	Clinical Commissioning Group		LTC	Long Term Conditions
CECS	Central Essex Community Services Community Interest Company		MEHT	Mid Essex Hospitals Trust
CHD	Coronary Heart Disease		NCB	National Health Service Commissioning Board
CIP	Cost Improvement Plan		NHS	National Health Service
CMHT	Community Mental Health Team		NEPFT	North Essex Partnership Foundation Trust
CMHT	Community Mental Health Team		NHSLA	National Health Service Litigation Authority
COO	Chief Operating Officer		OP	Outpatients
CQC	Care Quality Commission		PALS	Patient Advice Liaison Service
CQUIN	Commissioning for Quality and Innovation		PCF	Primary Care Forum
CQRG	Clinical Quality Review Group		PCT	Primary Care Trust
CRES	Cash releasing efficiency savings		PH	Public Health
CYP	Children & Young People		PMO	Programme Management Office
DDA	Disability Discrimination Act		PPE	Public & Patient Engagement
DH	Department of Health		PROMS	Patient Reported Outcome Measures
EAU	Emergency Assessment Unit		QIPP	Quality, Innovation, Productivity, Prevention
ECC	Essex County Council		RAU	Rapid Assessment Unit
FFCE	First Finished Consultant Episode		RCA	Root Cause Analysis
GP	General Practitioner		SHA	Strategic Health Authority
H&WB	Health and Wellbeing		SLA	Service Level Agreement
H&WBB	Health and Wellbeing Board		SPRG	Service Performance Review Group
HCAI	Healthcare Associated Infections		TIA	Transient Ischemic Attack
HRG	Healthcare resource Group (code)		UTI	Urinary Tract Infection
JHWS	Joint Health and Wellbeing Strategy		VTE	Venous Thromboembolism
JSNA	Joint Strategic Needs Assessment			