North East Essex
Clinical Commissioning Group

North East Essex CCG

2 Year Operational Plan

2014/15 – 2015/16

V12

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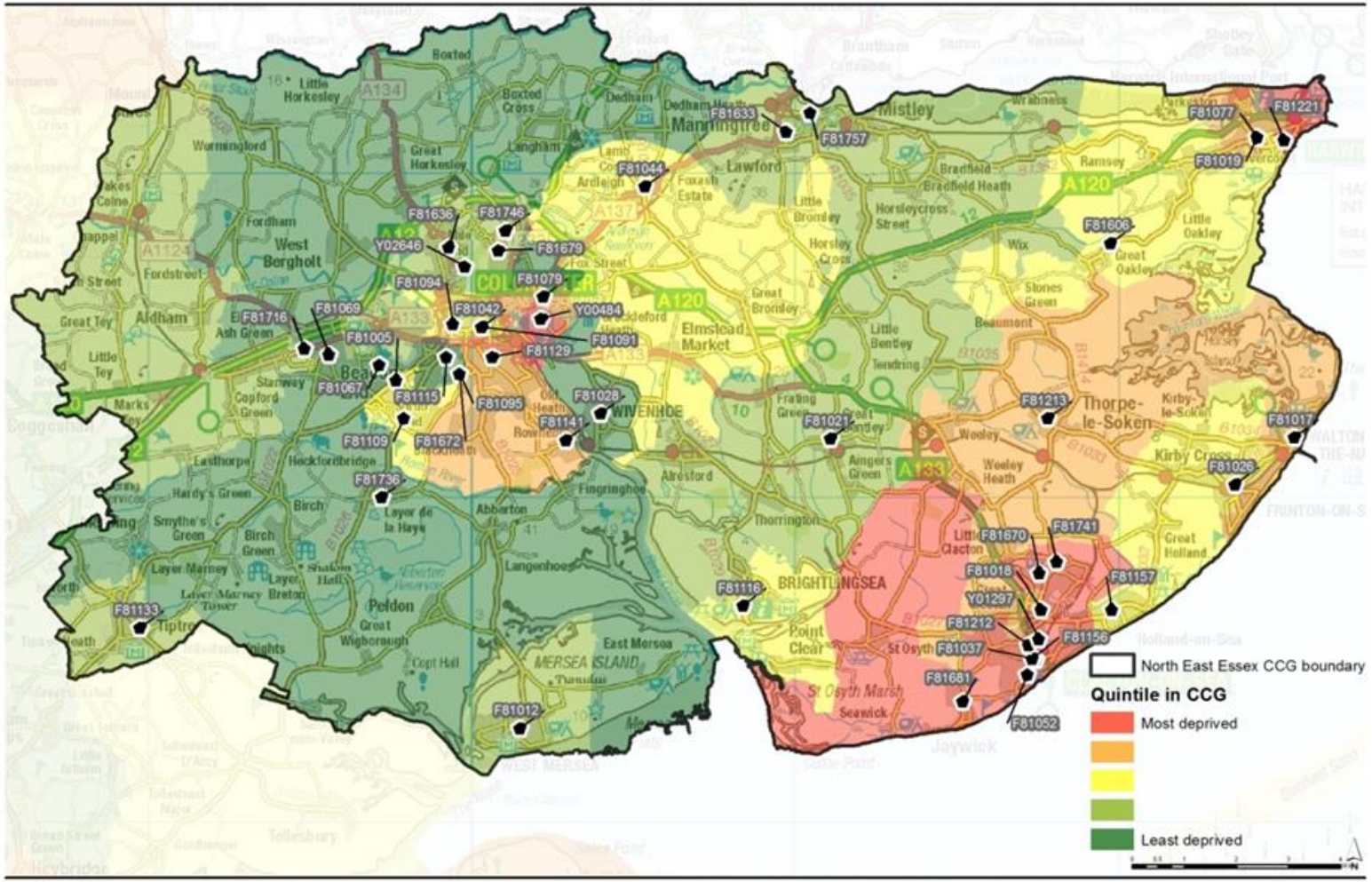
SECTION 1 INTRODUCTION

This section gives an overview of the health and social care system in North East Essex and how it will evolve over the next five years. It highlights the key strategic issues, our vision and values, and the approach we will take to ensure the delivery of high quality, cost-effective and integrated health and social care. North East Essex Clinical Commissioning Group will continue to work very closely with Essex County Council to jointly commission integrated services

North East Essex CCG is responsible for commissioning the majority of health services for the people who live in the areas covered by Colchester Borough Council and Tendring District Council. The CCG is made up of the 43 GP practices in Colchester and Tendring. The CCG is led by clinicians and there is a clinical majority on its Board and committees.

The CCG and Essex County Council (ECC) started working together before the CCG became a statutory body. The ECC representative on the CCG Board has full voting rights and has been actively involved in the production of this plan, along with key members of the ECC team. The CCG Chair and Clinical Chief Officer are active members of the Essex Health and Wellbeing Board and the Business Managers Group. The CCG Chair worked with Sir Thomas Hughes-Hallett as part of the Who Will Care? Commission into health and social care strategy.

GP Practices in the Clinical Commissioning Group area



Essex Health and Wellbeing Strategy

NEE CCG and ECC affirm their commitment to the Essex Health and Wellbeing Strategy with the 3 priorities of:

- 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.

We will:-

- promote a shift from acute services to the prevention of ill health, to primary health care, and to community-based provision;
- support investment in early intervention and the prevention of risks to health and wellbeing to deliver long-term improvements in overall health and wellbeing;
- support individuals in exercising personal choice and control, and influence over the commissioning of relevant services;
- enable local communities to influence and direct local priorities for better health and wellbeing strengthening their resilience and using community assets to reduce demand;
- promote integration across the health and social care systems to ensure that services are planned and commissioned in an integrated way where it is beneficial to do so;
- ensure resources are allocated consistent with the needs within and between the communities in Essex; and
- support individuals in making informed lifestyle choices and promoting the importance of individuals taking responsibility for their own health and wellbeing.

SECTION 2 VALUES AND PRINCIPLES

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We want to work in partnership with public, patients and carers in North East Essex to help them have greater choice, control and responsibility for health and wellbeing services:-

- People will be encouraged and supported to look after their own health and social care needs
- Carers will receive the support they need.
- Patients, public and community groups will take up opportunities to be involved in planning and developing services
- Services will be centred around the patient and will be high quality, evidence-based, cost effective and sustainable
- People will receive seamless and joined up services across their health and social care needs

We are committed to commissioning services which are equitable, inclusive and sustainable.

The values that lie at the heart of the work of the CCG are:-

- **Integrity** – We will work in the spirit of public service, professionalism and selflessness to serve our local population.
- **Inclusiveness** - Our commissioning will be driven by the health needs of the whole population. We will prioritise our commissioning towards work which delivers the greatest improvements in health and the best possible experience for all people throughout their care and treatment.
- **Improvement** - Our communities require high-quality services. This means services which are safe, personalised and deliver good clinical outcomes. We will seek to continually improve quality wherever possible and to embrace innovation to achieve this.
- **Patient-centred** – We will ensure that services respond to people as individuals, involving them in their individual care decisions and also in the planning of services.

We are committed to delivering the pledges of the NHS Constitution and upholding its values

SECTION 3 VISION AND TRANSFORMATION

Our vision is “Embracing better health and wellbeing for all.” We will focus on improving outcomes for the four priority populations we have identified with Essex County Council: the frail and elderly, people with mental health care needs, people with learning disabilities and children,. We will also focus on vulnerable and marginalised groups. Even though we will focus on priority groups within North East Essex, everybody should be able to expect an improved level of health and wellbeing from the services we commission, delivered through a simpler system. People will have greater choice, involvement and control regarding their health and wellbeing.
Our vision is based around 4 overarching principles of care:-

1. Care focused around people, not services
2. Seamless, harm free care
3. People have a large part to play in staying healthy
4. Efficient advice and care

We want to work in partnership with public, patients and carers in North East Essex to help them have greater choice, control and responsibility for health and wellbeing services. We are also committed to engaging in Essex-wide transformation where this improves the quality of services for our population. We are committed to commissioning services which are equitable, inclusive and sustainable. We will achieve this over the next five years through commissioning integrated physical and mental health and social services. A series of planned commissioning steps will deliver for patients a system where they can choose between end to end service providers offering seamless care.

This is likely to include up-skilling staff and maximising the use of technology, so that service users’ needs are met by a smaller core team and so that service users are supported by technology to remain in their own homes. Services will be commissioned for specific geographical populations so that we can focus on the different needs in different areas. This means that the improvement in outcomes we require may be greater in areas, or groups of people where outcomes are poorer at present.

SECTION 4 Joint Strategic Needs Assessment

The CCG has worked with ECC Public Health colleagues to produce a health need-focused JSNA to inform strategic planning by commissioners and providers, and to support the CCG's Values of *Inclusiveness* and *Improvement.* The JSNA uses benchmarking of local data on need, spend and outcomes to identify areas where either quality or value for money could be improved.

Demographic Challenges in NE Essex

- In Oct 2013, the GP registered population of NE Essex was 331,866 (male 162,480; female 169,386). The resident population of NE Essex CCG is expected to rise from 314,293 in 2012 to 357,121 in 2021 – a 43,000 (13%) increase. The greatest increases are expected to be in ages 56-75 years (13,300 increase) and 76+ years (9,700 increase). Integrated Planning by health and social care should take account of the anticipated additional demand for older people's services over the next 5-10 years. This includes the absolute increase in the number of older adults, but also the increased burden of multiple physical and mental conditions among older people.
- Service planning should take account of the needs of minority and marginalised communities including BME, Gypsy and Traveller, and Migrant communities, particularly in relation to services providing LTC, sexual health, maternity and children's services, where need is often higher in these communities. These communities can also experience lack of awareness of services, lack of knowledge about how to access services, and the need for translation services.
- In assessing the needs of patients, the needs and views of any carers, who may not self-identify as such, should also be taken into account and addressed. There are approximately 30,000 carers in NE Essex. How to improve the identification of carers, including young carers, should be considered further. Service planning should consider options for including carers in decision-making, and for increasing access to respite care, plus advice, practice and emotional support for carers. 30,000 care4rs in nee
- Integrated planning and QIPP planning should take account of the specific needs of high health need groups (including older people, BME and migrant communities, more deprived communities, people with mental health conditions). Commissioners

should consider alternative models of service delivery to target particularly high need communities, in order to maximise gains in health status and in system efficiency.

Health Inequalities

Inequalities in life expectancy are experienced in NE Essex by more deprived communities and by males. Deprivation is associated with a higher burden of ill health and worse health outcomes. Premature mortality (death under 75) is similar to England average in Tendring, but is lower in Colchester. NE Essex has the highest proportion of Disability Living Allowance (DLA) claimants in Essex.

There is considerable variation in the socioeconomic profiles of different communities in NE Essex:

- Out of 326 Local Authority areas, Tendring is ranked 86th most deprived in England[1] (a slight increase in relative deprivation, moving from 29th percentile in 2004 to 26th percentile in 2010[2])
- Out of 326 Local Authority areas, Colchester is ranked 205th most deprived in England (a slight reduction in relative deprivation, moving from 61st to 63rd percentile)
- The *most* deprived small area (LSOA; approximately 1,500 people) in England is in Tendring (LSOA E01021988). For comparison, the *least* deprived LSOA in NE Essex (LSOA E01021728) is ranked 32,169 out of 32,482 LSOAs in England i.e. is the 315th *least* deprived small area in England. Although Colchester is less deprived overall than Tendring, pockets of deprivation exist in both, and include both rural and urban areas.
- Health need varies considerably by practice in NE Essex. The need score for each NEE practice is compared to registered population in the graph below. Five practices on the coast have a particularly high patient needs relative to their practice size and funding. The CCG is working with NHS England to develop a joint strategy for health care in the worst affected area.

[1] IMD 2010
[2] IMD 2004 and IMD 2010

Quality and Patient Outcome Improvements

The table below summarises the areas where NE Essex CCG is an outlier or could make improvements in terms of clinical quality and patient outcomes. The issues identified are being taken forwards through outcome-based commissioning approaches, for example: delivery of the 8 key care processes for diabetes is a KPI subject to risk-share arrangements in the Integrated Diabetes Service contract which will start in April 2014; and Maternity services are to start CO2 screening all pregnant women in order to reduce smoking in pregnancy and resultant health complications such as low birth weight.

Programme	Issue
Healthy Lifestyles	NE Essex GP practices and other services should continue to focus on addressing under-diagnosis of long term conditions and increasing diagnosis rates (including of hypertension and other cardiovascular conditions, diabetes and respiratory conditions), in order to ensure people receive the treatment they need and to prevent future complications.
	Improvements in healthy eating should continue to be built on to increase the proportion of residents eating 5 portions of fruit and vegetables a day. Urgent co-ordinated action to reduce obesity in pre-school, primary and secondary school children is required through integrated children's commissioning processes.
	Levels of physical activity are difficult to assess, but increases are associated with reduced mortality and morbidity, so keeping active should be promoted across all age ranges.
	As the single greatest cause of avoidable death and ill-health, reducing smoking rates should continue to be a primary focus of all public services. Smoking cessation services should continue to have targets for quitting among more deprived communities, and services should ensure they are accessible to individuals from these communities. Commissioners and front line health staff should consider how to maximise Making Every Contact Count in respect of smoking status, despite personal objections that can be raised. Public services need to work together to take a multi-pronged approach to reducing people taking up smoking, for example through: working with youth health trainers, schools and other young people's services; working with the media; enhancing trading standards activity to target under-age sales; cutting access to contraband cigarettes etc. In order to reduce low birth weight births and future poor health, reducing smoking in pregnancy should be a priority for all services, and a variety of support should be available to expectant mothers.
	With increasing hospital admissions and over 40% of adults estimated to be at increasing or worse risk of problems from alcohol, commissioning and provision of all appropriate services should include Making Every Contact Count or Intervention and Brief Advice (IBA) regarding alcohol misuse. Patients report that the GP is their preferred point of contact for alcohol support, so ensuring that IBA coverage and awareness of alcohol services by GPs is maximised should be a priority for primary care commissioners.

Programme	Issue
Secondary Care	The observed SHMI level is higher than expected at Colchester Hospitals (CHUFT). There has however been a longstanding discrepancy between HSMR (Hospital Standardised Mortality Ratio; which has been within expected range for some time), and on-going detailed monitoring of mortality data is indicated.
	Patient feedback suggests that information-giving to patients could be more consistent in CHUFT.
Infectious Diseases	Uptake of flu vaccination in the over 65s is significantly lower than the England average. Uptake rates also remain low in other at risk groups. This may be partly responsible for the NEE CCG's high non-elective admission rates for influenza and pneumonia, and should be actively addressed in order to increase uptake.
Cancer & Tumours	Mortality data suggests that: Breast, Cervical and Lung cancer pathways should be reviewed to identify quality improvements; the two week wait pathway should be reviewed and improved to ensure rapid diagnosis and entry to treatment; access to palliative care for cancer patients should be assessed to ensure it reflects local need; and audit of non-elective Cancer admissions should be undertaken to identify tumour pathways where quality improvements may be possible.
	Patient feedback highlights that respect for, and communication of cancer clinical staff with, patients could be improved.
Endocrine, Metabolic and Nutritional	It is estimated that diabetes is around 20% under-diagnosed in NE Essex. How to improve timely diagnosis, in order to prevent future complications, should be considered.
	Basic care for diabetes (e.g. delivery of the 8 key care processes) still requires improvement across all providers, and all age ranges. Young people and younger adults with Type 1 diabetes require particular focus to prevent complications in later years, and quality of management of risk factors remains low compared to other areas of the country.
Mental Health	Mental health care should be integrated with routine physical health care wherever possible. This is particularly important for patients with diagnosed long term conditions (LTCs) who are at higher risk of poor mental health as well as having physical health problems.
	Improvements could be made in both primary care monitoring of physical health risks for patients with mental health problems, and access to mental health treatments (e.g. IAPT) for those with physical health conditions. Future commissioning of services should seek to integrate physical and mental health care.
	Commissioners should ensure that mental health care providers are commissioned to provide patients with support for activities of daily living such as securing stable accommodation and claiming benefits, in line with patient feedback.
	Commissioners, providers and public health should work together to address the need, expressed by young people supported by CAMHS and their parents, to raise awareness of mental health services available and to develop awareness/understanding of mental health issues.
Learning	People with Learning Disabilities experience substantial health inequalities. Commissioners and Service Providers should work together and with people with learning disabilities to ensure reasonable adjustments are made to enable access to mainstream services, and to ensure that specific targeted services are provided in a manner

Programme	Issue
Disabilities	acceptable to patients.
	Uptake of annual health checks remains low. All GP practices should ensure that all their patients with learning disabilities receive an annual health check. Feedback from service clients suggests that practices may need to make *reasonable adjustments* and be *thoughtful* in the way the service is delivered in order to maximise uptake.
Neurology	The Epilepsy Specialist Nurse service should address the gaps in service identified by patients, including availability of specialist advice to patients and carers, and conception advice.
	CCG should work with NHS England AT and local GPs to address gaps in knowledge and service in Primary Care, focusing on improving routine care such as provision of at least annual review including medication concordance, as recommended by NICE (2012).
	The high rate of A&E admission for children with epilepsy, compared to national rates, might suggest a lack of access to routine care, which should be investigated.
Circulatory Disease	Cardiovascular patient outcomes are relatively good in NE Essex, however variability in primary care quality could be reduced across pathways, particularly CHD and HF.
	42% of hypertension and 27% of CHD remains undiagnosed. Under-diagnosis of CVD should be systematically addressed, to ensure that people are getting effective treatment for their conditions, and to reduce future complications.
Respiratory	30% of COPD remains undiagnosed. Under-diagnosis of respiratory conditions should be systematically addressed, to ensure that people are getting effective treatment for their condition, and to reduce future complications.
	Patient feedback suggests that not all COPD patients have the knowledge and confidence to manage exacerbations of their COPD at home, and services should consider how this can be improved.
	Prescribing practice around respiratory disease should be reviewed to identify possible savings, including considering COPD patient feedback that having the necessary treatments available at home to manage exacerbations (e.g. a nebuliser or a basic stock of steroids) might reduce acute admissions out of hours.
Gastro Intestinal	GI mortality and underlying quality data should be reviewed to identify areas for improvement, in order to reduce avoidable morbidity and mortality. Commissioning for Value data suggests that up to 17 lives could be saved per year.
Musculo-Skeletal	Patient musculo-skeletal and trauma-related outcomes are outcomes generally good, however benchmarking suggests that patient outcomes could be improved even further in e.g. joint replacement. Data analysis should be undertaken to identify specific areas of hospital over-activity, to improve prevention of complications and of avoidable injuries.
Genito-Urinary	A review of renal risk identification and management pathways should be carried out to reduce functional deterioration and avoidable AKI (which is significantly high in NEE) and other complications.
Maternity	Agencies should continue to work together to further reduce teenage conceptions in NE Essex, with a particular focus on Tendring.
	Antenatal services should focus on supporting smoking cessation, good nutrition and exercise among pregnant women, especially in Tendring, in order to reduce the

Programme	Issue
	prevalence of low weight births, and give children the best start in life.
Children	Breastfeeding and immunisation rates are similar to or higher than the comparable national rates, but NHS England, the CCG, GPs and other service providers should work together to improve further in order to maximise health status for children. Urgent co-ordinated action to reduce obesity in pre-school, primary and secondary school children is required through integrated children's commissioning processes.
Social Care Needs	The substantial level of unmet need for social care in NE Essex should be addressed. This includes some people with high and very high needs. Improving access to social care overall may require additional provision and targeting of services by social care agencies, and enhancing the knowledge of health and other care professionals about how to refer to social care. Projects such as the Reach Out project could also be extended to support this. Access to reablement in NE Essex should be maximised, in order to enhance independence in old age. Given the high percentage of older people with health and care needs in Tendring, particular focus should be given to improving access in Tendring. Client feedback suggests that experience of social care could be improved in Essex.
Dental	Tendring has the highest prevalence of tooth decay among 5 year olds in Essex. NHS England, NEE CCG, and children's services should work together to improve preventative dental care and education, particularly in Tendring, in order to reduce avoidable dental health problems.

Opportunities for Cost and Productivity Savings at a Glance

The table below summarises areas where NE Essex CCG is an outlier in terms of cost and productivity. Please note that the total potential financial opportunity is not the sum of each of items listed in the table because items are derived from a range of data sources that may partly duplicate savings. For example, potential high spend listed in the Endocrine, Nutritional and Metabolic Problems programme will be partly a function of high diabetes prescribing costs. In addition, the savings are forecast at full PbR tariff rate, whereas they may only be realised at the 30% (marginal) rate. The areas identified have fed into QIPP and Integration planning for 14/15 and beyond.

Programme	Issue	Financial Opportunity	Criterion to deliver financial opportunity
Secondary Care	High rates of procedures of low or limited clinical value, including hysterectomy, D&C/hysteroscopy, tonsillectomy, lumbar spinal procedures and myringotomy.	£226,484	If operation rate per 100,000 population reduced to 25th percentile nationally
	Ambulatory Care Sensitive (ACS) admissions for the nineteen listed conditions could be reduced. Areas where over £50k p.a. could be saved are: Influenza and pneumonia;	£1,402,246	If admission rate per 100,000 population reduced to 25th percentile nationally

Programme	Issue	Financial Opportunity	Criterion to deliver financial opportunity
	COPD; Cellulitis; Heart failure; Asthma; Diabetes.		NB These conditions are mostly age-related, and NE Essex's high proportion of older people will potentially reduce the savings that can realistically be achieved compared to the 25th percentile areas, which have a lower percentage of older people.
	NE Essex has a significantly higher GP referral rate than average for England. When compared to the 9 most demographically similar CCGs in England, it is estimated that 26,799 1st OP attendances could be saved a year.	£2,519,000	If outpatient appointment rate per 100,000 population reduced to the performance of the top 5 most similar CCGs.
Healthy Lifestyles	Evaluation of the impact of the Tier 3 weight management service in NE Essex should include consideration of wider usage of services, including community services.	TBD	
Infectious Disease	In 2012/13, flu vaccination uptake among over 65s was significantly lower than average for England, and emergency admissions for Influenza were higher in NE Essex than average for England or the CCG's peer group of similar CCGs.	£637,528	Reduction of Influenza and Pneumonia acute admissions in NE Essex from 2012/13 levels to the rate seen in the lowest quartile (a reduction of 235 admissions).
Cancer & Tumours	Commissioning for Value pack (2013) states that non-elective admissions could be reduced by 305 p.a. and emergency bed days by 3,377.	£842,000	If the performance of the best 5 similar CCGs to NEE was replicated. Given that cancer pathways are usually planned elective pathways, audit of these non-elective admissions might be useful in identifying pathways where improvements could be made.
Endocrine, Nutritional and Metabolic	Spend on diabetes prescribing is higher than average (although overall spend is lower than cluster average). This is particularly marked in the spend on blood glucose testing strips.	£600,000	Spend on testing strips reduced to the level of the lowest 25% of CCGs nationally.
	Commissioning for Value data suggests further diabetes prescribing savings could be made over and above testing strip reductions.	£1,400,000	Spend reduced to the best 5 of the CCG's 10 most similar CCGs.
Mental Health	Commissioning for Value data suggests that mental health prescribing savings could be made.	£1,600,000	Spend reduced to that of the lowest similar CCG.

Programme	Issue	Financial Opportunity	Criterion to deliver financial opportunity
Neurological	Commissioning for Value data suggests that neurological prescribing costs could be reduced. Neurological spend overall is lower than cluster average however.	£1,325,000	Prescribing costs reduced to those of the lowest spending 5 CCGs in the CCG cluster.
Circulatory	Hypertension registers are significantly incomplete (by 40%) and CHD register also under-populated (by 27%). Potential for improvement in CHD and HF QOF indicators.	TBD	From strokes prevented if H/T QOF register completeness increased to 70%. Improvement in QOF scores to top quartile.
	Commissioning for Value data suggests that a saving could be made on cardiovascular prescribing in NE Essex.	£1,317,000	Prescribing costs reduced to those of the lowest spending 5 CCGs in the CCG cluster.
Respiratory	Commissioning for Value data suggests that savings. could be made on respiratory prescribing in NE Essex.	£1,333,000	Spend reduced to the best 5 of the CCG's 10 most similar CCGs.
Gastro Intestinal	Commissioning for Value data suggests that elective and non-elective admissions for GI conditions could be reduced.	£1,094,000	Spend reduced to the best 5 of the CCG's 10 most similar CCGs.
Skin	NEE CCG is in the highest spend quartile nationally for this category.	£2,925,000	Spend reduced to CCG cluster average.
Musculo-Skeletal	Commissioning for Value data suggests that NE Essex could make savings from elective and non-elective musculo-skeletal admissions It also identifies potential prescribing savings of £195k p.a. Reductions in Trauma and Injury emergency admissions.	£727,000 £195,000 £549,000	Spend reduced to the best 5 of the CCG's 10 most similar CCGs. Spend on this category should be reviewed carefully, and in line with quality of care. Trauma admissions are higher than in CCGs with a similar demographic profile.

Programme	Issue	Financial Opportunity	Criterion to deliver financial opportunity
Genito-urinary	Commissioning for Value data suggests that savings could be made by reducing elective and day case activity. It also suggests that savings of up to £285k p.a. could be made from prescribing.	£434,000 £285,000	Elective, day case and prescribing spend reduced to the best 5 of the CCG's 10 most similar CCGs. The impact of this reduction on quality and patient outcomes would need to be carefully considered however.
Prescribing	Prescribing spend should be benchmarked and reviewed in more detail in the following areas: cancer & tumours; circulation; endocrine (including diabetes); genitourinary; infectious disease; maternity & reproductive health; mental health; musculoskeletal; neurological; and respiratory.	£6,350,000	Prescribing spend reduced to the best 5 of the CCG's 10 most similar CCGs.

SECTION 5 OUTCOMES

5.1 The seven outcome ambitions and how we plan to achieve them

It should be noted that the seven outcomes ambitions are based on the five high level ambitions of the National Outcomes Framework (NOF), the only difference being that two of the NOF outcomes have been sub-divided into two parts.

See chart below

Outcome ambition	Measure to be used	Quality Premium measure	Support measure(s)	Action in 14/15	Additional Action in 15/16
1.Securing additional years of life for the people of England with treatable mental and physical health conditions.	Potential years of life lost from conditions considered amenable to healthcare – a rate generated by number of amenable deaths divided by the population of the area.	Improvement to be locally set and no less than 3.2%. CCGs should focus on improving in areas of deprivation in developing their plans for reducing mortality.	None	**Public Health** will commission a range of services to address this, including Senior Health Checks for over 75s, NHS Health Checks for 40-74 year olds, obesity management and smoking cessation services. All these services incentivise a focus on more deprived populations. NEE CCG will offer a contract for **enhanced primary care services**, including Anti-Coagulation Monitoring, DVT, Minor Injuries, Wound Care and Suture Removal, Learning Disabilities and IUCD. The contract will look at commissioning a single provider to offer safe, high quality and equitable services to all patients within North East Essex, reducing fragmentation and variation in accessibility that we current see …. **Integrated Diabetes Pathway** implemented from April 2014	The integration of physical and mental health care will be enhanced through the commissioning of the integrated **Care Closer to Home** community service, including implementing the priority areas identified in the recent report "Closing the Gap; priorities for essential change in mental health services" to achieve parity between mental and physical health services. Specific higher need sub-populations will enjoy targeted services.
2.Improving the health related quality of life of the 15 million+ people with one or more long-	Health related quality of life for people with long-term conditions (measured using the EQ5D tool in the GP Patient Survey).	IAPT roll-out: i. achieve 15% for CCGs below that level ii Additional locally set improvement	Increase dementia diagnosis rate to 67 per cent by March 2015. Achieve the	**Enhanced IAPT model** to be implemented from April 2014, including focus on those with LTCs **Promotion of self-care** agreed as a priority with providers, and a CQUIN on Behaviour Change training for clinicians proposed. **Dementia diagnosis**	Commissioning of the integrated **Care Closer to Home** community service should enhance holistic LTC care, including implementing the priority areas identified in the recent report "Closing the Gap; priorities for essential change in mental

term condition, including mental health conditions.		for those over 15% or near 15%.	IAPT recovery rate of 50%.	Continued development of Memory Service will increase number of people being diagnosed with dementia and direct them to appropriate support. **Integrated Diabetes Pathway** implemented from April 2014 Consulting with GPs on **supporting case management of >75s** through a range of services aligned with the BCF, including MDTs, diagnosis and prevention services etc	health services" to achieve parity between mental and physical health services.
3.Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	A rate comprised of: • Unplanned hospitalisation for chronic ambulatory care sensitive conditions. • Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s. • Emergency admissions for acute conditions that should not usually require hospital admission. • Emergency admissions for children with lower respiratory tract infections.	As per outcome measure	None	Avoidable emergency admissions will be monitored monthly by the CCG, allowing intervention if the metric is off-target. The CCG has commissioning bundles focusing on each of the composite measures in the metric: **Care Closer to Home** impacts on avoidable ACS admissions among older people, and a number of services to be included in this bundle are already in place including risk stratification and multi-disciplinary case management through virtual wards and other services to support case management of >75s in primary care; **Urgent Care** impacts on avoidable acute admissions among older people and children. In 14/15, 7 day working and admission avoidance through a new Rapid Assessment Unit in Clacton will be implemented; **End of Life** impacts on avoidable acute admissions among older people, through single point of access to care and support,	**Care Closer to Home** impacts on avoidable ACS admissions among older people will be enhanced through introduction of a **Community Gateway** and enhanced use of **risk stratification**.

				enhanced palliative care in non-acute settings etc; **Children's services** impact on avoidable chronic condition admissions among children.	
4.Increasing the proportion of older people living independently at home following discharge from hospital.	No indicator available at CCG level. CCGs and Area Teams will not be expected to set a quantitative level of ambition for this outcome. However, they will be expected to set out how they will improve outcomes on this ambition in their five year strategic plans.	None	A level of ambition needs to be established at Health and Wellbeing Board level on the *Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services.*	NEE CCG has one of the highest performing **stroke rehabilitation** services in the country, with 55% of patients receiving Early Supported Discharge. **Essex Social Care Services** and CHUFT will continue to work together and with ACE Community Health providers to ensure effective discharge support. ECC will use BCF investment in **reablement** to promote ward led discharge, development of rapid response services and to ensure assessment is taking place at the appropriate time in the appropriate environment. The nature of reablement cases will shift with short stays being replaced with more complex cases, which may impact on independent living rates. BCF funds to be used to increase the number of people to be offered reablement.	**Care Closer to Home** aims to provide seamless, simpler care for patients, wrapped around GP practices, providing holistic support to people in their own homes.
5.Increasing the number of people having a positive experience of hospital care.	Patient experience of inpatient care.	Friends and Family Test: specific actions to improve low scores.	None	F&F Test action plans – see Section 8 7 day working impacts – see Section 8 Cancer Action Plan - see Section 6	**Urgent care** system development
6.Increasing the number of	Composite indicator comprised of (i) GP services, (ii) GP Out of	None	None	Almost 1,000 people were reached with our Big Care Debate engagement over the productivity challenge. The key theme were	**Care Closer to Home** aims to provide seamless, simpler care for patients, wrapped

people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Hours.			:- • Self care People overwhelmingly understood that personal responsibility for their health is important. Diet, exercise and mental well-being were recurrent sub themes. • The role of family, friends and the voluntary sector in providing support mechanisms, care and social contact were also vital in helping people to avoid isolation and to remain independent, fit and healthy. Friends and Family test Use of technology and personal health budgets were supported as was better training of staff to help individuals become more independent in managing long term conditions **Access to information and services** Access to information and signposting to services was viewed as important. Use of plain English and guides to services were felt to be important. People felt this was crucial to self-care and to ensuring services were not used inappropriately when people needed support and/or advice for minor ailments and to reduce demand on other services. Appointments with GPs, dentists and professions allied to medicine such as physiotherapy or audiology, as well as	around GP practices.

				access through the walk in centre, were recurrent themes with some mixed commentary about the 111 service which has only recently gone live. Overwhelmingly, however, access to GPs for appointments was the single biggest point of satisfaction or concern dependent on how easy participants found it. There was an overwhelming view that GPs are the gateway to prevent other services being overloaded. **Prevention** The theme of access to information also extended to health promotion and education for individuals about to stay well and healthy and how to manage a long term condition so the individual remains in control. **Integration of services** There was a level of frustration with lack of integration of services, particularly around discharge from hospital but also with support services such as appliances or equipment when bereaved families found it difficult to return of items that were no longer needed. Suggestions included creating one budget for services and gateways/single point of contact for services that provided more clarity and removed barriers. Care closer to home and home visits for the vulnerable were key comments throughout the engagement whilst others felt centres where a range of services that could be accessed together were a good idea.	

				<u>Culture and Patient Centred Services</u> People felt there was still some way to go to develop the right culture in the NHS and Social Care, improving the way professionals speak to patients and carers creating a partnership rather than a dependency. Some BME community representatives felt that there were communication issues even when the use of English was not a barrier but that cultural values were not always understood. The engagement included meetings with BME communities including Chinese, Middle Eastern and Turkish representatives. Working families were reached through an online survey and young mothers were reached through children's centres Convergence between CCG strategies and NHS England **Primary Care Strategy** **Joint North Essex Mental Health Strategy** includes: • Developing and supporting community well-being, encouraging people to maintain healthy lifestyles that help keep themselves and their families mentally well. • Improving access and the gateway into services – more effective direction. • Ensuring smooth transition between services (CAMHS/Adult/Older People). • Ensuring a more holistic and integrated approach to mental health and physical health services. • Developing broader primary care and community based models of care for people across the spectrum of mental health	

				conditions. • Ensure in-patient and specialist services are responsive and meet the needs of patients with more complex needs.	
7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	Hospital deaths attributable to problems in care. This indicator is in development.	Improving the reporting of medication errors	MRSA zero tolerance *Clostridium difficile* reduction	Mortality Working Group Cancer Action Plan Regular Review by CCG Board and Quality Committees, including SI reporting, mortality rates, MRSA and *C.diff* rates, safety thermometer etc Participating in Child Death Review Panels	

5.2 Improving health - Commissioning for Prevention

Through its Organisational Development work, the CCG is developing a commissioning approach for delivery of its strategic priorities with partners. This approach will reflect the principles of "Call to Action: Commissioning for Prevention". The table below summarises how NE Essex CCG is already addressing each step in the framework to focus on prevention:

Framework Step	**Action in NEE CCG**
1. Analyse Key Health Problems	The CCG's Commissioning priorities and QIPP plans have been informed by the NEE CCG JSNA (summarised above and available at: Joint Strategic Needs Assessment (JSNA) Resources - Essex Insight). This document collates and analyses key national (e.g. Commissioning for Value) and local (e.g. local patient experience surveys) health and care need information, benchmarking it and highlighting priorities for service development and improvement work, and high need population groups. The JSNA has been presented to the CCG's Board and Transformation & Delivery Committee, and shared with staff and partners. It will continue to be used to identify priority areas for QIPP and service transformation, as well as informing the CCG's Commissioning Intentions. 'Deep Dives' are also undertaken into priority clinical areas to inform future commissioning, for example, urgent care, and cancer mortality and care quality. The CCG's QIPP planning is including more in-depth reviews into clinical pathways highlighted in the JSNA as potentially requiring quality and/or productivity improvements.
2. Prioritise & Set Common Goals	<u>Prioritisation</u> The CCG has developed a prioritisation framework that it uses to assess the priority of commissioning proposals against current services and other proposals. This framework was developed with input from patients, CCG staff and members,

	and partner agencies, in order to reflect the views of the whole system. The framework has also been adapted for use in prioritisation of voluntary sector grant bids and CQUIN proposals for 14/15 contracts. This framework allows every proposal to be scored against a weighted set of benefits, and for this benefit to be plotted against total annual cost and annual cost per patient, in order to allow the relative priority of services to be assessed for both commissioning and decommissioning decisions. <u>Setting Common Goals</u> The CCG has undertaken extensive consultation with the local population through the Big Care Debate. This has informed the CCG's draft Strategic Objectives, which were developed by the Board and elected clinical members, and with key partners: **Strategic objective 1: Holistic Approach** - Achieve our vision through an inclusive, holistic approach to patient and service user- centred commissioning, embedding personalisation of care through integrated health and social care services. **Strategic objective 2: Quality and Safety -** To transform care and drive continuous improvement in quality and safety. Achieve the best possible outcomes from our service users through high quality care **Strategic Objective 3: Best use of resources –** To use commissioning resources effectively and responsibly. To develop our organisation, teams and individual staff to be trusted, competent, well trained, talented, enthusiastic and dedicated. **Strategic Objective 4: Priority Health Goals -** To tackle the biggest health challenges in North East Essex reducing health inequalities

	The CCG's Vision, outlined above, reflects the Strategic Objectives, and has been refreshed as part of the 14/15 planning process to ensure it is fit for purpose. The CCG's commissioning priorities have been assessed against the Vision to ensure commissioning focus is in the right areas. A further planning workshop will be held in April/May to inform the economy's five year plan. Commissioning priorities are also escalated down into individual job plans. The CCG has developed organisation-wide objectives aligned with its vision, so that staff personal objectives set for 14/15 demonstrably support the delivery of the CCG's vision.
3. Identify High Impact Programmes	High impact programmes which address the CCG's priority areas have been identified through identification of best practice from elsewhere, local innovation, and use of evidence, including but not limited to: • Essex Annual Public Health Report 2013; • Reducing Unplanned Admissions: a review of the literature, Central Midlands Commissioning Support Unit (Knowledge and Evidence Team); • Key Success Factors in delivering great emergency care in Essex (slides) by Stephen J Duncan, National Head of Intensive Support, Emergency Care Intensive Support Team, NHS IMAS. The CCG has used this evidence, plus insight from local clinical members and others, to identify novel and/or innovative ways to improve quality and efficiency through the QIPP planning process. The CCG's current plans include action on prevention at several levels. Examples include:

	Primary Prevention Although responsibility for primary prevention now rests with public health teams in local authorities, the CCG's commissioning intentions include commissioning prevention of complications, such as through a Tier 3 weight management service and an AQP chronic back pain service. The CCG has agreed with ECC PH commissioners that commissioning of community services will be aligned, so that providers must ensure seamless access to primary prevention services. **Improving Diagnosis Rates** The CCG has a rolling programme of biannual Atrial Fibrillation screening trough pulse checks at flu vaccination clinics, focusing on high risk groups. **Secondary prevention** The CCG has commissioned a new integrated managed pathway for diabetes to start in April 2014. This has been commissioned in a way which incentivises risk factor management (such as HbA1c, hypertension etc) and reducing poor outcomes (such as diabetic foot disease) through contractual performance-related mechanisms.
4. Plan Resources	In order to deliver effectively, the CCG needs to consider the full range of resources available across the economy, and work with partners as appropriate to deliver our shared goals. The CCG has developed their medium term financial strategy which considers the:

	• Effective management arrangements that will ensure financial balance and stability • Ensures that the governing body is kept aware of the planning assumptions used and any deviations • Supports the delivery of the integrated operational plan through effective use of available resources • Secures value for money and efficiency in the CCGs commissioning responsibilities • Ensures robust arrangements are in place for investment and disinvestment decision which are aligned with investment and disinvestment. The CCG is currently developing a model of the whole system's activity and finances which will be used to map the impact of different service models and proposed changes. The impact can then be considered from a population, organisation and whole system perspective.
5. Measure & Experiment	<u>Measurement</u> The CCG is introducing enhanced programme management arrangements which will include enhanced monitoring of the delivery portfolio of the CCG. This will be supported by a number of tools including a portfolio management dashboard, how to guides, programme management support software and benefits trackers. Key components of the CCG portfolio, programme and project management include initiating and managing: • Governance • Programme and project briefing and initiation • Quality assurance and risk management • **Financial (QIPP)** and KPI development and monitoring • Programme and project engagement and communications • Programme and project delivery • Performance management, benefits capture and evaluation • Transition from project to business as usual – moving from pilot status

	<u>Experiment</u> NEE CCG has affiliated to Eastern Academic Health Science Network, and is a member of the Essex Node of the Network. The CCG is also making links with local academic institutions and actively supporting research locally in order to benefit from local innovation.

5.3 Equality Delivery System

- The Equality Delivery System (EDS) is managed by staff within our CCG. Over the last year our CCG has been working towards grading the outcomes of the EDS framework and developing objectives. These will then be delivered so our organisation can support the ongoing programme.
- The CCG agreed with the Quality Committee at the beginning of the year a plan to achieve this.
- In shaping the objectives staff from the CCG have met with, and gathered views from, over 100 individuals, groups and organisations. A set of controlled questions were asked to establish the issues that people from the protected groups face. The objectives that have been produced come from the themes expressed during this period. We then tested the proposed objectives with the protected groups. Our CCG shall be reporting and monitoring against these through the Quality Committee, our public Health Forum Committee and finally the board at the end of the year.
- The grading for the outcomes was produced by a publically held event. People and organisations representing the protected groups graded our CCG after being presented with a range of examples and evidence from staff. Benchmarked against previous grading our CCG has improved but can still do more.

5.4 Parity of esteem

- Details of how the CCG aims to achieve parity of esteem for people with mental health needs are in section 6.5

SECTION 6 PATIENT SERVICES

6.1 Patient engagement and empowerment

Our consultation and engagement strategy (refreshed in November 2013) sets out the following principles for engagement:

- Promoting the NHS constitution to our communities
- Working with our stakeholders to make sure we are effective, efficient and display financial prudence
- Using our stakeholders to tell us how the quality of services should improve
- Using our stakeholders to tell us how the quality of primary care services should improve
- Working in partnership with our communities to reduce inequalities
- Involving patients at all stages of what we do
- Working closely with all clinicians and healthcare professionals
- Developing partnerships
- Promoting equality
- Being innovative and forward thinking

<u>Patient, public, service user engagement</u>

The CCG has built on the previous work of health commissioners to establish relationships with local communities to identify needs and gaps and to ensure we have robust patient involvement in how health services and patient care are planned and delivered

When we took over the role of Public, Patient and Carer Engagement (PPCE) we produced a discussion document for our stakeholders to help us understand how we should improve the way we engage. We put together a working group of stakeholders that represented different backgrounds out of which was born the North East Essex Health Forum with the following features:-

- A greater voice is given to our local residents
- Largely owned by the people who use our services;
- Accountable for stakeholder engagement by having a GP lead whose portfolio is PPCE;
- An independent and democratically elected group (North East Essex Health Forum Committee) which sets the agenda for raising issues with commissioners. This committee has inclusive representation from patients/service users, carers, voluntary sector and Healthwatch
- The committee can make recommendations to the CCG Board
- A member from the Health Forum Committee sits on the CCG Board and members sit CCG sub- committees as well as commissioning working groups
- Locality Engagement Forums which set their own agendas with commissioners held to account for actions arising from Forums meetings.
- A coordinated relationship between Practice Patient Groups;
- The structure is shaped around stakeholders rather than for Commissioners;

Prior to authorisation we held a stakeholder event “Involving Local People in Health Decisions” where we presented our plans and priorities and invited feedback from the 100 strong audience. The outcomes of our stakeholder event were shared with the Health Forum (which has a membership of approximately 300) who monitor our progress on the priorities that were identified.

Local Engagement Forum meetings take place bi-monthly in Colchester, Harwich and Clacton, chaired by Health Forum representatives: the agendas reflect local issues and concerns and the CCG reports back to the next meeting on the actions taken. Minutes are posted on our website and emailed to all forum members.

To date, 85% of our member practices have Patient Participation Groups. The Health Forum Committee has set up a working group to find out how the work of the PPGs can be used on a systematic basis to influence commissioning decisions, including their views and experience of being offered and exercising choice. The CCG is also working with GP practices to develop these groups further and to ensure that they are well advertised.

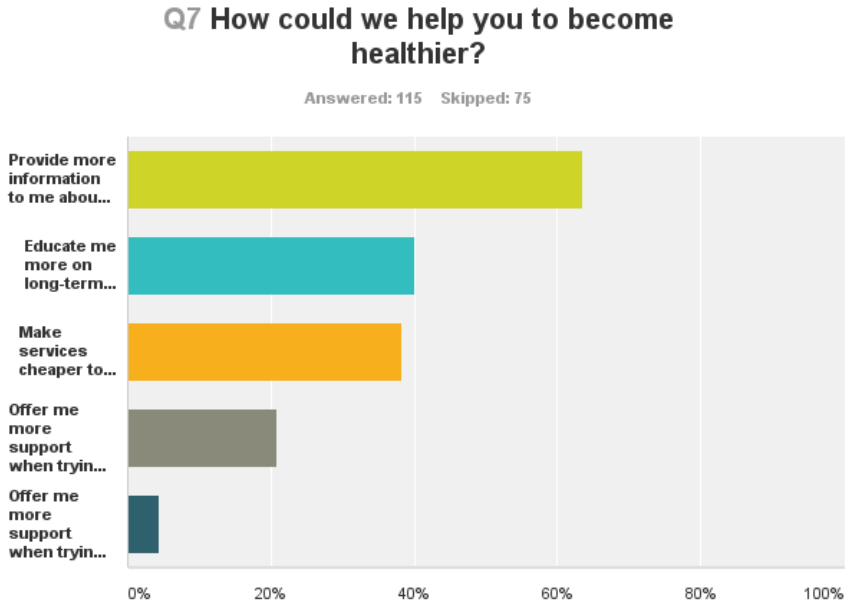
In addition to using the Health Forum to embed public and service user representation into our work, we also work with Healthwatch Essex and speciality service user groups such as Diabetes UK and our local Maternity Services Liaison Committee (to

name but two) to ensure we have strong user representation in our planning and commissioning work as well as in implementation to ensure there is strong service user involvement in how health services and patient care are delivered. As we recommission services inherited from the PCT we are systematically using this approach to ensure service users are involved in the service design and change specifying this as a requirement in our contracts.

We have taken a robust approach to patient and public engagement. In November 2013 we used the opportunity of NHS England's Call to Action to raise awareness of our local productivity challenges and how we propose to address them. The Big Care Debate has engaged with over 1,000 members of the public in two large set piece events, an online survey and outreach events where the community already gather such as Children's Centres, Older People's luncheon groups and PPGs.

The first phase qualitative survey was about identifying public priorities for care as well as raising awareness. A secondary benefit has been a rich stream of feedback which provides soft intelligence for our quality teams. It is clear from the Big Care Debate that our citizens want to be empowered and actively be involved in determining their future health and social care in partnership with an appetite for patient centred care, personalised budgets and signposting

Extract from Big Care Debate on line survey:-



The second phase is about feeding back how the public priorities map against our commissioning intentions and have influenced them – closing the loop. This engagement has also allowed us to identify service users and carers with specific patient experience that will assist in developing our strategies from intentions through to procurement.

Next steps will be a full 12 week consultation on our commissioning intentions to sense check that we have understood what the public has told us and integrated their ideas and concerns into our Care Closer to Home and Urgent Care Strategies.

We have sought to benchmark and verify our approach by commissioning Jeremy Taylor CEO of National Voices to undertake a review of our work to date.

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Patient, public, service user communication

In the last year we have further refined our website to make it simpler to navigate as well as being content rich (particularly featuring information about choice, managing illness and where treatment options are available as well has how to access friends and family test information) and have increased our use of social media to reach younger audiences and those who 'hard to reach' because they are working.

Our Facebook user involvement has doubled and our Twitter engagement has trebled. These digital media have been at the heart of multi-media campaigns to help patients stay well and to manage illness. Get Well Essex was developed in partnership with neighbouring CCGs using bus, radio, ambient advertising and PR stunts to raise awareness of the most appropriate urgent care services during the Winter.

Our Health Forum has also been actively involved in developing a service user led patient choice leaflet.

The CCG has a monthly column in the East Anglian Daily Times and is regularly featured in other local media with key messages around choice, quality, transparency (particularly in respect of recent issues at Colchester hospital)

Engagement with our practice members

The CCG consists of its member practices and has close and on-going engagement with them. The CCG Constitution was produced with the active participation of the practices and the Memorandum of Understanding sets out the mutual responsibilities of the CCG governing body and the practices, as well as between the practices themselves

Our 43 member practices are grouped into six Practice Forums. Each practice sends a clinician and a practice manager to the forum meetings, which are supported by an elected CCG member and a manager.

Engagement with providers

The CCG holds regular meetings throughout the year with the main providers of acute, community, mental health and learning disability services. These meetings include commissioning intentions, contestability plans and contract monitoring. The CCG makes

sure that providers are aware of the whole patient pathway, for example diabetes. Where pathways are being redesigned, the CCG ensures that the relevant providers are included in the reference groups.

Engagement with local authority partners and elected members

The CCG Chair is a member of the Essex Health and Wellbeing Board (HWB) and was a member of the task and finish group which established the governance arrangements for the HWB. The CCG Chair also worked with Sir Thomas Hughes-Hallett as part of the Who Will Care? Commission into health and social care strategy. The CCG Clinical Chief Officer is a member of the Business Management Group. The CCG regularly meets with Essex HWB, the Overview Scrutiny Committee (HOSC) and Tendring District Council Health and Colchester Borough Councils. Officers from Essex and Colchester council are also on the CCG board.

The ECC representative on the CCG Board has full voting rights and has been actively involved in the production of this plan, along with key members of the ECC team. ECC representatives also sit on the Integrated Commissioning Programme Board and project groups.

Regular meetings are held with elected members at local government and national level.

Engagement with system partners

The CCG chairs a system wide partnership group which brings together the strategic partners of the NE Essex health and social care system. Sectors represented include the voluntary sector, the local acute hospital, both upper and lower tier local authorities, the local provider for community services and mental health.

6.2 Wider primary care, at scale

Primary Care Development in North East Essex CCG

The CCG is not responsible for commissioning primary care: NHS England hold the contracts for General Practice, Dental Practices, Opticians and Pharmacies. However, the services provided by these organisations are key to the delivery of the strategy of the CCG. Patients often start their treatment pathway within primary care and therefore their experience at this stage is vital in ensuring their safe and effective treatment going forward. Good access to general medical services at their GP surgery is so important as otherwise people will use other services, which are not always appropriate, to access support, assurance and treatment.

During the CCGs Big Care Debate engagement with public, patients and their families there has been a consistent and overwhelming message that general practice services are valued and necessary to maintaining the health of the population. However, there is a real perception that there is not enough capacity within these services to meet the needs of the population and that access to these services needs to improve.

The CCG and NHS England are committed to supporting primary care in North East Essex to provide the best possible services to their patients The CCG recognise that it is in our patient's interest to work collaboratively and responsively with NHS England to ensure that collectively the services provided by primary care to our population does meet their needs in a timely and responsive way. Within the 'Transforming Primary Care in Essex' strategy there is an acknowledgement that across Essex there is an inconsistency in the quality and outcomes of care provided by primary care. Within North East Essex there is a need to reduce the unacceptable level of variability in quality outcomes to ensure that all patients receive the optimum level of care for their condition. Another key issue is the struggle of some practices, especially in Tendring, to recruit GPs and other staff, which is resulting in them now spending less time with each patient due to the demand for their services. There is a recognition that in North East Essex there are not enough GPs to provide a comprehensive service and the CCG will work actively with NHS England to improve the numbers of GPs for every 1500 people.

North East Essex CCG is leading the work, with NHS England, Essex LMC and Health Educate England on Primary Care Workforce across Essex. This includes considering short, medium and longer term workforce planning, for GPs, Practice Nurses and Practice Managers, different models of primary care, the role of primary care in urgent care and organisational development support to enable the primary care community to respond positively and actively to opportunities to play a much stronger role in improving health outcomes. The CCG and NHS England recognise the need to move from a reactive model to a more proactive and supportive model in 14/15. This work has started and will link with the workforce and capacity planning

The CCG is keen to work with NHS England on ensuring that resources from both organisations are invested in the most effective way, this includes both financial and non-financial resources. The CCG will work with NHS England to ensure that all investment the CCG makes into the infrastructure and workforce within primary care can be sustained through the funding available within the NHS England budget.

There is recognition from both organisations that there may be the need to consider different models of delivery of primary care in North East Essex, thus supporting the CCG's vision of creating services around patients rather than organisations. There is a need to acknowledge and respond to the diverse needs of patients within different sections of the community and move away from the one model fits all.

Within the next year the joint working group, which will include patient groups as well as other stakeholders, will produce a small number of different models of delivery of primary care services that will provide opportunities for NHS England and the CCG to commission services that meet the needs of different populations.

In North East Essex we will work with GP Primary Choice – a group of 41 local practices that have come together to form a company to encourage the collaboration and joint working opportunities that the new commissioning approach could offer. This gives the CCG an opportunity to work with a group of practices under one umbrella in a co-ordinated and consistent way to the benefit of our population. It will provide the practices with a vehicle to drive out efficiencies and productivity without damaging the underlying values of each individual practice.

We will also work with NHS England to explore the opportunities for practices to collaborate and possibly merge to further support primary care sustainability in NEE. The CCG has commissioned a piece of work from primary care which will provide guidance to practices who are considering this action as a way of spreading lessons identified.

Within the "Everyone Counts" planning guidance NHS England have determined that there should be a specific focus during 2014/15 on those patients aged 75 and over and those with complex needs. This is further supported by the new GP contract securing specific arrangements for all patients aged 75 and over to have an accountable GP and for those who need it to have a comprehensive and co-ordinated package of care. There is an expectation that similar arrangements will be put in place for those people with long term conditions in future years. The new contract also introduces more systematic risk profiling and proactive care management arrangements for those patients with the most complex health and care needs.

There is an expectation within this document that CCGs will support practices in transforming the care of patients aged 75 or older by commissioning services from primary care to support the reduction of avoidable admissions.

North East Essex CCG will work with NHS England to ensure that this additional investment in services meets the following principles:

- Meets the needs of our local over 75 year old population
- Does not commission services that are already commissioned through core contracts or enhanced services
- That are developed in partnership with patients and practices
- That all plans are aligned and complementary to the Better Care Fund
- Reduces the number of emergency avoidable admissions
- Supports and contributes towards the overarching Primary Care Strategy

The additional investment could be used to:

- Reduce the number of falls resulting in an ambulance conveyance and a subsequent admission
- Work with NHS England to improve the uptake of flu vaccinations in the over 75s and care home residents
- Enhance the end of life services available to North East Essex patients
- Enhance the use of prescribing to reduce the numbers of emergency respiratory admissions
- Commission the range of enablement service to enable people to remain at home without having to get to a crisis in order to receive reablement services.
- Worke with social care commissioners to reach out to people over 75 to support them to access services across health and social care
- Work with Public Health and social care commissioners to commission services to encourage patients over 75 to undertake regular appropriate exercise.
- Encourage providers of health and social care to maximise Making Every Contact Count
- Support primary care to deliver annual health checks on all over 75 year old patients
- Reduce the number of requests for ambulances to attend the over 75's who have not received the assurance that they needed to stay at home and therefore result in a conveyance to hospital
- Support primary care to identify an accountable lead professional for integrated packages of care – though the delivery of the virtual ward model and case management

The CCG will continue to work with stakeholders including our local acute Trust, Colchester Hospital, to improve communication and joint working across different sectors of health and social care in North East Essex. Colchester Hospital have recently recruited a GP to help them to do this which has resulted in the development of a virtual GP office within the hospital, which is going to support the communication between the hospital and GP practices.

6.3 Modern integrated care

As set out in our vision, the CCG is committed to commissioning joined up health and social care for local people. The Care Closer to Home project will

- improve the quality of and experience of care for patients and their carers
- commission integrated, both mental and physical health and social care pathways
- combine and streamline commissioning and procurement across health and social care
- reduce the complexity of care making it seamless at the point of delivery
- promote self-care for patients and support for family and carers
- promote prevention, early diagnosis and early intervention
- deliver more care in the home and community - with care in hospital only where it adds value
- ensure that delivery of health and social care remains sustainable in the context of financial and demographic challenges – QIPP

The final product will be a fully commissioned integrated community service across North East Essex. The model of care will be based on a community gateway service that will co-ordinate the long term management of all patients within the community who require health and social care input to maintain their wellbeing in a community setting. The community gateway will work in collaboration with other community functions such as reablement and virtual ward, which are time limited services designed to assess, treat and improve a patient's wellbeing in the community. The community services will maximise the patients outcomes, identify the continued long term needs and handover the patients to the community gateway and care co-ordinating team. This team will reassess patients on a regular basis to ensure their long term care package addresses the needs identified to manage risk and optimise health.

It is anticipated that the community gateway will be supported by a consultant led MDT to provide support and advice to care co-ordinators when a patients risk categorisation has changed significantly and a revised package of care is required. The referral and assessment route will be supported by a single referral and assessment process, including a decision support tool, which will include documentation and definitive information flows. Agreed response timeframes in the management of referrals will be defined by clinical urgency and outcomes, as specified by the Department of Health 18 week referral to treatment targets.

The service will also include a rapid response service with a response timeframe of 2 hours, linking directly with the Rapid Assessment Unit (RAU) service identified within the Urgent Care Strategy. The rapid assessment unit will be defined as a rapid response to support patients continue their care in the community, preferably at their usual place of residence, however the model does include a step-up bed provision in Harwich and Clacton Hospitals. The rapid assessment/response service is not a clinical emergency service provider; clinical emergencies will be managed through the pathways defined within the urgent care strategy.

The model is based on predictive modelling which will focus on identifying those patient/clients at risk and the pro-active actions that can be provided to avoid deterioration and the requirement for acute care. The model appreciates that health needs are seldom in isolation therefore the integrated assessment and service provision model will provide the holistic approach required to prevent delays and maximise effectiveness.

Older People's Services

Essex CC's Older People's Services can be described in three elements:

- Early Intervention
- Intermediate Care Services and
- On-going Support Care

All elements interact with NHS services but particular focus in 2014/15 will be on Intermediate Care, where an integrated intermediate care pathway is being developed to ensure that people are able to access services at the right time in the right place. This is a key component of the overall frailty pathway and a key support for people in the LTC and Frailty phase of life.

Early intervention	Intermediate care	On-going support

• Information Advice and Guidance (IAG), Self-Serve and Signposting
Strengthening Communities
Targeted approach to prevention and early intervention providing low level services which:
• are community focused
• are community led
• utilise community agents
• encourage voluntary sector development
• prevent social isolation
	Preventative, integrated and targeted approach to expanding jointly commissioned, reablement and intermediate services to:
	• minimise the need for on-going support care services
	• delay or avoid demand pressures from 2014 through:
	  • Rapid Response
	  • Home from Hospital
	  • Domiciliary reablement
	  • Residential reablement
		Long term care
		• Residential / nursing
		• Specialist day care
		• Domiciliary care
		• Continuing Healthcare (CHC)
		• End of Life (EOL)

Within the LTC and Frailty phases, the CCG and ECC share the ambition to enable people to remain safe and independent at home and so will shift their approach to a more preventative, integrated and targeted approach to providing services for older

people, expanding jointly commissioned, reablement and intermediate services. This will minimise the need for on-going support care services, and delay or avoid demand pressures from 2014.

To deliver this ECC will:

- Move to a proactive model of care that addresses key areas of demand which include the high number of people going through acute care that were not previously known to have an assessed social care need

- Work with the CCG to redesign the intermediate care pathway to ensure that the people who use the services are getting the right level of support at the right time and the pathway is joined up to enable people to remain independent in the community
- Deliver its aims and objectives by locating its care and assessment resources and its care services to support people to stay in their homes
- Locate its hospital discharge capacity into the community and intermediate care pathways
- Work with independent and voluntary sector partners to ensure that care services are available 7 days per week to facilitate discharge and avoid unnecessary admission.

- Be looking to benefit from health schemes that allows it to deliver its responsibilities within a cash position 30% lower than its current spend
- Move as much of its resources as possible from residential and domiciliary care into more reablement and proactive case finding to address the issue that most of ECCs demand comes from hospital discharges which is driven by peoples deterioration in health.

End of Life Care Services

The EoL Strategy has been approved by CCG Board. This document is a 5 year strategy detailing the future commissioning of end of life services across the health and social care economy. The document identifies the importance of raising the profile of achieving ‘a good death’ and putting mechanisms in place to achieve this

The focus will be an integrated approach, co-ordinated through a single point of access and determined by the end of life register and advance care planning. The elements of the model to be commissioned include:

- End of life register
- Advance Care Planning
- Single Point of Access
- Key workers/care co-ordinators
- Rapid response
- Specialist Nursing and community teams
- Improving Access to Psychological Therapies
- Hospice Care
- Transport
- Social care

There is a high prevalence of undiagnosed dementia across north east Essex and people with dementia who are dying should have the same access to end of life care services as those without dementia. The Care Closer to Home Strategy will commission services to improve early diagnosis and care for people with dementia, and this strategy identifies action across the economy to support end of life planning for patients, their family and carers and the health and social care workers providing care and support specific to the needs of people with dementia.

6.4 Urgent and emergency care access including winter plans

NEE CCG strategy on Urgent Care, in line with the vision and proposals set out in the Urgent and Emergency Care Review Phase One Report aims to ensure;

- We reduce complexity in the system to enable patients and clinicians to make an informed choice
- There is consistency of provision across the services regardless of what time of day or day of the week the patient presents
- Services are provided by people with the right skills, in the right place and at the right time.
- Utilises the resources available in an efficient way and is sustainable to deliver the requirements through periods of peak demand.

We need to be ambitious and demonstrate to our patients that we have a clear vision of how services will be delivered during the next 5 years. We will commission services that provide the same level of service irrespective of the time of presentation by the patient.

We have identified a number of key enablers to achieve this, including;

- Information Sharing
- Training and development
- Primary care development
- Agreed core hours of delivery on a 7 day basis across the system to reduce complexity where appropriate.
- Commissioned PTS to try and avoid ambulances arriving at ED in waves creating additional pressures,
- Use of QP to improve data collection from Primary Care.
- Working closely with ECIST to explore a system wide 'perfect week' exercise to quickly identify improvements that could be made in the system.
- Redesign of supporting services e.g. reablement, intermediate care, admission avoidance schemes etc. in to one service that is inclusive, responsive and meet the needs of the individual. Services could range from be-friending to double handed care.

<u>NHS IQ</u>

The NEE local health system has also signed up to working with NHS Improving Quality to undertake a series of system wide bespoke workshops (including patients and carers), to identify the requirements from the system in the future. We will be looking to agree a joint vision with all Partners with each organisation being held to account in achieving this aim through aligned incentives. This will include undertaking detailed data analysis of current patient pathways and flows and how future demand is likely to impact on these in future years.

The workshops take place monthly from March to September 2014 and will include commissioning for transformation and improving the whole patient journey. The CCG recognises that the cost envelope will reduce over the coming 5 years and therefore we need to commission services that will provide value for money maximise efficiency.

Additional work which has either started or is scheduled includes:-

- Review of high intensity users in order to develop a multidisciplinary approach
- Wound closure training for ambulance crew to enable patients to stay at home
- Supporting our Acute provider in redesigning their discharge processes for short stay patients.
- A review of the current use of community beds, to move to a model which is focused on the 'step-up' of patients and increased community support. This will include a rapid assessment unit where a holistic assessment of the patients' needs will be undertaken, in order to promote independence and rehabilitation.
- Analyse the benefits of an urgent care centre compared with other models for simplifying and improving urgent care system across the local economy

Our aim is to implement a simplified urgent care system, which effectively channels patients to the right place at the right time rather than expecting patients to choose from a wide range of similar but slightly different services.

A&E Performance

The annual performance for the 95% 4 hour standard is currently below the required standard. Considerable work has been undertaken within our Urgent Care recovery group to recover the target after performance significantly dropped from October 2013. Although this has been a large area of focus across the economy and a number of changes and improvements have been made, it remains a significant challenge to deliver against the year end position.
A number of lessons have been learnt across the system and we are continuing to meet on a weekly basis to ensure the improvements in performance being seen are sustainable and the 4 hour standard is maintained with the increased demands in 14/15.

Clinical Decision Making

The focus continues to be that all patients attending ED will be seen and treated by a senior doctor within 60 minutes of arrival. Patients requiring a specialist doctor should be seen within 30 minutes of referral. Performances against these standards are monitored at the weekly Urgent Care recovery meetings and are accountable to the Clinical Director for Urgent Care.

Ambulatory Care Pilot

This pilot commenced in January 2014, in order to reduce the number of short stay admissions in the hospital and to improve the overall bed flow within the hospital. Initial stages of the pilot have proved successful and therefore this has been expanded to operate 4 days a week.

Staffing Levels

10 additional nurses have been appointed to work in ED and are due to start within the next quarter, with a further 10 nursing posts appointed for Paediatric ED. Recruitment to substantive posts for medical staff is ongoing with temporary staff supporting rota gaps. CHUFT acknowledge that currently there is high medical locum cover and are implementing an acute physician to work the late shift in ED in order to effectively meet the periods of high demand.

Leadership

The change of leadership at CHUFT has inevitably caused some challenges, however it has also provided some opportunities for increased collaboration and we have agreed an integrated approach to the redesign of urgent care with the support of NHS IQ.

A&E Re-design

The A&E redesign is due to be completed by April. It has been acknowledged that this has caused some significant challenges to performance, however, assurance has been provided that the new design should increase capacity to the required levels and contribute to sustained performance against the 4 hour standard.

Process for Winter Planning

The CCG has undertaken an evaluation of the winter schemes implemented for 13/14 in order to fully understand which elements of the system have had the most impact. This will inform our strategy and contract negotiations for 14/15.

The CCG, building on the lessons we have learnt from 13/14 and the outcomes from our winter funding evaluation, the CCG is currently designing a specification for the delivery of community based services. The intention is to use winter resources to increase admission avoidance, accelerate discharge and support patients to be cared for out of hospital. This will take the form of a mini procurement and will require integrated working from all Providers to support the system during 14/15.
An initial draft of this specification will be available by May 2014.

6.5 Mental health services

NEE CCG is committed to lead in developing mental health services to ensure that:

- everyone who needs mental health care should get the right support at the right time,
- people are offered services that encourage recovery,
- those who could benefit from psychological therapy will be able to access suitable therapies and
- physical care and mental health care will work in an integrated way.

In the past five years NEE CCG has invested in Improving Access to Psychological Therapies, with over 30,000 people referred to the service in that period, and has recently procured a new service provider to continue to build on that success.

NEE CCG has worked together with other CCG in North Essex to form a mental health strategy which is out lined below

Joint Health and Social Care North Essex Mental Health Strategy 2013-2017

Our Vision

- People will have good mental health
- People with mental health problems will recover
- People with mental health problems will have good physical health, and people with physical health problems will have good mental health
- People with mental health problems will have the best possible quality of life

We Will Achieve Our Vision By

- Developing and supporting community well-being, encouraging people to maintain healthy lifestyles and keep themselves and their families mentally well
- Improving access and the gateway into services – more effective direction
- Ensuring smooth transition between services (CAMHS/Adult/Older People)
- Ensuring a more holistic and integrated approach to mental health and physical health services
- Developing broader primary and community based models of care for people across the spectrum of mental health conditions
- Ensure in-patient and specialist services are responsive and meet the needs of patients with more complex needs

The Challenges

- Currently 1 in 6 people will experience mental health problems at any one time in their lives
- Prevalence of mental illness is predicted to increase with population growth (a predicted increase in demand of 2.7% by 2020). Predicted increase in prevalence of dementia as a consequence of the increase in elderly people in North Essex
- There is a strong relationship between physical health and mental health
- Inequity and variance of provision across the three North Essex CCGs
- Disaggregation of mental health budgets (CCG/Specialised)

- Insufficient housing and reablement currently for people with mental health conditions leading to delayed discharges
- Effective decommissioning of health services as a consequence of service redesign and roll out of personal health budgets

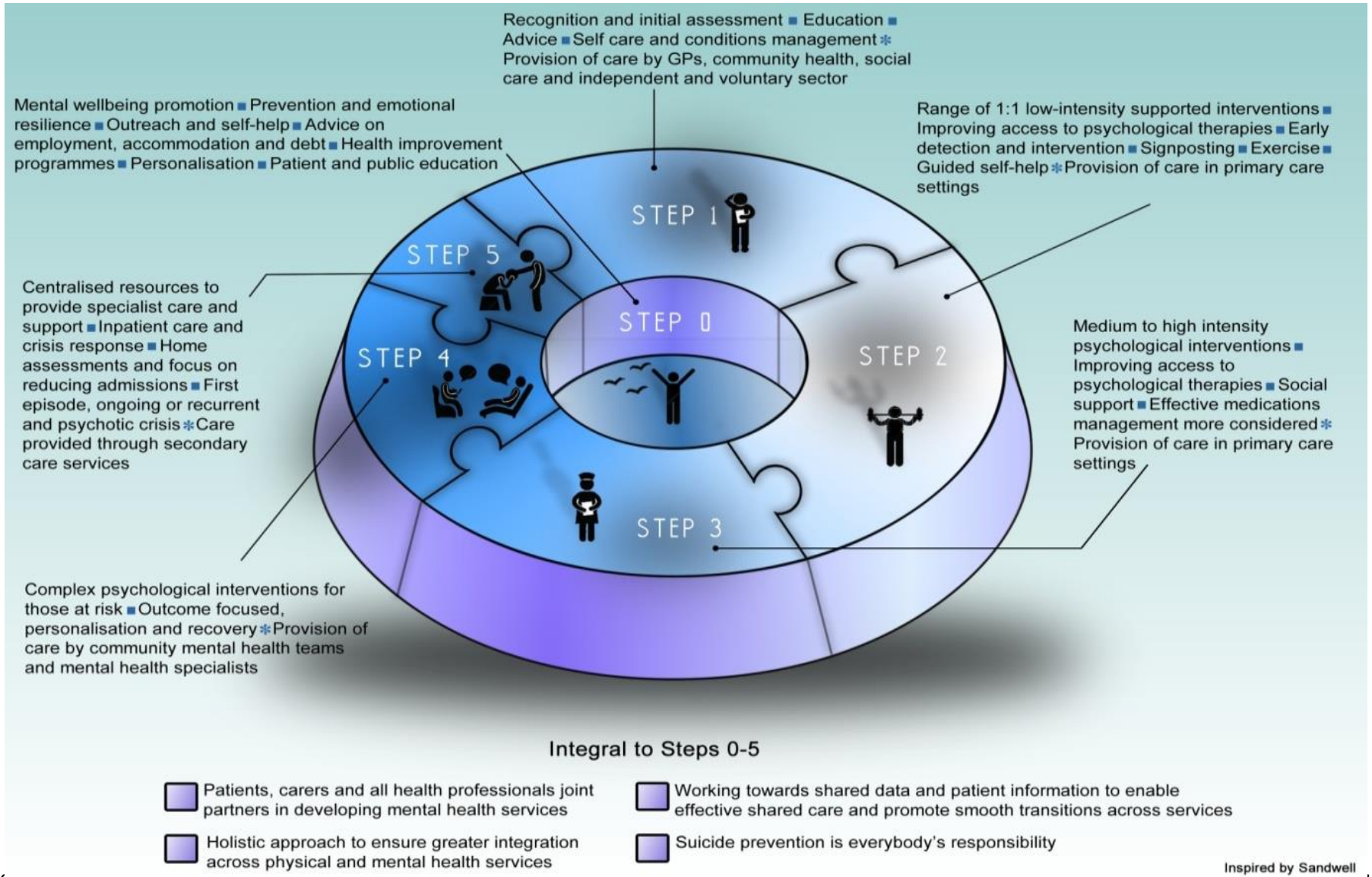
Recent Achievements

- Delivery of comprehensive IAPT programmes across three CCGs
- Development of Recovery College in Mid Essex
- Improving dementia pathways
- Joint Commissioning with social care (section 256)
- ECC development of Community Dementia Service, Accommodation Strategy and Procurement
- Individual Placements
- Veterans First Pilot
- Mother and Baby Psychotherapy
- Personality Disorder Service, joint initiative with Probation service
- Edward House
- Good CQC inspections and reports

Key Messages

- The model will support the wellbeing agenda
- There is recognition that suicide prevention is a responsibility for all.
- All people with mental health condition will receive care in the most appropriate place for their treatment and experience a smooth transition through services
- There is a need to ensure there is a holistic approach with true integration of mental health services with physical health provision
- There is a need to transfer low intensity services into the community to develop greater provision in primary care
- We will maximise our impact by commissioning services through jointly agreed strategies; such as Children and Adolescent Mental Health, learning disabilities, older people and the recently produce mental health clinical outcomes framework
- There is a need to work more closely and collaboratively with voluntary and community services to support local populations

North Essex: A New Model of Care for Mental Health



A New Model of Care

The proposed ambitions and models of delivery have been developed in conjunction with the North Essex Mental Health Strategy.

- No Health Without Mental Health (DH 2011)
- Building resilient communities – making every contact count for public mental health (MIND/Mental Health Foundation Aug 2013)
- Joint Commissioning Panel for Mental Health (series of papers updated August 2013)
- Kings Fund: Long Term conditions and mental health (Feb 2012)
- NHS Confederation: A primary care approach to mental health and wellbeing (2013)

Our local ambitions:

- To develop community wellbeing, supporting and empowering individuals to manage their own mental health
- To develop integrated primary/community based care for the delivery of mental health services and the management of long term conditions
- To establish improved crisis pathways to reduce A&E attendances, admissions and the time people stay in acute beds
- To improve access to services and reduce waiting times for assessments, diagnosis and treatment, including 7 day working and the transition from CAMHS to Adult Services and Adult to Older People's Services
- To improve provision of urgent care pathways, in-patient provision and specialist services

We will achieve this by:

Year 1

- Explore opportunities of joint commissioning with public health colleagues to support early intervention and community wellbeing, including families and carers
- Suicide prevention – commencing with pathfinder application led by Mid Essex – learning to be shared across North
- Establish North Essex Mental Health Clinical Network (likely locality forums) input into service and pathway redesign
- Development of a series of "Think Tanks" to explore across all providers opportunities for improvement. Suggestions to date: Urgent Care, Management of Long Term Conditions, Stroke and Pain
- Further development of IAPT, primary and community mental health services. National Funding/project management support sourced
- Development and roll out of Primary Care (General Practice), Mental Health Education Programme. Link to EQUIP and establishment of North Essex Mental Health Clinical Network

- Commence Development of single point of access (primary care) based. Business case to be produced for individual CCG/North Essex Pilot (6 months)

Year 1 (2014/2015)

- Development of Personality Disorder Strategy for North Essex
- Preparation for joint procurement of new CAMHS tier 2 and 3 service
- Repatriation programme for out of area placements
- Proposed collaborative working with specialised commissioning for Personality Disorders and Locked Rehabilitation Services
- Section 12 Procurement
- Effective contract discussions with NEP to support:
  - Development of proposals to integrate service provision for patients with mental health and long term conditions
  - Improve access to consultant psychiatrists
  - Establishing effective KPIs to improve quality, provision of data and clinical effectiveness
- Development of a comprehensive service review programme to explore and fully understand the provision of NEP services (community, CRHT/inpatient and dementia services), exploring opportunities for integration and to make recommendation for future delivery of the North Essex Mental Health Strategy and CCG locality plans via collaboration and contestability
- Review of Mid Essex Recovery Pilot with potential roll out to other North Essex CCGs

Our local delivery plan:

Year 2/3 (2015/2017)

- Further development of primary care mental health including establishment of “hub” model. Roll out based on early implementers across North Essex. Need to incorporate second level education programme to support new function (required in-practice presence from secondary care and assignment of care workers)
- Development and implementation of GPwSI role – suggestion is to start with dementia. Proposal to work through Strategic Network to understand national practice and build on existing service models
- Implement Mental Health Redesign Programme – based on the finding of the 2014/2015 review programme to enable the delivery of the strategy and local plans focusing on early intervention, community well-being, integration of physical and mental health services, rehabilitation pathways/recovery models and the provision of high quality specialist in patient serviceS

Parity of Esteem

Resources allocation:

The draft North Essex Joint Mental Health Commissioning Strategy 2014 – 2017 has been subject to a period of wider consultation with service users and stakeholders during 2013/14. It sets out to describe the vision for the commissioning and delivery of mental health services for North Essex over the next three years and recognises the importance of joint commissioning with social care, developing community well-being, delivering services closer to home in primary and community settings and the need to integrate physical and mental health services more effectively.

The Strategy has been developed in partnership across the three North Essex CCGs and Essex County Council. The principles of the strategy are now being adopted locally in Mid, West and North East Essex with implementation underway specifically with regards the development of more community based provision for patients with mild to moderate mental health illness.

Both the Strategy and the local delivery plans for mental health recognise the need to improve parity of esteem. The associated work plans include the need to undertake comprehensive clinical service reviews of community, urgent and older people's pathways to better understand provision, patient outcomes and experience. It will also explore the opportunities of further integration between mental and physical health services to close the 20 year gap and to improve urgent care provision. The outcome of this work will be reported to the three CCGs and The North Essex Partnership Foundation University Trust (NEP) in September 2014, with service changes to be embedded either through contract discussions with NEP or as a consequence of a procurement programme likely to commence April 15.

In terms of additional resources, we are proposing a number of CQUINs and service developments to further strengthen the delivery of parity of esteem. The CQUINs include supporting frail and older people including those at the end of their life, those experiencing urgent care services and the adoption of the national CQUIN 'Improving physical healthcare to reduce premature mortality in people with severe mental illness (SMI)'.

Within the proposed Service Development Improvement plan in addition to supporting primary care development, suicide prevention and the safe transition of patients in clusters 1 – 4, we are aiming to establish improved communications by exploring the development of a telephone advice line to provide general advice and guidance including medications and risk. We are also

planning to monitor closely and apply contractual leverage with regards Trust communications/documentation following outpatients/admissions etc.

In respect of on-going projects, The Mid Essex Recovery College and Hub pilot is currently underway and will be evaluated during 2014. The Recovery College delivers educational courses to people with mental health problems, their families, carers and staff who work alongside people who experience mental ill health. It is planned that the learning of this project will be rolled out across North East and West Essex CCG localities.

A key feature of recovery-focused mental health services is the adoption of an 'educational' and 'coaching', rather than a 'therapeutic', model of services. Helping people to recognise develop and make the most of their talents and resources in order to become experts in their own care and do the things they want to do in life. Personalisation reinforces this through the idea that people are best placed to know what they need and how those needs can best be met. It means that people have choice and control for themselves and can make their own decisions about what they require, but that they should also have information and support to enable them to do so.

We are also exploring the opportunities for joint commissioning opportunities with Public Mental Health services. There are plans to explore what has been achieved in Northampton and to consider opportunities as to how this may bring service improvement for North Essex. This may include earlier intervention for children and supporting families.

Improving access to psychological therapies (IAPT) remains a high priority. The local IAPT service has recently been re-procured and the new service goes live on 1st April 2014. Access will be increased to 15% coverage by March 2016. It is envisaged that this new service will support the CCGs proposals to facilitate, where clinically appropriate, the safe transition of patients currently being treated under Mental Health Care Clusters 1 – 4 in secondary care to a primary care setting.

There is an IAPT Children's pilot in North East Essex where we would hope any learning shared and would inform future commissioning opportunities.

Reduction in gap in life expectancy:

In addition to the proposed CQUINs and the SDIP proposals for our Mental Health Service provider, as noted above, there are further plans underway which include the;

- Development of a primary care mental health education programme
- Development of a North Essex Mental Health Clinical Network and Associated "Think Tank" aimed at clinicians working together to develop new pathways both in mental health and the acute sector, this will concentrate on both the development of Parity of Esteem and the Mental Health Crisis Concordant
- A strategy target that 100% of patients admitted to mental health will receive a health check on admission
- Discussions on-going on possibilities of data sharing – the first area to focus on will be investigation results
- Joint commissioning with public health – including programmes focussing on early intervention and traditional public health screening
- The development suicide prevention across North Essex. The programme of work is to be led by Mid Essex as a consequence of receiving a pathfinder grant but learning will be shared across the three CCGs with joint training being made available where possible.
- The development of a personality disorder strategy which will link to both the health and suicide prevention agenda

Finally as part of their longer term strategic plans it is noted that MECCG/WECCG/NEECCG are developing transformation plans for Frailty/Older People which will seek to integrate pathways more effectively involving community, acute and mental health provision.

Young people with mental health problems:

Child and Adolescent Mental Health services (CAMHS) are currently being redesigned and re-commissioned across Essex with a view to improve the emotional health and wellbeing of children and young people from conception to their twenty fifth birthday. One of the primary aims of the redesign is to address the current gaps identified by the Emotional Health and Wellbeing JSNA in particular behaviour management which transcends both paediatric and adult services through transition.

We are also working closely with current CAMHS providers with regards the improvement transition of adolescents to adult services.

6.6 Elective care and productivity

The Care Closer to Home plans include transfer of certain elective pathways into that contract, in clinical areas including: dermatology, ENT, ophthalmology, lymphoedema, tissue viability, musculoskeletal, pain, spinal, rheumatology, urology, ENT.

The CCG is undertaking modelling of the impact of its strategic commissioning plans. This will enable to the CCG to assess whether we can achieve a 20% productivity improvement within 5 years, so that existing activity levels can be delivered with better outcomes and 20% less resource.

These findings will be discussed with providers as part of development of the 5 year plan for the NE Essex care economy. We will work collaboratively with providers and other stakeholders to address any gap between the national aspiration and the CCG's current plans.

6.7 Specialised services

The report into the immediate review of Cancer Services at Colchester Hospital was published on 19th December 2013 and can be found on

Incident page: http://www.england.nhs.uk/publications/incident-mng-rep/

News item: http://www.england.nhs.uk/2013/12/19/review-cancer-services/

Seventeen cancer pathways were visited by teams comprising cancer experts, local GPs, Area Team clinicians and members of the cancer network administration. Six pathways were placed under intensive or enhanced monitoring. These pathways will be re-visited in April 2014 and a second report generated.

The Colchester Hospital cancer action plan is embedded here

CHUFT Cancer Action Plan_28_01_1

The CCG will work with specialist commissioning and NHS England to ensure that the urology and anal cancer are IOG compliant.

The CCG also will work with the 5 Rivers Vascular Network, specialist commissioning and NHS England to ensure that the vascular pathway is compliant.

6.8 Children's services

The requirement to work in an integrated manner between Health and ECC presents opportunities to re-consider the entire CYP structure of delivery and to consider the options for fully integrated services delivering both improved outcomes for service users and cost benefits.

Alongside these fundamentals are significant projects currently being worked up to deliver change/implementation in the following areas;

- Child and Adolescent Mental Health Services (CAMHS)
- The Local Offer delivering centralised access to available services for Social Care, Health, Education and other agencies (**Children and Families Bill 2013**)
- The 'One Plan' the ECC name for the single assessment requirement and data sharing across (EHC) Education, Health and Social Care (**Children and Families Bill 2013**)
- Centralised / shared Equipment services
- Transition to adult services
- Re-commissioning / consideration of Children's Centres and expansion of usage
- Personal Budgets

The project is scoping existing services and aims to deliver the following:-

- Delivery of seamless care pathways for young service users reflecting best practice and NICE guidance
- Equity of access and delivery for all children regardless of disability or disadvantage
- Clear ownership of care pathways but with expanded multidisciplinary team (MDT) opportunities and multi-agency integrated working
- Meeting of all requirements of the **Children and Families Bill 2013**
- Integration between Education, Health and Social Care (EHC) to deliver best outcomes, reduce inefficiencies and generate cost savings
- Delivery of unique early intervention services within Emotional Health & Wellbeing (EHWB) to radically reduce escalation (with accompanying costs and stress) and to work with ECC Family Solutions team to deliver a whole family approach to Children's mental health
- Movement closer to home of activity from secondary and urgent care
- The meeting of NICE and additional clinical standards
- The reflection in all services of the input from service users
- Fully integrated Looked After Children (LAC) and Safeguarding requirements

6.8 Maternity Services

NHS North East Essex (NEE) Clinical Commissioning Group (CCG) and Colchester Hospital University Foundation NHS Trust (the Trust) working in close collaboration with the NEE Maternity Services Liaison Committee (MSLC) are planning changes in the way that community maternity services are currently delivered. This will facilitate the development of the existing service and deliver a less variable service across the district for women and their families with increased local access, support and continuity of maternity care available in the community. There will continue to be provision of a safe service which is clinically and financially sustainable whilst maintaining choice for women in the future.

- The ambition is to continue to provide a high quality, safe service that is equitable and clinically and financially sustainable for the future and provides one-to-one care in established labour whilst continuing to offer a choice of where to give birth and providing increased access and continuity of care in the community. A PID and related documentation including action plan is currently in place

6.9 Intellectual disability services

NHS CCG is committed to offering equal access to service for all the population. People who have an intellectual disability (previously called learning disability) or who suffer with Autistic Spectrum Conditions will be offered reasonable adjustments by all provider services to ensure they can access the same quality of services as the general population. Until March 2014, intellectual disability services were commissioned by West Essex CCG on behalf of CCG s in North Essex but responsibility for services currently offered by health services to people with intellectual disabilities will be transferring to the Local Authority from 1st April 2014. This will include community services and assessment and treatment services currently provided by Hertfordshire Partnership Foundation Trust at the Lexden Hospital site. The key challenges and plans are shown below.

The Michael Report: *Healthcare for All* (2008) and the Mencap report: *74 Lives and Counting* (2012) provide clear evidence that people with an intellectual disability have unequal access to health services and are often at risk through failures to make reasonable adjustments to meet their needs.

The impact of these greater health needs and unequal access to general health services is that people with an intellectual disability are likely to die prematurely. The recently published *Confidential Inquiry into Premature Deaths of People with a Learning Disability*: 2013 (University of Bristol; Improving Health and Lives Learning Disability Public Health Observatory) identifies from the cohort they studied that men with intellectual disabilities died on average 13 years sooner than men in the general population; and women with intellectual disabilities died 20 years sooner than women in the general population. Overall, 22% were under the age of 50 when they died; 43% of the deaths investigated were identified as ‘unexpected’ and 42% ‘premature’ whilst fewer deaths of people with intellectual disabilities (38%) were reported to the coroner compared with the general population (46%).

The view is that an integrated health and social care team is best placed to take responsibility for the end-to-end health and social care experiences of people with intellectual disabilities. This will support an improvement in safeguarding and access to services, enhancing the experiences and outcomes from both health and social care.

Key Patient Benefits
• Experience will improve and better outcomes will be achieved for people with learning disabilities.
• People will no longer become "stuck" in hospital assessment and treatment services (this happens currently because the current pathway between health and social care services is disjointed and managed separately);
• Funding disputes between CCGs and ECC (which can cause delays to people receiving the services they need) will no longer occur; • Social care services will be enabled to work with health services to ensure that people's health needs are being met effectively and that people are being supported to live healthy lifestyles;
• The same health interventions and services will be accessible to people with learning disabilities that are available to any other citizen within Essex.

- The same health interventions and services will be accessible to people with learning disabilities that are available to any other citizen within Essex. - **April 2014**
- Formal Pan Essex integration of commissioning resource (North and South Essex). - **April 2015**
- Service design - Integrated pathways for all cohorts – **throughout 2015**
- Joined-up care management and assessment **– April 2016**

A Modern Model of Integration – Intellectual Disabilities

Principles

- Increasing pressure on the health and social care system is potentially best mitigated through integration.
- There is a pressing requirement to respond to the national Winterbourne View action plan, which requires us to demonstrate that we are delivering joined-up services for people with learning disabilities.
- Integrating LD will act as a key "early adopter" project to test and evidence the impact that can be delivered. The lessons can be translated across other areas

- Integrating LD commissioning will safeguard the benefits defined in the WAA Increasing Independence programme, through ensuring contractual buy-in to solutions that are best for the total combined expenditure
- There is some evidence that demand is a factor not only of demography, but also of the design of the system; an integrated approach to management and design of the system will mitigate the potential negative impacts
- The market continues to innovate and develop solutions for the separate budget and procurement processes. The market will only provide the innovative joined-up community-based solutions when the integrated budget puts those out to tender. Similarly the stand-alone nature of current performance and contract management makes it more difficult to hold suppliers to account for performance across the whole system;

Outcomes

- To improve customer experience and outcomes for people with learning disabilities through integrated pathways
- To create organisational capacity to address the impact of the projected demographic pressures
- To deliver the requirements of the Government response to Winterbourne View
- To bring the commissioning budgets together to drive greater value from the market with an increased focus on avoiding the poor experiences and outcomes which the cohort can suffer
- To drive value as well as managing increasing demand by developing integrated specifications
- To reduce the potential risk of systemic failure by creating integrated care pathways that improve experiences
- The development of integrated care and support pathways, to deliver the integrated specifications to deliver the *"Behaviours that Challenge"* work stream within the "*Increasing Independence for Working Age Adults"* programme*
- To address the issue that people with learning disabilities continue to have lower life expectancy and experience poorer health outcomes than the general population, despite increasing levels of funding over recent years

Priorities

- The approach to commissioning will have changed to enable people with learning disabilities to have improved customer experience and outcomes.
- Commissioning teams for Health and Social Care will be co-located, with commissioners working as a single team to define integrated specifications
- Commissioning of services will be carried out as a joint activity between Health and Social Care, with budgets jointly managed
- There will be an approach to governance in place which enables and operationally manages joint commissioning and provides delegated authority to make commissioning decisions
- Commissioners will commission services which are delivered via integrated pathways between Health and Social Care, with seamless service and minimal hand offs
- People with learning disabilities will be supported to live healthy and fulfilling lives, with health and social care services working together to enable this to happen.

SECTION 7 ACCESS

7.1 Access to all services especially Mental Health services and tailored to minority groups

Alongside the CCG's engagement model (see section 6) our CCG will be relying heavily on what people from the protected groups within the equality act told us when we undertook the Equality Delivery System. We have developed objectives that will address reducing inequality and improving health outcomes, experience and access. Underneath these objectives will be outcomes and measures which we hope to report on to our stakeholder groups so we are held to account for delivering good access to services for minority groups.

7.2 NHS Constitution standards

The CCG monitors monthly performance against the NHS Constitution standards, below, ensuring that local providers uphold patients' rights within the agreed thresholds. Where individuals do not receive their treatment within this framework; the CCG ensure that patient safety has not been impacted in a negative way. Where providers fall below expected standards contractual mechanisms are used to ensure that performance is improved and where appropriate a remedial action plan is formed to manage sustained improvement to the measure.

The CCG monitors on a daily basis the health care systems performance against the standards expected in the NHS Constitution. Whilst local urgent care services have worked hard to ensure their performance remains above the established thresholds during periods of peak demands, unfortunately this has not been consistent in terms of the 4 hour A&E standard. The CCG are currently holding weekly recovery meeting with all system partners to troubleshoot where any issues lie and implement mitigation plans to overcome these. These meetings are focusing on sustainable improvements which have

resulted in improvements to performance and we will continue to closely monitor and support organisations in maintaining these standards

Cancer standards have fallen below thresholds on a number of occasions in 2013-14 this initially came to light after the Keogh review, subsequently Colchester hospital has been placed in special measures whilst cancer services are investigated. The CCG has worked with cancer leads at the hospital to monitor cancer waiting lists to ensure that patient safety has not been affected by any delays in their pathways. As a result of the investigation and this work a number of cancer tumour site pathways are being reviewed and plans are in place to improve the effectiveness of these pathways. Monitor is working with the trust to improve cancer standards and subsequent CCG plans will reflect the outcomes of the agreed action plan.

The CCG is part of a commissioning consortium working with the East of England ambulance service, which has not been able to uphold the NHS constitution pledges for ambulance response times. The lead commissioner had agreed a remedial action plan with the ambulance service which has not produced the expected results. A recent risk summit has been held to identify what can be done to improve ambulance responses and the results of this summit will be reflected in subsequent CCG plans.

NHS Constitution Standards can be found in full in Appendix D and are explained further in the NHS Constitution handbook which can be found online

The CCG monitors performance against the 3 pathways for referral to treatment where 90% of patients should be treated within 18 weeks if their treatment requires an hospital admission, 95% if treatment can be provided in an outpatient setting and 92% of patients still waiting for treatment have not exceeded 18 weeks. These thresholds apply to both aggregate and specialty level, Colchester Hospital are currently underperforming in a number of specialties and have invited the intensive support team in to provide guidance, their review is expected to report in March. At the present time several specialties including dermatology and ENT are not expecting to have reached the required threshold until June 2014. The CCG are working with CHUFT colleagues on a weekly basis to identify issues with long waiters on their outstanding patient waiting list. As soon as the Trust's remedial action plan is received this will be closely monitored by the CCG, with the intention of ensuring that these standards are recovered in a timely fashion.

7.3 Digital access and data – to be added

Through its website, the CCG provides links to NHS Choices and other websites offering information and signposting, which help patients to make informed choices.

Telehealth and telecare can be effective ways of helping patients to maintain independence. We will expect providers to include these in their models of care, but in line with our outcomes-based commissioning approach we will not be prescriptive, but rather devolve decisions on how best to use these to the providers.

Community voluntary services provide training in health literacy but the CCG will explore further ways of supporting this work?

The CCG receives assurance from CHUFT that all patients undergoing procedures for hip and knee replacements, groin hernias and varicose veins are offered the pre-operative questionnaire as part of the national survey on Patient Reported Outcome Measures. These are followed up nationally, asking patients to complete the second part of the survey.

The CCG has not been able to use the NHS number for a prolonged period due to national restrictions. Having been granted Accredited Safe Haven (ASH) status and having put DSCRO arrangements in place, the CCG is now in a position to begin receiving patient identifiable data. Ongoing restrictions apply, but the CCG will be in a position to use NHS number, or a pseudonymised version of, for 2014/15 reporting.

In line with ECC, our strategic ambitions for data management, systems development and performance/financial reporting have the NHS number as a single consistent patient identifier. This is crucial for us in terms of understanding patient pathways and end-to-end commissioning of these – and providing quality data to GP Practices to support patient care. As noted there will be restrictions on the CCGs ability to receive process and share the NHS number with other parties, and this will include data sharing with ECC for non-primary usage purposes.

SECTION 8 QUALITY

The CCG quality team have integrated into the bundles structure of the organisation with quality leads for mental health, care closer to home, urgent care, maternity and children's care and end of life. The quality team provide clinical input into the development of the strategic plans through the bundles work with specific input into;

- Developing new pathways/models of care
- Resource modelling in relation to beds and staffing
- Risk management and safety
- KPIs
- CQUINs

The clinical quality agenda is part of the overall contract monitoring agenda with monthly (or more frequent) meetings with all providers through the Clinical Quality Review Groups.

The team take a multi-faceted approach to assuring quality across the organisation and across providers;

- Contracts; developing KPIs, CQUINs, safeguarding and infection prevention and control, producing quality accounts. The CQRG is now part of the overall contract monitoring agenda.
- Walkarounds; a schedule of multi-practitioner walkarounds across all providers is undertaken against specific quality checklists with lay members attending to capture patient experience direct feedback. The outcome of the workarounds forms part of the overall performance monitoring.

- Procurement; the quality team provide specific information and PPQ standards to inform all procurement processes and participate in tender evaluations.
- Patient safety; working both strategically and locally processes are in place for the management of SINE
- Complaints management and PALs; overall co-ordination and reporting and review.
- Monthly Quality Committees; addresses all elements of quality across all disciplines and provides action and mitigation for the corporate risk register.

8.1 Response to Francis, Berwick and Winterbourne View

A focus for the CCG has been the outcomes of the recommendations of the Keogh review; The Keogh Review into the quality of care and treatment provided by Colchester Hospital University Foundation Trust (CHUFT) identified the need for further joint working across the economy to find solutions for patients who could appropriately be at home, or in their normal place of residence to receive end of life care.

The CCG have worked collectively with all providers to produce a North East Essex End of Life Strategy which clarifies the economy wide approach to the provision of the best practice model of care supported by the commissioning intentions for the delivery of this best practice model. The model includes; my care choices, a single point of access, improved training across all service providers to support the Gold Standards Framework, improved carer and family support including care after death.

The model identifies the economy wide approach to single point for all patients and service providers and the success of this is qualified by the activity reports, patient feedback and provider feedback. An example is the very successful work undertaken between St Helena's Hospice and the East of England Ambulance Service Trust to provide the education and training for ambulance staff attending patients who are at end of life and how to access the single point and the best support for the patients through the rapid response service, avoiding patients experiencing unnecessary A&E attendances in the end of life.

The Keogh review found that the Summary Level Hospital Mortality Index (SHMI) at CHUFT was higher than expected and concluded that this was in part a consequence of the lack of genuine choice and support for patients and their families in identifying their preferred place of care.

Much work has gone on across the economy to implement ‘my care choices’ empowering patients and their families to plan for their end of life with the care and support appropriate to them and identification of the preferred place of care. Activity figures across NEE identify that 37 of the 43 practices are participating in my care choices. Quarter 3 reports identify 65% of patient deaths were on the end of life register and 49% of these patients died at their preferred place of care.

The community have also faced challenges as a result of the outcome of Monitor’s review of cancer services at CHUFT. The CCG have worked jointly with Monitor and the acute provider to review all processes and implement changes in many aspects of the care provision to assure the quality and safety of cancer services at CHUFT. The quality team have been working to support the review of complaints and incidences raised by patients and or their relatives as a follow-on to the release of the Monitor report.

The Report on Winterbourne View came about as a result of BBC Panorama programme, which exposed abuse at this private hospital in Gloucestershire for people with intellectual disabilities and challenging behaviour. The abuse was criminal and management allowed a culture of abuse to flourish. The key recommendations of the report were to:-

- Commission the right model of care, focusing on individual needs
- Commission flexible, community based services
- Listen to people and their families
- Spot and act on early warning signs
- Only local action can guarantee good practice, stop abuse and transform local services.
- Minimise number of people requiring hospital admission due to lack of early support
- Plan for transition from children to adult services to avoid crisis.

The following action points form part of the delivery plan for services for people with intellectual disabilities which is now in place:-

- Implement Winterbourne and DH requirements including local registers and person centred support/move on plans for everyone in health funded in-patient services.
- Implement integrated model of care, joint commissioning and procurement including pooled budget
- Introduce a single birth to 25 years assessment process and individual birth to 25 years Education, Health and Care Plans through the Children and Families Bill.

8.2 Patient safety

Patient Safety is a key domain of ensuring overall delivery of a quality service and will continue to be reviewed monthly via the Clinical Quality Review Group; concerns with provider performance against safety standards are escalated internally to the Quality Committee and through to Board, to ensure that key safety concerns are always recognised and acted upon in all levels within the CCG.

The CCG fully support the Harm Free Care agenda across all commissioned services and will continue to work with all providers to ultimately ensure that no avoidable harm is caused. To support the Harm Free Care agenda, the CCG collaboratively works will all providers and other CCGs in North Essex to hold the Harm Free Care Collaborative, which actively shares good practice and lessons learnt across all providers on a quarterly basis.

The CCG work collaboratively with providers in the management of health care acquired infections and strive towards zero tolerance in relation to existing MRSA and Clostridium Difficile across the systems.

New initiative and CQUINS will be used to address incidents of surgical site infections and catheter associated urinary tract infections. This has included the revision of surgical prep and the use of catheter passports.

The Quality Team, on behalf of the NEE CCG manage and co-ordinate the processes for the management of serious incidents. The systems and processes are consistent with and aligned to the NHS Commissioning Board Serious Incidents Framework.

The CCG Serious Incident Management Policy (July 2013) provides guidance to the local health economy providers and managers to take appropriate steps in the best interest of their patients/clients/service users, staff and the NHS as a whole. It details the minimum reporting requirements expected in North East Essex.

The CCG is responsible for holding to account NHS funded acute, community, mental health and other commissioned providers for their compliance with this policy and where appropriate to co-ordinate serious incident investigations.

The role of the CCG is to ensure that serious incidents are robustly investigated, that action has been taken to improve clinical safety and that lessons have been learned and widely disseminated in order to minimise the risk of similar incidents occurring in the future.

As part of the North Essex Quality Collaborative, NEE CCG Quality Team review serious incident reports across North Essex as part of a panel review and internally review serious incident and never events at a weekly assurance meeting. The north Essex SINE panel ensure peer review of local processes, and shared learning across north Essex.

Reports are produced by the Quality Team and shared internally with commissioning teams and externally with provider organisations at the Clinical Quality Review Groups and providers are held to account for any themes that are occurring and Learning from Experience Action Plans (LEAPs).

All providers are required to demonstrate evidence that they have robust systems in place for the dissemination, management and monitoring of all safety alerts.

The Quality team have had a key role working with Monitor and Keogh in providing assurance to the safety of the cancer pathways locally.

The Quality Team have been in discussion with NHS England to request information by practice of any serious incident or never events to ensure the CCG are aware of any safety issues across the economy.

Several indicators are monitored for each provider through the Clinical Quality Review Groups focussed specifically on national safety triggers; VTE risk assessment and treatment, MUST nutritional assessment, intentional rounding, falls, duty of candour, think glucose assessment tool, reporting of grades 2, 3 and 4 pressure ulcers, safeguarding training, children and adults, HSMR.

Issue logs from the CQRG meetings are reported to the CCG Quality Committee for review, advice, actions or escalation to the CCG Board.

8.3 Patient Engagement

The CCG engaged with over 800 people face-to-face and 200 people completed online surveys regarding patient experience and views from November 2013 to February 2014 at a series of meetings, some specially arranged, some joining pre-existing groups and societies. Specially convened meetings for ethnic, age and gender groups were also included. All comments were recorded, analysed and used to inform planning strategies and commissioning projects. The three key themes from the engagement exercise were;

People voted at the meeting to say that the best way to stop the NHS going bust is early help and advice so that people can be treated in the community rather than in hospital.

- People voted to say the best way to get better access to your GP surgery was a guarantee to see a health professional, such as a nurse, within 24 hours;
- People voted to say the best way to look after yourself and help the NHS was to develop ways to support people better who live with long-term conditions
- Patients have been involved in designing service, such as the engagement re diabetes mobilisation, and involvement in procurement, such as diabetes procurement process with Diabetes UK reps.

The public were also engaged in the work of the Maternity Services Liaison Committee regarding the Maternity Services Review and the patients and public meetings held for people interested in the Community Beds Project at Clacton Hospital. From the Big Care Debate, patients and public have made their priorities and views very clear, with support for self-care, easy and quick access to services, prevention work, integration and avoiding waste. The Big Care debate targeted a range of vulnerable groups where the agenda was tailored specifically for the audience. We also shall be acting upon the feedback provided at a recent Equality and diversity event where vulnerable groups helped shaped the objectives for our organisation going forward. The ambition is to incorporate carer feedback as part of our integrated agenda with Essex County Council. Future commissioning plans, including improving the experience of carers, have been developed with carer's groups where suitable and relevant outcomes are expected to be in place to measure this.

8.4 Patient experience

The CCG PALs and Complaints service monitor the issues, complaints and platitudes received from patients with regard to commissioned services and where multiple providers are involved in a complaint.

If the PALS contact is an informal concern they will follow up with the provider of the service, or the commissioner of the service, to find answers for the person contacting

Answers are fed back to the person contacting, by the same method used to contact initially, which is usually telephone or email. If they are happy with the explanation or the PALS team have been able to resolve or put right what has gone wrong it will be closed and information recorded on the PALS module. Patients are kept up to date with progress throughout the enquiry.

If the issue is not resolved the person will be advised how to make a formal complaint and who that can be made to. In straightforward cases this will always be the provider. CCG complaints only deal with those relating to commissioning decisions or where more than one provider is involved and the providers cannot agree who should lead on the complaint.

Information about the contact is recorded on Datix and is used in bi-monthly PALS and Complaints reports to the CCG Quality Committee (anonymised). The Quality Team also uses data from the provider monthly reports to CQRG's in the reports to identify any trends emerging about particular services. If a trend is identified before a report the team will raise this as an issue within Quality Team Management Structure and action taken to raise this within the CCG or appropriate service.

The PALS and Complaints team provide monthly reports to the Quality Committee as a measure of the patient experience across commissioned services and to ensure these issues are being addressed and escalated when required. The Team also provide commissioning teams with reports to support improvements required within contract management and to inform commissioning processes when new services are being commissioned.

The CCG take part in the Essex wide Patient Experience Forum and the feedback from this meeting is reported through the CCG Quality Committee.

Within the development of all service specifications, key performance indicators are identified specifically in relation to patient experience. All providers are expected to capture patient experience information and this information is reported at the CQRGs on a monthly basis. Our acute and community providers use a combination of patient experience trackers and questionnaires. The Friends and Family test has been implemented by both our acute and community providers; through the minor injury units and A&E, through the inpatient units and across community and inpatient maternity care. The inpatient capture has remained fairly consistent at 15 % however maternity capture is proving difficult due to the subdivision of the care pathway across antenatal and post natal as well as across the two care settings, acute and community. A&E and Minor Injuries units are now piloting various data capture methodologies in an attempt to encourage patients to provide a response to the F&FT. This will be reviewed in the spring to determine how effective the various methods have been and if this would be suitable for use across the maternity service.

The Children's Commissioning team within the CCG have been working jointly with Essex County Council Children's Leads as well as working pan Essex with health care and education to identify areas for improved joint commissioning and the implementation of national guidance.

The CCG are part of a collaborative commissioning group that commission the CSU to manage the provision of Personal Health Budgets, working jointly with the centrally commissioned Continuing Health Care Team at the CSU.

Working jointly with ECC and the Public Health Team, the CCG are guided by the joint strategic needs assessment (JSNA) to identify particular areas of need and the type of services to be commissioned. The JSNA, national directives (NHS Mandate, Winterbourne View, Francis Report) and local directives (Keogh Review) have been used to inform the commissioning strategies for the CCG; Care Closer to Home, End of Life and Urgent Care.

8.5 Compassion in practice

The CCG is in the process of developing its Quality Strategy. This strategy is aligned with the Governments Compassion in Practice campaign, underpinned by 6 Cs. These are:

- Care
- Compassion
- Competence
- Communication
- Courage
- Commitment

The Government launched an implementation plan to ensure that the 6Cs are embedded in practice. The CCG vision and strategic direction relates directly to the six action areas were identified:

Number	Action	CCG Strategic Agenda
1	Helping people to stay independent, maximizing well-being and improving health outcomes	Care Closer to Home Strategy focusing on ensuring the appropriate care and support is available where and when patients need this. Developments such as risk stratification, virtual ward, reablement, handy man services, hospital to home have been put in place to support patients and their carers to remain at home safely for as long as possible. End of Life strategy – ensuring patients are supported in their preferred place of care

		The Care Closer to Home Strategy ensures care co-ordination in the long term management of patients with care co-ordinators for all patients experience sustained disruption to their wellbeing as a result of one or more long term conditions. The care co-ordinators are supported by a community multi-disciplinary team.
2	Working with people to provide a positive experience of care	The CCG and Essex County Council have undertaken a consultation with the NEE population to identify what the people across NEE want from their health and social care commissioners. This information has been collated and used to inform the strategic direction for integrated commissioning. The CCG have a PALS and Complaints Policy and this is managed by the PALS and Complaints Team. The team provide weekly complaints reports, monthly PALS and Complaints reports by themes, attend PALS meetings with provider organisations and provide patient stories information to commissioning teams to inform commissioning and performance management processes.
3	Delivering high quality care and measuring impact	All working groups across the CCG have representation from Patient Forum members.
4	Building and strengthening leadership	The CCG are working jointly with the Local Education and Training Board to identify training and development requirements across the economy in the realisation of the commissioning strategies.
5	Ensuring we have the right staff, with the right skills, in the right place	The CCG have commissioned an external company to provide organisational development across the CCG workforce to assess the capabilities of the teams against the organisational needs and to address the development gap to support the delivery of the strategy. Staffing resources for commissioned services are outlined within service specifications in relation to levels of

		qualifications/professional registrations and experience. Some staffing levels are reportable through the CQRG for example maternity services. All strategic developments for example the care Closer to Home Strategy, Urgent Care Strategy and End of Life strategy are shared with LETB and they in turn provide an advisory and intermediary role in the workforce planning. Joint funding has been identified with the CCG and ECC to recruit a project lead for the role out of 7 day working across the health and social care economy in NEE.
6	Supporting Positive Staff Experience	Staff surveys are used to inform the management team of how people in the organisation feel about their roles and contribution. Action plans have been put in place to address areas identified for improvement; Investment in staff with regards to training budgets, training sessions in-house on a variety of strategic issues, support and counselling offered for staff affected by the outcomes of the recent CQC cancer review at CHUFT. The Organisation's Whistleblowing Policy is currently being reviewed to incorporate whistleblowing within the CCG as well as within provider organisations.

The Quality Team have lead advisor roles within each commissioning bundle and have the responsibility for assuring the level of quality in the care commissioned. Using the Quality Impact Assessment Tool, each service to be commissioned is RAG related to provide the level of quality assurance from the proposed service plan. This process also provides information on areas within the service proposal that need further clarification and improvement actions in order to ensure the service is safe, effective and value for money. The QIA tool measures the level of compliance against; clinical effectiveness, patient experience, patient safety, governance and value for money.

Quality Leads take responsibility for working with providers in relation to any CQC reports and actions required, providing assurance or recommendation to the CCG Board through the monthly Quality Committee. The Quality Team triangulate information received through the CQRG, SI Reports, Complaints and issues identified during walk arounds, to identify any areas of concerns. These are raised with the providers and with the CCG Programme Board. Failure to receive assurance within specified timeframes results in escalation to Executive Board level and decisions are then made of further escalation.

8.6 Staff satisfaction

As a new statutory body, the CCG held its first annual staff survey in autumn 2013. The survey was designed by a focus group of staff and the topics included development opportunities, job satisfaction and health and wellbeing. Outcomes were shared with staff and are being used in the refresh of the CCG's Organisational Development Plan. The first in a series of follow up surveys has already been carried out and will be repeated at regular intervals.

8.7 Seven day services across Health and Social Care in North East Essex

Introduction

The North East Essex Health and Social Care system are keen to explore further the benefits for our population on providing a range of services across a seven day week.

North East Essex CCG have, as part of the call to action and to meet their statutory responsibilities, participated and hosted a number of events during the past 6 months to capture the views and thoughts of our local population. There have been a number of themes that have emerged from this work which we are including in our planning processes.

One of the key messages from the public was the need to use the resources we have across 7 days a week to maximise efficiencies of estate and workforce. There was a clear message that services, especially those in the community and primary care were often not available during out of hours when required, resulting in patients reaching crisis point and then accessing emergency services.

NHS England have stated in their Everyone Counts: planning for patients 2014/15 to 2018/19 that the seven day a week services is an essential component for the NHS to focus on. There is no 'one size fits all' answer to introducing seven day services and therefore local solutions need to be found. However, NHS England did commission a forum, chaired by the National Medical Director, to consider how NHS services could be improved to provide a more responsive and patient centred service across the seven day week. http://www.england.nhs.uk/wp-content/uploads/2013/12/brd-dec-13.pdf

This forum has made a number of recommendations which the CCG plan to consider with system partners – these include:

- The forum's clinical standards should be adopted to support the NHS to drive up clinical outcomes and improve patient experience at weekends and that these should be adopted in every community in England by the end of 2016/17
- That NHS England and other commissioners use incentives, rewards and sanctions through the contract to support the scale of change required.
- That the Better Care Fund (BCF) is identified as a key enabler for change and that CCGs and Local Authorities utilise this resource to support seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at the weekend.

The 2014/15 GMS contract changes also support this by introducing a new enhanced service to avoid unplanned admissions and proactive case management and continuing to commission the extended hour access enhanced service

As financial and service pressures intensify within health and social care, the need to accelerate integrated care to improve patient's outcomes and experience have never been greater.

In June 2013 the Chancellor announced in his spending round that there would be a £3.8 billion Integration Transformation Fund created (this is now called the Better Care Fund) which would enable the pooling of budgets for health and social care services to enable closer working in local areas. In NEE Essex we have specifically indicated that during 2-14/15 we will utilise the BCF as one of our enablers for moving towards routine health and social care services being available across 7 days a week.

Key Points to Note:

- North East Essex health and social care system need to develop an approach to 7 day a week working, from both a commissioner and provider perspective. This approach needs to be developed with the local population.
- Seven day a week working is not just about the hospital – it is about the whole system, which includes health and social care. It does not just mean NHS providers either, NEE will need to co-develop a strategy that covers all providers if appropriate.
- The strategy will need to consider a range of issues and challenges including workforce planning.
- The NHS England, NHS Services Seven Days a week forum, have produced a set of clinical standards describing the standard of urgent and emergency care that all patients should expect to receive seven days a week. These should be used in NEE as basis for developing plans.
- The Better Care Fund should be used to enable the health and social care system in North East Essex to develop a comprehensive action plan to deliver the clinical standards.
- Opportunities need to be explored and tested out with primary care to provide general medical services across a 7 day a week period using the current contractual arrangements and by working with the GP Provider company to maximise resources efficiently.

Actions

- North East Essex in partnership with Essex County Council and Health Educate England recruit a fixed term programme manager to work across the system to develop:
    - Seven day a week service strategy for NEE
    - A system wide action on how to deliver the clinical standards as defined by the forum
    - A system wide workforce strategy on how the system will deliver 7 day a week services in an environment that needs to deliver consider financial efficiencies
- The development of the strategy feeds into overall commissioning strategy for North East Essex CCG
- Progress against this programme of work reports into the Integrated Commissioning Programme Board
- That any learning is shared with the wider Essex community

8.8 Safeguarding

The CCG safeguarding monitoring is in line with Section 11 of the safeguarding audit tool. This provides the CCG with the assurance that providers are meeting the safequarding regulation and contract requirements. Providers are required to evidence;

- Senior management leadership and commitment to safeguarding
- Lines of accountability
- Embedded safeguarding policy
- Interagency working
- Information sharing
- Learning and improvement
- Service development and emerging issues
- Safe recruitment, vetting and allegations management

The expectation is that providers will attend the Health Education Forum where the attendance is monitored and this forum reports to the ESCB. External assurance is provided by CQC and Ofsted.

Identification of domestic abuse is implicit in all training packages and an expectation that all practitioners will demonstrate an awareness of domestic abuse and how to escalate these concerns. Further joint working will be undertaken with ECC in progressing the planned provision of services.

8.9 Medicines management

The main elements of the medicines management policy are:-

- Working across the health system in NE Essex to optimise patient's medicines and obtain value for money
- Targeting antibiotic prescribing - supporting practices with reduction of prescribing and ensuring that appropriate drug choices and treatment length are made for each infection
- Optimising respiratory care across the health system – to include ensuring appropriate lifestyle interventions have been made e.g. stop smoking, reduced exposure to allergens, appropriate referral to pulmonary rehabilitation, improved patient inhaler technique, training for practice nurses, cost-effective drug choice and appropriate use of BTS guidelines for asthmatics. Engaging with secondary care, patients, practices and community pharmacies to deliver the agenda
- QIPP will be implemented using pharmacy technicians to support practices and the Prescribing Incentive Scheme as an enabler
- Supporting practices with optimising prescribing in angina
- Continuing to promote safety in prescribing across the health system e.g. appropriate use and review of drugs, prescribing in the appropriate sector of care, regular review is taking place, shared care agreements are in place and up to date
- Supporting medicines management and medication review for residents of care homes
- Medication review for patients with dementia taking antipsychotic medication
- Supporting service redesign to ensure that they incorporate appropriate medicines management principles
- Managing the introduction of new drugs
- Ensuring that Nice TAs and guidance are implemented
- Ensure the safe and appropriate use of anticoagulant therapy in the management of non-valvular atrial fibrillation
- Encourage effective joint working across the health economy to ensure safe and effective use of medication particularly in the management of long term conditions.
- Promote effective communication at transfer of care (secondary to primary care, transfer to residential care) to ensure medication safety and continuity of care.

SECTION 9 PUBLIC HEALTH IMPROVEMENT IN NORTH EAST ESSEX

Public Health Commissioning

The Public Health vision for Essex is for the people of Essex to enjoy long, healthy, disease free lives and for this to be possible wherever they live and whoever they are.

Essex County Council's Public Health spend in the NEE CCG area is £8.6m. The Public Health commissioning strategy is informed by the Essex Health and Wellbeing Strategy, the Essex County Council Corporate Plan, the National Public Health Outcomes Framework, centrally mandated areas for public health action and locally assessed needs.

ECC's strategic approach to public health was informed by a member's reference group that defined four key principles. These are in line with the CCG's commissioning approach:

- We recognise a broad definition of health and public health interventions
- Our approach will be locality focused and led
- Addressing health inequalities is a priority
- We will commission what evidence tells us is needed locally and what works

Mandatory Deliverables for ECC Public Health:

- Sexual health services – STI Testing and treatment
- Sexual health services – Contraception
- NHS Health Check programme
- Local Authority role in Health Protection
- Public Health advice to the NHS
- National Child Measurement Programme

ECC Public Health Spend in NE Essex

Other services commissioned include priority areas from the JSNA, and services that deliver system productivity. Evidence shows that improvements can particularly be made from new, enhanced and/or targeted spend in the following areas:

- Falls prevention
- Alcohol harm reduction
- Enhanced diagnosis of cardiovascular disease in older people
- Diagnosis and treatment of depression in older people
- Smoking cessation support
- Improved public mental health
- Improved physical activity rates
- Reducing obesity rates
- Child health services
- Drug and alcohol treatment
- Gypsy and Traveller health
- Domestic violence advocacy
- Workplace health

ECC Public Health Spend in NE Essex by Clinical Area

Service Area	**Spend (£000s)**
Alcohol/Substance Misuse	£169
Breastfeeding Support	£167
Community Wellbeing / Health Improvement	£458
Falls	£570
Grant - Alcohol/Substance Misuse	£145
Grant - Community Health Services	£519
Grant - Other	£140
Grant - Targeted Parenting	£18
Health advice, prevention & promotion	£436
Health Checks	£943
Health Trainers	£543
Obesity/Weight Management	£487
Other Public Health	£122
Physical Activity	£55
School Health Improvement	£898
Sexual Health - chlamydia screening	£319
Sexual Health - GUM	£1,560
Sexual Health advice, prevention, promotion	£504
Stop Smoking Services	£572

TOTAL	**£8,624**

The CCG has agreed with ECC colleagues that public health services that support Care Closer to Home service bundle will be commissioned in an aligned way, ensuring public health and CCG-commissioned services provide an integrated and seamless service.

NHS England / PH England Local Area Team Public Health Deliverables

- The number of Health Visitors will increase to 383fte by 31 March 2015.
- Family Nurse Partnership will be rolled out across all of Essex.
- Improved child health information services (CHIS) resulting in better outcomes for children and families.
- Commissioning responsibilities for the 0-5 Healthy Child Programme will be successfully transitioned to local authorities.
- Increases in immunisation coverage, particularly in respect of MMR at both 2 and 5 years and Influenza amongst clinical risk groups.
- Implementation of a Meningitis C catch up programme for university entrants.
- Continuation of our childhood flu vaccination pilot in South East Essex for primary school children. Pilots of childhood flu vaccination for secondary school children will be developed.
- A review of the commissioning arrangements for vaccination programmes will be complete and outcomes actioned.
- All Diabetic Eye Screening providers will be implementing the Common Surveillance Pathway.
- All Breast Screening providers will have implemented age extension.
- Introduction of flexible sigmoidoscopy into bowel screening programmes.

- Improved outcome measures across all screening programmes.
- Improved quality within Sexual Assault Services Pathways, and new contract for SARC.

SECTION 10 RESEARCH AND INNOVATION

In line with the NHS Constitution, NEE CCG is required to:-

- Be Research Active, including promoting patient participation in research
- Ensure research and management governance arrangements in place
- Ensure knowledge management and evidence based commissioning is practised

We will:-

- Make patients aware of opportunities to take part in research.
- Promote research :-
    - There is a section on the our website about research and innovation, with links to the National Institute for Health Research website, which lists all portfolio studies eligible for support in NHS;
    - Work with Essex &Herts Comprehensive Local Research Network (CLRN) to promote research via display screens in waiting areas etc;
    - Work with NE Essex Health Forum to promote research;
    - Work with NHS England to promote primary care research and cascade information, e.g. on Research Incentive Support Scheme, to practices.
- Share membership of CLRN Board between the three North Essex CCGs.
- Encourage participation in Primary care research projects and Local Specialty Groups funded by the E&H CLRN. These groups consider local feasibility matters for studies to proceed locally.
- Ensure providers have in place arrangements for Research Governance and issuing NHS Permission for Research.

- Ensure CSU Medicines Management support for the Designated Signatory role for covering excess treatment costs of NIHR Portfolio research undertaken by Providers
- Promote evidence-based commissioning
- Ensure through our Memorandum of Understanding with Public Health and contract with CSU that appropriate support for evidence-based commissioning and innovation is in place.

Work with local Academic Health Sciences Network (AHSN) to promote best practice and innovation. AHSNs are local partnerships between the NHS, academia and industry to lead and support innovation and improvement

The following draft strategy has been produced with input from representatives from the following groups:-

GPs, North Essex Partnership Foundation Trust, Colchester Hospital University Foundation Trust, Mid Essex Hospital Trust, Essex and Hertfordshire Comprehensive Local Research Network, NEE CCG, ECC

Draft research and innovation strategy

AIMS

1. **Promotion of patient access to participating in research, as per the CCG Constitution**
   This will primarily be achieved through increasing opportunities for participation in research in NE Essex through practice participation in NIHR research studies.

2. **Developing research capacity in NE Essex**
   This will include capacity to participate in NIHR portfolio studies, but also ultimately capacity to generate research proposals locally. It will also include development of links between interested organisations and promotion of proportionate governance and delivery of research.

3. **Supporting CCG strategic priorities through research**

A longer term aim will be to support addressing high priority health needs through the local research strategy. This will initially start with mapping high priority patient needs, and priority strategic development areas against current open NIHR projects. Ultimately the aim would be to support robust evaluation of strategic innovations.

Actions
Increase visibility of primary and secondary care research in NE Essex through: • Produce annual research report for CCG Board • Require contracted providers to ensure their Boards receive at least an annual update on research activity (e.g. in line with Southend dashboard) • Produce summary of active research for local circulation • Use CCG and other communications channels to increase circulation of updates on local research
Address barriers to practices participating in research: • Research mapping by Primary Care Research Facilitator/Nurses and CCG quarterly updates to be circulated to identify barriers • Address perceived barriers through provision of information to practices via communications, primary care research nurse roles etc • Include session on how practices can participate in research at GP Educational Event • Publicise Research Site Initiative and other support e.g. 'Buddying', GCP training, to support research in primary care • Support full staffing of primary care research support team
Enhance research capacity and capability locally through partnership: • Establish virtual Research Network for information sharing • Open up Primary Care Research Group to all interested practices • Establish links into the Research Network for EAHSN, University of Essex, NIHR Research Design Service, GP Trainers workshop etc • Agree 2-5 year targets for enhanced participation in research by both NEE providers including primary care and patients
Alignment of research activity to local need and priorities: • Open Primary Care research projects to be mapped to local needs and strategic priorities • Open secondary care research projects to be mapped to local needs and strategic priorities • Consider how local research capability can support evaluation of transformational change

Innovation Health and Wealth, accelerating adoption and diffusion in the NHS

The areas within this are:

The 6 High Impact Innovations

- **Child in a chair in a day**;
- **3 million lives** (add reference to CC2H strategy re managing LTCs);
- **Digital First** (Think we could mention the bid going off today for the Prime minister Challenge Fund, This is a pilot that incorporates weekend opening which will also include appointments by Skype and Telephone, training for GPs is to run alongside this with regard to diagnosis and understanding from in non face to face contact . In addition to this there is a proposal to put in a Medical Interoperability Gateway which will allow GPs to see a patients record from another GP practice where the patient gives authority, allowing GPs to work effectively in a Cluster, this should also cross reference to “Primary Care wider and at Scale”)
- **Intra-operative Fluid Management**
- **Support for Carers for people with dementia** (add reference to CC2H, carers and MH)
- **International and commercial** - is the High Impact Innovation that calls for the NHS to look at the economic and industrial role it has, both with respect to health and care related industries and the wider economy.

Academic Health Science Networks
NICE compliance to ensure rapid implementation of NICE Technology Appraisals
Clinical Practice Research Data Link

SECTION 11 DELIVERING FINANCIAL VALUE AND SUSTAINABILITY

The CCG has developed a 5 year Medium Term Financial Strategy which will be added as an appendix. This includes the detailed 2 year financial plan and high level 5 year plan.

SECTION 12 SUSTAINABLIITY

Sustainability means meeting the needs of the present without compromising the ability of future generations to meet their own needs. It has three main inter-related strands – social, economic and environmental. The CCG has duties to promote sustainability, both as a commissioner and as a corporate body.

We are committed to tackling sustainability in the widest possible terms and to ensuring that this approach is part of our everyday work. We will work with all our partners to commission sustainable healthcare and help ensure that the people of North East Essex receive the highest quality services both now and into the future.

The CCG has a Sustainable Development Management Plan (SDMP) which is available on our website. The CCG undertakes the Good Corporate Citizen online assessment at six monthly intervals and uses the results to update the SDMP. The assessment covers travel, procurement, facilities management, workforce, community engagement, buildings, adaptation and models of care. In April 2013 the CCG scored 70% and in October 2013 this had risen to 75%.

In 2014/15 and 2015/16 the CCG will continue to focus on ensuring that the services commissioned are sustainable and contribute to the wider NHS targets around carbon reduction in England.

It will continue to work with the other CCGs in Essex on adaptation and resilience

SECTION 13 GOVERNANCE

NEECCG has established clear and robust governance arrangements to ensure the organisation fulfils its overall purpose, achieves its intended outcomes and operates in an effective, efficient and ethical manner.

The NEECCG Constitution and the NEECCG Governance Assurance Framework clearly sets out the principles and methods NEE CCG will adhere to in delivering its roles and functions. It also sets out the procedures by which our Governing Body and statutory committees will operate, be governed and held to account on how we conduct our business, how we embed our commitment to openness and how we make ourselves accountable to the people and communities we serve.

NEE CCG has developed and adopted a Performance Management Process Framework which clearly sets out how the organisation will monitor, measure and track performance against its strategic objectives, commissioning intentions and two year operational plan to ensure delivery and allow pro-active planning and forecasting.

Operational Plan success will be championed and ultimately evaluated by the Governing Body to provide assurance that NEECCG have delivered the plan objectives and are commissioning high quality, cost effective, sustainable healthcare that improves the health and life expectancy of the NEE population.


NEE CCG
Governance Assuran


Draft NEE CCG
Performance Process

SECTION 14 Appendices

Appendix A NEE CCG Better Care Fund Parts 1 and 2 – to be added

Appendix B Essex-wide Better Care Fund Essex Parts 1 and 2 – to be added

Appendix C CCG Governance structure – to be added

Appendix D NHS Constitution Measures – to be added

Appendix E NEE Plan on a Page

APPENDIX E **North East Essex CCG Integrated Commissioning Plan on a Page**

Vision	A simpler system for patients. People have greater choice, involvement and control regarding their health and wellbeing. A series of planned commissioning steps will deliver for patients a system where they can choose between end to end service providers offering seamless care.
Commissioning principles/ approach	Patient centred care; improving the patient/service user experience; patient choice; experienced based commissioning (using NEE Big Care Debate outcomes to inform). Evidence-based pathways (CCG JSNA and ECC Annual PH Report will inform); commissioning to NICE guidelines. Integrated commissioning and provision of health and social care; sustainable system; continual quality improvement; equality of outcomes; collaborative; using contractual/procurement levers; release money to frontline care. Initial procurement of 3 care bundles: End of Life; Care Closer to Home; Urgent Care
Integration principles/approach	Reduce complexity in the system, with integration of services driven by contracts and partnership. Integration focused on Care Closer to Home and End of Life Care Bundles. Improved integration of community services will reduce dependence on acute services and avoid admissions
Strategic context and challenges	Everyone Counts – Essex Health & Wellbeing Strategy – Essex Joint Strategic Needs Assessment –– collaborative working across North Essex Large increase in over 70s – inequalities in life expectancy – low levels of non-elective admissions – variations in primary care
Developing integration/enablers	Shared vision with ECC and providers – ECC membership of CCG projects and programme board – developing joint approach by ECC and CCG on HR/IT/IG/Estates – Care Bundles and Better Care Fund are first steps on pathway to fully integrated care – Management of interdependencies between care bundles will form integral part of specifications and contracts.
Budget Position/Savings	Financial balance – delivery of 1% surplus and 2% transformation monies - £15 – 20m QIPP challenges in 2014/15
Key Risks	Continued clinical engagement, provider engagement, delivering transformation in primary care without levers, alignment of national and local priorities, shared information systems, acknowledgment that public health changes take time to deliver, integrated commissioning; ensuring commitment, alignment different cultures, timelines and priorities; financial balance, risk and benefit share agreement for pooled monies, funding increased activity in acute services if BCF doesn't deliver required outcomes; risk of CCG paying for empty premises if new providers don't use them?

Priority areas	Priorities 2014/15	Priorities 2015/16	5 Year Ambition
Children	• Education Health & Care Plans • CAMHS specification • Directory of Health Services to support the Local Offer • Personal Health Budgets	Commissioning of Children's services	Full range of integrated children's services delivered from a community facility. Seamless transition between child and adult services. Integrated CAMHS and behavioural services tier 1-3.
Frail, Elderly & Vulnerable	End of Life Bundle implementation Commissioning of Care Closer to Home Bundle Commissioning of Urgent Care Bundle Equity of access for vulnerable & marginalised groups	Care Closer to Home contract in place Urgent Care contract in place	Client feels safe and in control. Rapid access to most appropriate care through Community Gateway. Client received least complex and least intrusive care. Client had good quality of life and good death. Co-location of health and social care.
Mental Health	Commissioning of Care Closer to Home Bundle	Care Closer to Home contract in place	Focus on prevention and early intervention. Integrated care delivered in home and community. Specialists services only where they add value.
Learning Disabilities	North system wide approach - commissioning	North system wide contract in place	People with learning disabilities: adopt health lifestyles; have equal access to services; learn to manage and improve their own physical and mental health.
Other	Voluntary sector grants alignment Urgent care centre planning QIPP	Urgent care centre operational QIPP	Service users received integrated care, delivered with minimum interventions. Service users are supported to self-care. System efficiency and stability.
BCF Schemes	2014/15 onwards: 7 day working, Reablement, Carers, Sustainability Fund Services		
	2015/16 onwards: As above plus Care Closer to Home health and social care elements		