Castle Point and Rochford
Clinical Commissioning Group

Commissioning Integrated Plan 2013-14

Castle Point and Rochford Clinical Commissioning Group

(developed in partnership with Essex County Council)

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SECTION 1: CLINICALLY-LED COMMISSIONING IN CASTLE POINT & ROCHFORD

1.1 EXECUTIVE SUMMARY

We are pleased to introduce the NHS Castle Point Clinical Commissioning Group (CCG) Integrated Plan. It is a strategic plan for the localities, which both reflects and builds upon the 2012/13- 2014/15 Operational Plan for NHS South Essex. The plan sets out the work we are undertaking in collaboration with our partners in neighbouring CCGs and Essex County Council.

This is an Integrated Plan for the Castle Point and Rochford Clinical Commissioning Group (CP&RCCG) in the service of the Castle Point and Rayleigh & Rochford localities. A single CCG Integrated Plan for 2013/14 serving both locality groups is appropriate for several reasons, namely: historical commissioning connections across localities; commonality of commissioning priorities, their sharing of geographical boundaries with Essex County Council and our application to be authorised as a single Clinical Commissioning Group for Castle Point & Rochford in 2012/13.

The plan reflects the aspirations and intentions of a committed collaboration between the 'Castle Point' and 'Rayleigh Rochford' locality groups, like-minded clinicians and practices to learn understand and take responsibility for the commissioning of health services on behalf of its relevant patient population.

The key performance indicators and outcomes are designed to reflect the right balance of current capability of CCG practices alongside challenging intentions. Achieving financial balance of the devolved budget is expected with the intention to go further and realise efficiency gains. As well as financial efficiencies, the QIPP contribution includes clinical commissioning intentions specifically on referral management, planned care, prescribing, unplanned care and long-term conditions to improve quality and productivity.

Our patients will have the opportunity to fully integrate with the commissioning business processes of the CCG. The CCG intends to define engagement by our patients as ownership, responsibility and commitment and set out the operational details of this engagement in its Communication & Engagement Strategy. Our aim is for all of our CCG practices to have practice-level patient representative groups and a CCG level Commissioning Reference Group (Patient Engagement Committee) will be drawn from these practice groups alongside engagement with our third sector.

In order to support the effective delivery of commissioning, the CCG will address five key challenges:

- Making the NHS patient centred;
- Reinforcing the multidisciplinary approach;
- Working closely with the Local Authority;
- Creating a seamless service, and;
- Expanding primary healthcare services.

The CCG recognises the need for robust risk management. As a developing CCG, the group will vigorously acquire knowledge and expertise in the full range of risk management, particularly financial risk and associated risk-pooling via a shared model of collaboration with neighbouring CCGs. The service risk associated with healthcare budgets is better understood by CCG practices than other risks; however, greater emphasis will be placed upon demand management tools and techniques during 2013/14 to support the intention of realising efficiency gains.

Next year it is the envisaged that the CCG will be authorised as a statutory body with all the responsibilities, all the challenges and opportunities this offers. As a CCG, with the sole commissioning responsibility and accountability placed on it, provides the means by which the continuing improvement in local health services can be measured against the growing demands of the population. The budget holder for the CCG will be the Clinical Accountable Officer (CAO) who will report to the NHS Commissioning Board Local Director.

This Integrated Plan for 2013/14 details how the localities through a single CCG intend to deliver improvements to the population it serves, ensuring the best quality and value in health services. The current economic situation means that the NHS has to continue to provide excellent healthcare while living in leaner times. The CCG's ambition is to ensure that the populations of Rayleigh, Hockley, Rochford, Great Wakering, Hadleigh, Benfleet and Canvey Island continue to enjoy the best possible health. This plan sets out how the CCG intends to realise that ambition.

1.2 CASTLE POINT & ROCHFORD – AN INTRODUCTION

Castle Point and Rochford localities make up a large swathe of land surrounding the Southend locality. Each locality is served by its own borough council

The CCG is made up of 28 practices. Their total registered population (taken from the Attribution Data Set in April 2011) is 177,000. This compares to an average for all 212 CCGs in England of 261,000.

15.9% of Castle Point and Rochford CCG registered population are under age 15 (England average 17.1%) and 9.3% are age 75 or over (England average 7.5%). 50.6% are female (England average 50.2%). Table 1 below shows how the CCG population is expected to grow by 2015, 2020, and 2025. This is based on applying weighted averages of ONS population projections by age and Local
Authority to the CCG's population.

Year	Population	population 75+
Current (2011)	177,091	16,536
2015	181,491	18,817
2020	188,006	22,445
2025	194,855	27,492
Average annual growth rate 2011 to 2020	0.7%	3.5%
England average annual growth rate 2011 to 2020	0.7%	2.3%

Table 1: CCG Population Growth

The CCG's registered patients live in a single upper tier Local Authorities which is Essex County Council. For the CCG's main local authority, the CCG accounts for 12% of its population.

Based on the average level of deprivation (measured by the IMD2010) in the LSOAs where this CCG's population live, this CCG is ranked 180 out of 212 CCGs (where 1 is the most deprived). 3% of the CCG's population lives in an LSOA that is one of the 20% most deprived in England. This CCG's main provider is Southend University Hospital NHS FT and accounts for 46,077 (83%) of
it's overall admissions. These represent 43% of that provider's total admissions.

1.2.1 Castle Point Locality

Castle Point is the second most densely populated district in Essex (89,000+ residents). The population is expected to increase by 10,000 by 2030. 30% of population will be over 65 (2nd highest proportion in county)

The 2010 indices of deprivation (IMD) indicated that Castle Point locality has 2 LSOAs within the 20% most deprived quintile in England (none in 2007) Castle Point locality ranks 198 out of 326 LA areas (1 = most deprived) and is above average for all domains

The health of people in Castle Point is generally similar to the England average. However, diet-related indicators are worse than average: fewer people eat healthily and more are obese and have diabetes.

There are health inequalities within Castle Point. Men in the least deprived areas can expect to live 5 and a half years longer than men in the most deprived areas. Overall, men's life expectancy in Castle Point is better than the average while women's life expectancy is similar to the England figure.

Early death rates from heart disease and stroke and men's deaths from all causes seem to be improving faster than the England average and are well below the England rate. Early deaths from cancer and women's deaths from all causes are tracking the England trend very closely.

Fewer children than average live in poverty; however, children's health is mostly close to the England average. Teenage pregnancy and dental health in children are significantly better than the average

1.2.2 Rochford Locality

Rochford population density is just over that for the county, but has quite a variety depending on ward. Roughly 15,000 additional people are expected to reside in Rochford by 2030. 26% will be over 65 (4th highest)

Rochford has only one LSOA in the 20% most deprived areas in 2010 indices (0 in 2007). Rochford ranks 299 out of 326 LA areas so is in the least deprived quintile

The health of people in Rochford area is generally better than the England average. Deprivation is lower than average, however 1,795 children live in poverty. Life expectancy for both men and women is higher than the England average.

Life expectancy is 3.9 years lower for men in the most deprived areas of Rochford than in the least deprived areas (based on the Slope Index of Inequality published on 5th January 2011).

Over the last 10 years, all-cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen and are better than the England average.

About 15.0% of Year 6 children are classified as obese. A lower percentage than average of pupils spends at least three hours each week on school sport.

71.4% of mothers initiate breast feeding and 15.0% of expectant mothers smoke during pregnancy. An estimated 12.1% of adults smoke and 25.4% are obese. There were 1,760 hospital stays for alcohol related harm in 2009/10 and there are 129 deaths from smoking each year.

1.2.3 Secondary Care Environment and Patient Flows

In 2010/11, this CCG's practices had 55,305 inpatient admissions. The table below shows the main providers that were used, the number of admissions at each provider (and as a percent of the CCG's total), the number of those admissions that were elective, and this CCG's admissions as a percent of the provider's total admissions.

Table 2: CCG Activity by main Providers

Provider	Number of Admissions (%)	*Of which elective*	% of Provider total
Southend Univ Hospital NHS FT	46,077 (83%)	*21,521*	43.1%
Basildon & Thurrock Univ Hospitals NHS FT	3,181 (6%)	*1,586*	3.5%
Mid Essex Hospital Services NHS Trust	1,610 (3%)	*945*	1.6%
Spire Healthcare	749 (1%)	*749*	1.9%
Barts & The London NHS Trust	557 (1%)	*362*	0.6%
Other	3,131 (6%)	*1,901*	n/a
Total	55,305 (100%)	*27,064*	n/a

Southend Univ Hospital NHS FT is the main provider for all of the CCG's practices.

1.3 INTRODUCING CASTLE POINT & ROCHFORD CCG

The South East Essex health economy is supporting two emerging Clinical Commissioning Groups serving 5 localities. These are set out in table below:

Table 3: South East Essex CCG Configuration

Clinical Commissioning Group	Locality Commissioning Group	Clinical Leads	Population served
Castle Point and Rochford	Castle Point Locality	Drs Gupta & Kamdar & Gardiner & Siddiqui	84,960
	Rayleigh & Rochford Locality	Drs Taylor & Saad & Kuriakose & Merali	76,174
Southend	Southend Central Locality	Dr Pelta	40,939
	Southend Estuary Locality	Dr Husselbee	79,511
	Thorpe Bay Locality	Dr Agha	73,206

The Castle Point and Rochford Clinical Commissioning Group is newly formed organisation (see practice membership in ***Appendix 1***) and will continue their organisational evolution during 2013/14 by acquiring the appropriate health system management knowledge and expertise to secure CCG authorisation.

The emerging CCG will be responsible for devolved healthcare budgets of approximately £196m on behalf of 177,000 registered patients. The proportion for NHS contracts is circa £109m of which £80m is included in the Southend Hospital NHS Foundation Trust contract, £7m for Basildon University Hospital University NHS Trust and £22m for South Essex Partnership Trust - Mental health £17m and Community Services £5m. The remaining balance relates to NHS prescribing and other commissioned services.

The CCG is committed to developing a health market consisting of a plurality of providers offering good access, good quality and good value services.

A strong working relationship with the local Acute and Mental Health / Community Foundation Trusts based upon clinician to clinician engagement has been a priority for the CCG in 2012/13 and will be actively developed further during 2013/14 as part of the CCG's organisational evolution.

The Organisational Development Plans are designed to reflect the transition nature of developing CCG with organisational and leadership learning requirements which they will seek to acquire through its core commissioning business during 2013/14.

The CCG is committed to delivering efficiencies through QIPP schemes and prioritised in 2012/13 their need to reduce outpatient referrals, prescribing spend and emergency admission rates as commissioning priorities. All of which they are managing to do so with varying degrees of success. These priorities will continue into 2013/14 some in collaboration with our neighbouring Southend CCG.

1.3.1 CCG Leadership Team & Responsibilities

As a membership organisation, the CCG will be run by its member practices. To do this effectively the CCG has established a Governing Body, which will act to perform those functions and responsibilities delegated by the CCG member practices and those accountabilities required in the Health & Social Care Act (2012).

The CCG Governing Body is responsible for assuring the delivery of commissioning and corporate objectives set out in this Integrated Plan. The CCG is clinically-led and will operate with a locality-focused management team to direct activities across the scope of the commissioning portfolio.

Although the Governing Body will act to take decisions on the vast majority of CCG business, members have agreed to maintain two locality groups for more direct practice involvement in decision making with every practice is represented. The Locality Groups will meet monthly and also act to both approve the annual commissioning plan and to seek direct assurance from the Governing Body that it is delivering the plans.

The Locality Groups will also be the forum for considering any changes to the CCG Constitution ahead of proposing these to the NHS Commissioning Board. Each practice will nominate a GP practice representative who will be responsible for a number of important CCG commissioning activities within their practice.

Member practices will be engaged in the operation of the CCG through the CCG locality structure, which will operate as a forum for members to hold their GP Governing Body representative to account and to work with them to influence and support the CCG in achieving its strategic ambition. Whilst sitting outside of the formal committee structure, the localities are the 'power house' of the CCG membership organisation.

For further detail see *NHS Castle Point & Rochford CCG Organisational Structure in Organisational Development Plan* document.

1.3.2 CCG Leadership Selection / Election

Eight GP leads are elected to the CCG Governing Body for tenures of 3 years. The leadership team includes representatives from each of the two CP&R localities. The CCG clinical leadership will agree portfolios of responsibility that each covers a clinical and corporate area. Clinical portfolio areas will directly reflect the CCG's strategic priority areas.

Full details of the CCG Election are included in the *NHS Castle Point CCG Organisational Structure* document.

Table 4: Appointed GP Lead Board Members (Feb 2013)

Name	Portfolio 1 - Clinical/Contracting	Portfolio 2 - Corporate
Dr Mike Saad	Chair / SEPT Contract	Governance
Dr Sunil Gupta	Clinical Accountable Officer	Health & Well Being Board / Education

Dr Roger Gardiner	Integrated Care / 111	Collaboration / Business Intelligence
Dr Mahesh Kamdar	Unplanned Care	Quality / Safeguarding
Dr Steve Taylor	Prescribing/Respiratory	Finance
Dr Kashif Siddiqui	MH/Dementia/Children's	Patient & Public Engagement
Dr Biju Kuriakose	Cardiac	Planning / Service Redesign
Dr Sadik Merali	Frail Elderly	Planning / Service Redesign

2.8 CCG Headline Finance Position

The CCG will operate in the first full year post authorisation with a commissioning budget of **£192m**. The overall CCG risk-profile is high as a consequence of financial performance in 2011/12 however the situation is improving because of the steps taken ahead of this year to manage financial risk. This includes reducing the risk of provider over-performance and strengthening our reserve position. It is envisaged Castle Point CCG will inherit a sound financial platform, although must deliver the major QIPP (Quality, Innovation, Prevention, Productivity) programmes set out in this plan to maintain financial balance in the years ahead.

A detailed view of the CCG financial position is included as Section 4 of this document.

1.4 THE CCG's VISION, VALUES & GOALS

Vision: Enable the people of Castle Point and Rayleigh Rochford localities to ***live longer, healthier*** and with ***improved quality of life*** through commissioning high quality health related services ***sensitive to local needs***, putting the ***patient and family at the centre*** of their care.

In pursuit of this vision the CCG will function to ensure:

- Improved patient outcomes and Improved quality of care.
- Improved patient experience.
- Improve access to services for patients.
- Empowered patients.
- Improved Patient Safety.
- Reduced costs without compromising patient care.
- Redesigned pathways with the help of primary and secondary care clinicians to ensure appropriate patient care is available at the right time, in the right place, with the right person
- Improved information to patients to support self-care and choices including alternatives to hospital treatment.
- Sharing of good ideas and best practice with all Constituent Practices.
- Working with other CCGs to help to share risks and learn from each other.

Values

The CCG have agreed that they will abide by principles, values and rights clearly set out in the ***NHS Constitution*** to ensure that the NHS in Castle Point and Rayleigh/Rochford works fairly and effectively.

The seven key principles that the CCG will abide to are:

1. *The NHS provides a comprehensive service, available to all.*
2. *Access to NHS services is based on clinical need, not an individual's ability to pay.*
3. *The NHS aspires to the highest standards of excellence and professionalism*
4. *NHS services must reflect the needs and preferences of patients, their families and their carers.*
5. *The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.*
6. *The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.*
7. *The NHS is accountable to the public, communities and patients that it serves.*

Nolan Principles of Public Life & Principles of Good Governance

The CCG strongly believe in the Nolan Principles of public life which are: Selflessness; Integrity; Objectivity; Accountability; Openness; Honesty, and Leadership. Full details are set out in the CCG Constitution.

The CCG recognises its responsibility as a public body and the importance of abiding by its values in all that it does. Members of the CCG Governing Body – as the leadership team of the CCG – have agreed to adopt the Nolan Principles in recognition of their role in public life (*See NHS Castle Point & Rochford CCG Constitution*).

The CCG maintains a register of interests for all members of the Governing Body and has followed national guidance in developing robust arrangements for the management of conflicts of interest. The CCG has also developed a dedicated Conflict of Interest Policy, which is reflected in the NHS *Castle Point & Rochford CCG Constitution*.

1.4.1 CCG Goals and Purpose

- The overarching goal will be to **eliminate unnecessary waste** from the system to maximise reinvestment, at the same time **improving the quality** of services, and to improve the health and quality of life for our population. The CCG will continue to deliver on both national and regional commitments and targets.

- The aim is to lead the local health community to ensure that **patient insight** shapes services, ensuring the best value for the best services.

- Some of the challenges CCGs face are common across the NHS – the economic downturn, more people with **long term conditions and an ageing population**. As groups of GPs, the CCGs aim to engage and work collaboratively with all stakeholders in **redesigning patient pathways** to improve efficiency, whilst maintaining standards of care, in such areas.

- Using the **Public Health Data** available, and by analysing performance reports for both secondary and primary care, the CCG will prioritise programmes with the greatest opportunity to deliver benefit in meeting the goals.

- The CCG will continue to deliver efficiency savings through the successful Peer Review process as the preferred approach to **referral management**.

- The CCG will work collaboratively with the other emerging CCGs in South Essex on the comprehensive review and **redesign of MSK** including consideration of Integrated Hub model.

- The CCG will work closely with the Essex County Council on the transformation of **Community Services** ensuring that the services commissioned ultimately meet the needs of our patents.

- Close working relationships will be forged with **local district and borough councils**, in delivering the Health and Wellness agenda and health services in relation to older people.

- The CCG have no outlying health indicators, other than **cancer**, which Public Health data attributes to the high elderly population. The CCGs do wish to focus on any obvious gaps in health care services evident across the member practices.

- The CCG is keen to assist all **member practices** in becoming more efficient and cost effective by helping them through their CQC application processes, guaranteeing that they are all fit for purpose.

1.5 CCG PRIORITIES AND OUTCOMES

The previous section sets out our vision for the future of health services in Castle Point & Rochford and the principles that will enable us to get there. But what will change in Castle Point & Rochford? What services currently used by patients will be different in future? This section sets out to answer these questions.

1.5.1 Strategic Framework

The CCG strategic framework forms the core of this Integrated Plan and sets our approach to commissioning over the next five years. In addition to providing the strategic context covering the full three year period, the Integrated Plan addresses how the CCG will deliver its key responsibilities in the final year of transition (2012/13) as well as establishing the CCG's commissioning intentions for the first year it will operate as a statutory organisation in 2013/14.

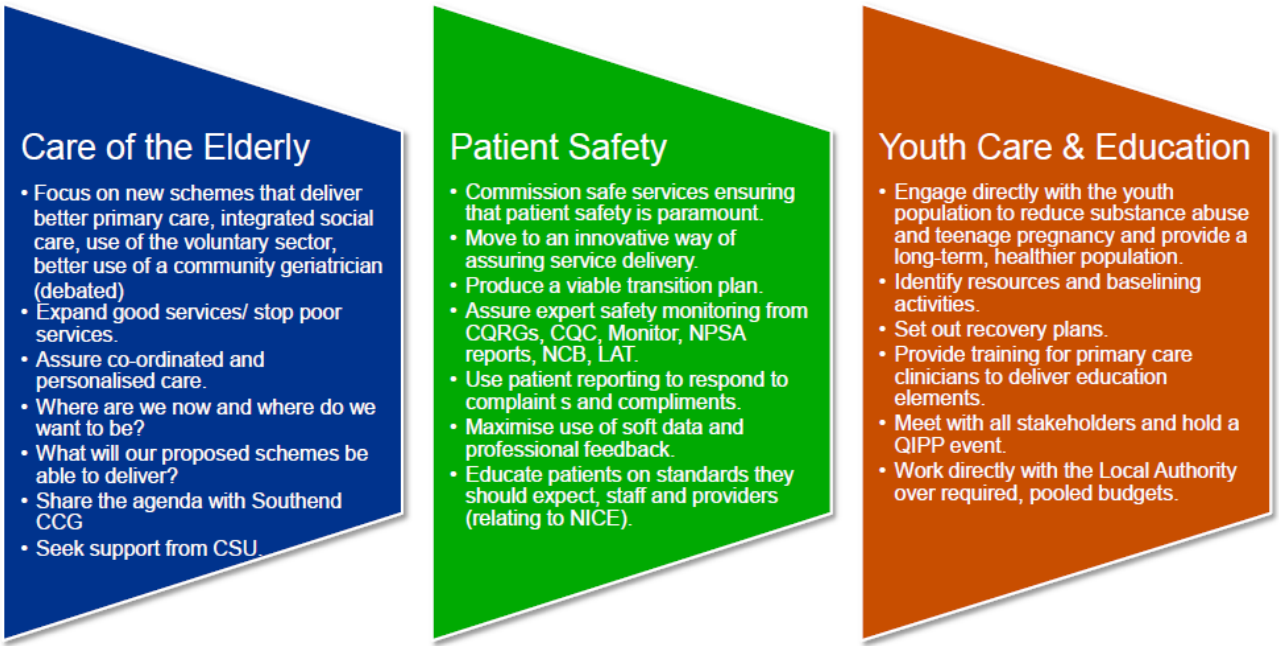
Since the beginning of the year the CCG has been undertaking engagement with clinicians, local patients and partners to set out the CCG's strategic framework. We have engaged CCG members through our locality structures and visited individual practices across Castle Point & Rochford.

The approach to developing the framework has been designed to give the maximum possible scope for clinicians to work with patients, partners and other professional experts to establish the goals and priorities of the CCG.

Through this engagement we have reached conclusions, taking care to ensure the framework is clinically-led, evidence-based and locally determined in line with the CCG vision and values. We have also taken steps to communicate our vision and priorities to patients and the public through our Patient and Public Engagement arrangements and governance structures (see *NHS Castle Point CCG Communications & Engagement Strategy*).

As the part of our strategic framework we have identified high level strategic priories, which are the broad areas we see will be achieved if we successfully implement improvements in our key priority areas. In November 2012 the CCG held a workshop the purpose of which was to work towards the top three priority areas for Castle Point and Rochford CCG from the existing ten strategic priority areas and nineteen potential priorities provided in the JSNA/ JHWS/ Commissioning Intentions.

Primary focus for the three top priorities aimed to ensure suitability for the next two years of commissioning activity, starting with the 2013-14 financial year. Existing priorities were presented to the Governing Body that demonstrated the health challenges of the Castle Point and Rochford localities making clear the recommended priority areas in the JSNA and these were used to inform the strategic priorities of the CCG to be set out in this plan and CCG commissioning intentions. The summary below provides a snapshot view of the three priority areas that were agreed by the CCG.



The CCG throughout this plan makes reference to joint working and integration with Essex County Council with shared priorities. A fundamental key shared priority with ECC is Care of the Elderly.

Our Specific shared CCG/ECC priority areas include

- Closing the gap of health inequalities between the most and least deprived.
- Improving the general mental health and well-being of the population.
- Preventing the causes of ill health and unnecessary illness.
- Providing services to cope with an ageing population to ensure there is increased choice and services available for end of life care and people with long term conditions, including dementia.
- Improving quality and safety of services to enhance patient experience and patient satisfaction.
- Ensuring that resources are used more productively and that actions are taken to release funding that can be used to invest in the priority areas above.
- To develop commissioners' capabilities to ensure high quality services for the population of their area within available resources.
- To develop integrated approaches for vulnerable children and young people through a joint commissioning approach
- Ensuring Safeguarding across adult and children's services remains a priority as organisational reform is implemented.

1.5.2 National Priorities

We understand our responsibilities as set out in the: NHS Constitution; NHS Outcomes Framework; NHS Planning Guidance 2013/14, and; NHS Mandate (to the NHS Commissioning Board). Our CCG's strategic priorities reflect these national priorities whilst also responding to our local health needs.

NHS Operating Framework

The Department of Health Operating Framework for the NHS in England 2012/13 has identified the following key priority areas that all NHS organisations need to focus on during 2012/13:

- putting patients at the centre of decision making in preparing for an outcomes approach to service delivery, whilst improving dignity and meeting essential standards of care;
- completion of the last year of transition to the new system, building the capacity of emerging clinical commissioning groups (CCGs) and supporting the establishment of Health and Wellbeing Boards so that they become key drivers of improvement across the NHS;
- increasing the pace on delivery of the quality, innovation, productivity and prevention (QIPP) challenge; and
- maintaining a strong grip on service and financial performance, including ensuring that the NHS Constitution right to treatment within 18 weeks is met.

1.5.3 Midlands and East Priorities

In addition the Midlands and East SHA has set 5 ambitions that will be delivered in 2012/13:

- Eliminating avoidable pressure ulcers
- Making Every Contact Count
- Significantly improve quality and safety in Primary Care
- Ensuring radically strengthened partnership between the NHS and Local Government
- Create a revolution in patient and customer experience

1.5.4 CCG Local Commissioning Priorities

The Castle Point and Rochford CCG have identified a range of key priorities for 2013/14. These reflect the need to develop the CCG over the next 12 months to ensure it becomes fit for purpose and reflects the needs of the patient population served by the Castle Point & Rochford CCG member practices.

It is the intention of the CCG to develop KPIs for each of the priority areas, which will be monitored on a monthly basis. There are 10 high level priorities for the CCG, some of which would be addressed in partnership with ECC:

1. Managing Elective Activity including improving Referral Quality
2. Effective Medicines Management
3. Managing Emergency Activity – Urgent Care **(with ECC)**
4. Active Support for Self-management for Long term conditions (**with ECC)**
5. Managing Ambulatory Care Sensitive Conditions inc. CHF, diabetes, asthma, COPD
6. Improving provision for and management of patients, both children and adults, with both mental and physical health needs **(with ECC).**
7. Care coordination through integrated teams working with adults, children, and young people.

8. Improving primary care management of End-of-Life Care **(with ECC)**
9. A focus on Primary Prevention **(with ECC and Public Health Colleagues)**
10. A focus on Secondary Prevention

1.5.5 Targeted Outcomes & Planned Programmes of Work

A central part of developing the CCG strategic framework has been to identify the key outcome indicators we will use to ensure the work we do as a CCG is genuinely contributing to an improvement in patient outcomes.

These outcomes are the main things we believe need to improve to enhance the health of our population in our priority areas. The CCG leadership team has worked very closely with colleagues in the Essex Public Health department and also with patients and other professionals to identify a range of outcome indicators in each priority area that will be monitored to assess our progress. In selecting these measures we have also taken care to consider the following:

1. Relevant outcome measures included in the NHS Outcomes Framework, NHS Mandate and NHS Constitution
2. Priority areas agreed in the Essex Health & Wellbeing Strategy
3. Priority thematic areas included in the Essex Joint Strategic Needs Assessment
4. Impact of the outcome on health inequalities

The table in ***Appendix 3*** is based on NHS Operating Framework and sets out the planning, performance and financial requirements for NHS organisations in 2013/14. Castle Point and Rochford CCG recognises these objectives as our key priority areas for 2013/14 and the actions being taken to implement these objectives are noted in the table in Appendix 3. Included within these priorities are the actions that the CCG plan to undertake to implement the NHS National Commissioning Board's ambitions for 2013/14 which are listed above in section 1.5.3.

1.6 THE CASTLE POINT & ROCHFORD CONTEXT

There are a number of important parts that together form the local setting within which the CCG operates. This section provides an introduction to these parts, situating the CCG in the context of our JSNA; our provider landscape; the way we collaborate with NHS partners and Essex local authority and our headline financial position.

1.6.1 Summary of Joint Services Needs Assessment (JSNA)

The Joint Strategic Needs Assessment (JSNA) identifies priorities for health, wellbeing and social care across Essex and informs CCG commissioning priorities. This assessment of available data undertaken jointly by NHS South Essex and Essex County Council highlights the following key health challenges:

- tackling inequalities in health and social need, in particular by reducing levels of smoking
- continuing to reduce levels of heart disease and stroke
- continuing to reduce early deaths from cancer
- halting the rising levels of obesity and diabetes
- managing the rising demand for services due to an increasingly older population

The Essex Joint Health and Well Being Strategy sets out the following vision and priorities that we use to inform our CCG Integrated Plan.

The vision for better health and wellbeing in Essex

By 2018 residents and local communities in Essex will have greater choice, control, and responsibility for health and wellbeing services. Life expectancy overall will have increased and the inequalities within and between our communities will have reduced. Every child and adult will be given more opportunities to enjoy better health and wellbeing.

Taken from Essex Health & Well Being Strategy 2012

To pursue the vision, the Essex Health and Wellbeing Board 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;
- In line with ECC's 'Strengthening Communities' agenda, 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, for example, developing joint service specifications with Essex County Council;

- ensure resources are allocated consistent with the needs within and between the communities in Essex (this fits with a clear need to examine the resource implications of integrated/joint commissioning arrangements for all partners including Essex County Council; and
- support individuals in making informed lifestyle choices and promoting the importance of individuals taking responsibility for their own health and wellbeing.

1.6.2 What People Say About Castle Point & Rochford

Some Patient Participation Groups (PPGs) have been established at practice level in Castle Point & Rochford (aim is for all practices to have one) to capture patient views on the quality of local services. Practices are asked to identify one or two representatives to attend each of the two locality groups. There are also patient public representatives sitting on the Commissioning Reference Group (CCG Patient & Public Experience Group [CRG]) which is a sub-group of the Castle Point & Rochford Governing Body and will become a sub-committee of the Governing Body post-authorisation. This group includes representatives from the PPGs, Castle Point and Rochford Voluntary Sector and Essex Healthwatch and to enable a wider dialogue between clinical leads and patient groups is attended by our GP clinical lead with the Patient and Public Engagement portfolio.

Engagement through the CRG structure and links to Practice level Groups and through borough-wide events (e.g. Community Breakfast) has allowed clinical leads to identify a consensus on a number of priority areas that patients want to see addressed in this plan. These include:

- Primary and community services should be more easily accessible with better patient information provided
- Specialist services should be provided in community settings where possible
- Services should give greater focus to the prevention of ill health
- More support should be given to people to enable them to better manage their long term conditions
- A greater emphasis should be placed on screening and increasing rates of early diagnosis

Patients recognised that underpinning many of the issues they identified is the need for better communication between different parts of the system and particularly between secondary and primary care.

Older People's Health & Wellbeing Survey

A survey was undertaken by Castle Point Association of Voluntary Services (CAVS) and Rayleigh & Rochford Association of Voluntary Services (RRAVS), with some input from NHS South East Essex. The survey was distributed to users of voluntary and community organisations across Castle Point and Rochford. The survey evidenced worries about health (either their own or that of their close family) and the fear of losing independence featured highly. The full report is available on CCG website.

The CCG continues to secure patients views through survey to gain better understanding of the concerns of our population, and what can be done to address them. The first follow-up survey was undertaken at the CAVS Community Breakfast on 20th September. The feedback from these surveys will be used to inform our work and commissioning plans further. Survey forms are also available for completion on our website.

1.6.3 Provider Landscape

Castle Point & Rochford is largely served by one major provider trusts. Southend University Hospital NHS Foundation Trust (SUHFT), providing a full range of general hospital services for over 700,000 people in the boroughs of Castle Point, Rochford and Southend and providing some specialised services that are available to patients across South Essex.

South Essex Partnership Foundation Trust (SEPT) provide both Community and Mental Health services to the localities of South Essex. Castle Point & Rochford CCG host and lead contract negotiations with SEPT on both Mental Health and Community services.

1.6.4 Engaging Secondary Care

Castle Point clinical commissioning leads have given high priority to engaging with secondary care clinicians to secure the development of shared work programmes with acute and mental health clinicians locally.

Clinical commissioners have established a Joint Service Development Board (JSDB) for this work. It is jointly chaired by a clinical lead from the CCG and the Medical Director from SUHFT. This has led to the development of a shared work programme to deliver agreed priorities and the agreement to develop a key integrated pathways e.g. Musclo-skeletal and ophthalmology. Engagement with SUHFT has been given high priority alongside participation in South East Essex QIPP work streams schemes with clinicians from primary and secondary care to work collaboratively to agree and shape QIPP plans for next year.

1.6.5 Integrated Care and Unplanned Care

Integrated Care is an important part of the CCG's approach to delivering its strategy. South East Essex Unplanned Programme Board (SEEUPB) is a programme bringing together all key providers and commissioners in the local health economy, with focus on the development of integrated care and service models that reduce rising number of acute unplanned admissions across South Essex.

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

The SEEUPB will fundamentally change the way in which people are supported in taking charge of their own care and conditions. The programme's initial focus, through integration with Essex County Council, is on caring for older people and its scope will be systematically broadened over the next three years (2013-15) – with Frail Elderly and Long Term Conditions being the focus the next phase of work.

The aim of the collaborative Unplanned Programme is to drive up the quality of care and drive down costs of providing it:

- improving the value of care we provide to local people by joining up care around people, across providers;
- identifying and managing people's care needs better and intervening earlier;
- ensuring care is provided in the most appropriate setting, particularly at times of acute crisis and by ensuring the right incentives exist for providers to work in integrated ways.

The overall aim of the Unplanned Work Programme within 3 years is to:

- A total of XX,XXX (XX%) unnecessary bed days currently spent in hospital are avoided for older people
- XXX older people are supported so they do not have to go into care homes (XX fewer care home packages) – delivered through integration with Essex County Council.
- £XX.Xm per annum less resource will be needed to operate sustainable health system

2013/14 planning work will need to clearly define these activity reductions

In 2013/14 the system will continue to be led by a board of health and social care providers with an overarching integrated board structure. The board will work in partnership with clinical commissioners and be responsible for the shared delivery of care along agreed pathways.

The process of service change will be evolutionary. During 2012/13 the PCT/CCGs (and included in QIPP plans – more detail in Section 4) have commissioned new admissions avoidance schemes, (some in direct partnership with Essex County Council) such as the:

- Admission Avoidance Car
- GP triage is Accident and Emergency (Pilot)
- Single Point of Referral (health and social care) in partnership with Essex County Council
- Intermediate Care Bed Facility (Princess Anne Ward)
- Improved access to reablement services, in partnership with Essex County Council.
- Community Geriatrician Service Model,
- Risk profiling to identify vulnerable patients and reporting in general practice, in partnership with Essex County Council
- Community and Practice level MDT to discuss high risk patients (in partnership with Essex County Council)

During 2013/14 SEEUPB will develop patient-based risk registers and increase reporting in GP practices, holistic health assessment (including mental health) and case management for older

people through GP practices and urgent access 'hot' geriatric outpatient clinics for rapid diagnosis of older people.

1.6.6 Approach to Collaborative Commissioning

To be effective commissioners NHS Castle Point & Rochford CCG will need to work in formal collaboration with neighbouring CCGs to address strategic and performance issues and challenges which apply across a broader geography than the CCG boundary. Over the past year CCG Chairs, clinical leaders, Chief Officers (designate) and senior managers have been working together at a series of meetings and events, to design the collaborative approaches to clinical commissioning that will be required in order to operate effectively as authorised CCGs from April 2013.

Many of the mechanisms for CCG collaboration in South Essex have been established for some time (via clustered PCT). In particular, the South Essex CCG Joint Commissioning Collaborative Group (formally known as Commissioning Executive Committee) has brought together the CCG Chairs and Chief Officers on a regular basis to design and agree the arrangements for collaboration.

South Essex CCGs have already used our collaborative arrangements to consider our shared approach to commissioning support capability in the establishment of the Essex Commissioning Support Unit (CSU).

In order to support the collaborative activities South Essex CCGs have identified the need to come
together to establish a structure that will allow them to:

- Share and align strategic priorities and to share best practice on issues that are of common interest to more than one CCG
- Create formal and shared committees of the relevant CCG Governing Bodies to allow decision making at scale
- Gain collective assurance on the quality and performance of the commissioned services of shared providers
- Plan, co-ordinate and deliver collective work programmes

Accountability and responsibility for decision making sits with each CCG as outlined in their respective constitutions and discussions that take place at a collaborative level will often support that decision making at Governing Body level within each individual CCG.

In South Essex the committees listed in table 5 below will be formal (joint) committees of each Governing Body and their members will be mandated by their Governing Body to take decisions on the CCG's behalf according to individual terms of reference.

These committees will be supported and co-ordinated by the South Essex CCG Chief Officers Group that is also responsible for overseeing the full range of collaborative arrangements outlined by the framework.

Over the transition period many of these committees and groups have been run in tandem and in shadow form alongside the Cluster. This will allow for a smooth transition and has allowed these forums to act in shadow form – with full CCG leadership – to support the annual commissioning cycle in advance of 2013/14.

Full details are also included in the ***South Essex CCGs Collaborative Agreement*** *(February 2013)*.

Table 5: South Essex CCG Collaborative Committees

Committee	Chair	Terms of Reference	Frequency
South Essex CCG Joint Collaborative Forum	Dr Anil Chopra, Basildon & Brentwood CCG	See South Essex CCG Collaborative Agreement (Appendix 1)	Monthly
South Essex Mental Health Board	Castle Point & Rochford CCG	1. Purpose : To lead and coordinate commissioning activity for mental health across all health and social care commissioning agencies in South Essex : • Castle Point & Rochford CCG (host for SEPT MH/Comm Contract) • Southend CCG • Basildon & Brentwood CCG • Thurrock CCG • Essex County Council • Southend Borough Council • Thurrock Borough Council (NB: The scope of the SEMHCB will be adults with functional mental health needs. It will not include at this stage dementia, learning disabilities, CAMHS or drugs and alcohol services. It will, however, need to ensure effective transition and interface arrangements are in place.) 2. Membership : The membership of SEMHCB should reflect the strategic senior nature of the Board and so normally would be the Senior Officer for the CCG and the Director of Adult Services for the local authority. 3. Frequency of meetings : Bi-monthly. This will be kept under review and may be need to be more frequent on transition to NHS Commissioning infrastructure. 4. Reporting arrangements : Each organisation will come with the appropriate level of delegated authority from their respective organisation and equally will need to refer matters elsewhere depending on what level of decision-making is required. Collectively the SEMHCB will report relevant matters into the three respective Shadow Health and Well-being Boards. 5. Chairing arrangements : Agreed for 6 months at a time and then reviewed. 6. Description of tasks : • To commission and oversee the development of a Mental Health Commissioning Strategy for South Essex; • To ensure that across health and social care an integrated approach to the development of our mental health commissioning strategies; • To establish and then give guidance to a “virtual officer team” (provided by Commissioning Support Unit (CSU) which will drive the work of the SEMHCB; • To oversee the renewal and updating of the relevant Section 75 agreements; • To oversee the relevant QIPP programmes for mental health – the SEMHCB will not be accountable for the delivery of the schemes which remains a responsibility of the CCG, it will however, ensure that relevant health and social input is maximised and comment on the delivery plan. • To ensure that there is a strong mental health input into	Monthly

		the 3 new refreshed JSNAs and the forthcoming Health and Well-being Plans; • To oversee the development of specific commissioning intentions plans for 2013/14 and beyond; • To lead the contract negotiation process with our main provider – SEPT; • To lead the discussions over the appropriate SERVICE MODEL for the delivery of mental health services locally which deliver the best outcomes for service users and carers; • To oversee the development of an integrated Performance Framework for the whole of South Essex; • To encourage participation and actively work with the emerging Clinical Commissioning groups to ensure that there is full primary care and clinical input into the work of the SEMHCB. • To actively seek the views of users and carers so that they can influence and shape commissioning plans.	
South Essex Children's and Young People Clinical Engagement Group (with Essex County Council representation)	South Essex Lead Commissioner for C&YP	The role of the CEG is to bring clinicians together across South Essex to inform the commissioning of service for children and young people. This note sets out how CEG will operate at its meetings. CEG will • Focus on the child or young person • Make recommendations to CCGs about the commissioning of services for children/young people • Provide constructive challenge to service providers about service delivery, with the aim of securing improvements in outcomes and the use of resources, and reducing disparities between the two PCTs and CCGs • Acknowledge local achievement and commitment • Seek out examples of good practice and evidence-based care which can be implemented in South Essex • Maintain an overview of the QIPP programme in South Essex	Monthly
South East Essex Unplanned Delivery Board (with Essex County Council representation)	Malcolm McCann Director SEPT	The role of the Unplanned Care Programme Board is to: 1. lead the whole system for unplanned care across all adult services 2. hold the overall responsibility for 'unplanned care', for acute admission avoidance into both hospital and mental health wards, and the responsibility for working with system commissioner and provider partners to co-design an out of hospital model of care 3. monitor QIPP schemes for the care of the elderly (including end of life), urgent care, and the management of long-term conditions across the system, and provide overall governance to the QIPP projects 4. provide leadership, to provide clarity of view and signal clear messages in respect of the change management programme for unplanned care. The group will ensure that the QIPP programme objectives for Unplanned Care and the responsibility for providing whole system leadership are met. The work streams within this Programme are: • Care of the Elderly including End of Life • Urgent Care • Management of Long-Term Conditions Each of these work streams is underpinned with a detailed work plan and in some cases more detailed work strands due to the size and complexity of the work stream. In respect of the work streams identified, specified projects which report into this group may overlap due to the nature of the services. This will include the implementation of admission avoidance (GP filter) schemes, the End of Life and Case Management initiatives.	Monthly
Joint Service Delivery Board	Dr Sunil Gupta (AO CP&R	Purpose: This Clinically-led Board will operate to inform and	Monthly

(South East)	CCG) and Medical Director SUHFT	recommend to commissioners the jointly agreed clinical pathways and associated implementation plans. It will also have the following key roles and responsibilities: • Oversee and monitor progress and effectiveness at a clinical level of the Pathway development/revision programme as it relates to QIPP Programme. • Ensure alignment between Pathway development work, led by each organisation, to avoid duplication of effort and achieve successful outcomes. • Jointly recognise the intended purpose and outcome of each Pathway/QIPP work stream project at the outset. • Nominate appropriate Clinicians to advise on component parts of the Pathway/Work scheme. • Identify, minimise and resolve blockages in Pathway/work scheme development and agreement. • Jointly sign off final outputs. • Act as the forum for jointly testing significant clinical innovation and development ideas. • Identify and confirm the time required from individuals to support pathway/work scheme projects. • Commission audit reports on Pathway changes to validate effectiveness. • Key forum to generate ideas for service redesign and improvement in the delivery of QIPP	
Joint Service Delivery Board (South West)	Dr Anil Chopra	Same as above	Monthly

Additional forums may need to be developed as the new clinical commissioning arrangements bed in, for example, on specific strategic or commissioning issues. There are a number of areas for which CCGs in South Essex have established joint programme boards across CCG areas for the delivery of the commissioning intentions outlined by their integrated plans or operational groups for collaboration or joint working at an operational level. A recent example is MSK and diabetes Pathway work.

1.6.7 Collaboration with Southend CCG

Prior to and over the period of our CCG development and transition year we have developed strong working relationships with Southend CCG's clinical commissioners recognising our often shared priorities, similar populations and identical set of acute and mental health providers. Post-authorisation we recognise that this relationship will be pivotal to our success and as a result we have established a monthly clinical review forum for the respective clinical leadership teams to meet to discuss key issues relevant to both organisations. We have also agreed shared leadership roles where Castle Point leads attend groups on behalf of both localities and vice versa. In order to deliver against all of our statutory and performance responsibilities with regard monitoring of the quality of commissioned services both CCGs have agreed to work in partnership on contract monitoring and quality management of our main acute providers.

In addition, Castle Point & Rochford and Southend CCGs operate together within joint programme boards for planned and unplanned care to deliver their key strategic and operational objectives in these major areas of service redesign. Our approach ensures alignment of programmes that impact upon the same provider groups.

A Director from SEPT CCG chairs the Unplanned Care Programme. The board as mentioned above brings together the clinical leads and commissioning teams from both Castle Point and Southend to ensure coordination.

SECTION 2 INTEGRATED COMMISSIONING WITH ESSEX COUNTY COUNCIL

2.1 ECC Commitment to Integrated Commissioning

It is imperative that ECC and Health partners build on the Whole Essex Community Budgets work to meet the demographic pressures and requirements for financial savings together. The planned phased activity of the ECC Transformation Mark 11 programme includes having integrated commissioning in place with partners by March 2016.

ECC aims to secure lock-in to integrated commissioning arrangements with CCGs through joint appointments and joint contracts for services. To achieve this aim ECC is committed to reviewing jointly its procurement pipeline and CCG contestability plans to identify opportunities for joint commissioning. These should lead to the development of joint specifications, followed by joint procurement and contract management, with deliverable savings for the partners.

ECC will wish to have clarity with CCGs on the leadership of cross-CCG system issues such as Mental Health, Child and Adolescent Mental Health, All Age Disability, Learning Disabilities and Children's Services early help and starting well.

In more concrete terms ECC agrees that joint commissioning in Adult Mental Health should be on a north and south Essex systems basis. ECC understands the lead CCG commissioner in north Essex will be North East Essex CCG and Castle Point and Rochford CCG in south Essex.

ECC has stated its offer to lead the commissioning of Learning Disability services across Essex and would wish to have access to specialist NHS commissioning advice and support. Initially this would be on a North Essex/South Essex systems basis, looking to West Essex and CSU capacity in South Essex, with the ambition to work on a pan-Essex basis in the medium term.

The final versions of the Integrated Plans will specify how Reablement funds will be used on a joint commissioning basis.

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

The initial proposals for the use of sustainability funds transferring from the NHS to ECC, which have yet to be agreed between the NCB- LAT, ECC and CCG lead Commissioners, are:-

- To appoint an ECC Integrated Commissioning Director within each CCG.
- Provide CSU and Project Management capacity for the development of integrated specifications and the delivery of plans
- Resources for mutually beneficial demand management schemes.

2.2 Health & Wellbeing Board

There is a consensus between Castle Point CCG and Essex County Council to use the opportunity of establishing a shadow Health and Wellbeing Board to redefine local partnership working. The changes in the Health and Social Care Act, which provide for closer working relationships between the Council, local GPs and the health community, are an opportunity to deliver improved outcomes together. The CCG sees the Essex Health & Wellbeing Board as a key forum for strategic planning and delivery going forward. The Clinical Accountable Officer for the CCG is a core member of the Essex Health and well Being Board. This CCG and County Council collaboration will be unlike previous collaborations with a real willingness to talk of pooled budgets and joint commissioning to deliver real outcomes focused improvements.

2.3 Health & Wellbeing Board Planning

In 2011 a Planning Group was established consisting of key stakeholders from the Council, NHS and the voluntary sector in order to commence work on establishing a health and wellbeing partnership in Essex.

The CCG and Council in Essex committed to establish a shadow Health and Wellbeing Board just under a year prior to the Board gaining statutory powers. This timeframe, which has been adhered to, provides the Council, the local NHS and other key partners the opportunity to work together on the implications of the legislation through the shadow year and to commence work with all partners in the borough to address the health and wellbeing challenges in Essex.

In the remainder of 2012/13, the shadow Board have developed and led the implementation of a Joint Health and Wellbeing Strategy (JHWS) (agreed at shadow board in Sept 2012), informed by a needs assessment of the county's (and its respective boroughs) population. The JHWS will sit within a policy framework for Castle Point & Rochford which includes the Council Plan and the NHS Clinical Commissioning Group's Strategic Framework.

The strategy builds on what already works in the county, and also provide a framework for the Council to lead the transformation of public health. Castle Point Clinical Commissioners see one of the key roles of the shadow Board will be to champion joint working between the Council, NHS and other partners where this already works. It will encourage integration across areas where this can improve the services that are delivered to patients, clients and families in the CCG.

The Health & Well Being is a new opportunity for the CCG to engage with the whole of the local authority rather than unilaterally with Adult Social Care and Children's Services departments. It also offers an opportunity to develop integrated commissioning in those areas where priorities included in the CCG Integrated Plan are aligned with those included in the Health & Wellbeing Strategy.

2.4 Health and Well Being Strategy

The CCG and ECC affirm their commitment to the Joint Health and Wellbeing Strategy for Essex, 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.

ECC also affirms its commitment to the Health and Wellbeing Board as the overarching partnership board to facilitate and encourage integration of health and wellbeing services for the population of Essex.

2.5 Joint/Integrated Commissioning

Castle Point & Rochford Clinical Commissioners have established a positive working relationship with the local authority since its decision to apply for Pathfinder status, a decision that the Local Authority supported in full. Since that time the Leader, portfolio holders within the Council have engaged on a regular basis with the CCG, via locality groups, CCG Board, SEEUPB and holding 1-to-1 meetings with GP and managerial leads.

In turn the CCG has identified a portfolio holder (Clinical Accountable Officer) to work on those interface issues such as HWB, public health, joint commissioning and to ensure the CCG is playing a full part in the development of the Essex Health and Wellbeing Strategy. The Commissioning and Delivery Director of the Local Authority also sits on the CP&R CCG Governing Body.

The Local Authority and Castle Point Clinical Commissioners have agreed areas of joint work and are keen to develop new governance arrangements to oversee the implementation of these key programmes. Together Castle Point & Rochford Clinical Commissioners and the Essex County Council will begin four immediate areas of partnership work, aligned to key QIPP and JSNA priority areas for 2013/14:

- Urgent care responses with focus on frail elderly across health and social care with particular focus given to admissions avoidance and reablement, and in particular in working to shift the balance of care in Castle Point & Rochford.
- The prevention agenda
- Tackling health inequalities - and improvements in public health more generally in the borough.
- Children and Young people's services including safeguarding.

2.6 CCG/ECC Shared Priorities

Joint ECC/CCG workshop events have taken place in January 2013 focusing on two of the above shared priority areas, namely frail elderly and children/young people. The outputs of which have been used to inform our shared Integrated Plan.

2.6.1 Framework for Frail Older People

There is consensus across Essex that services for Frail Older People should be commissioned locally (within CCG boundaries) within an overall ECC/CCG strategic framework, against locally determined priorities. The strategic framework aims to achieve optimum levels of independence for older people and reduce health inequalities.

There are 3 agreed high level outcomes:-

1. Client feels safe and in control
2. Client receives least complex and least intrusive care
3. Client has good quality of life and a good death

The Essex-wide framework will enable locally integrated planning and commissioning across the following themes:

- **Social inclusion including prevention and early intervention - information and advice**
    a. Primary Care report large number of people accessing GP surgeries and A & E as a result of social isolation and loneliness.
    b. An integrated approach will be developed in 2013/14 to facilitate individuals to identify and use their own or community resources at an early stage thereby reducing the demand on GP surgeries and the public sector generally.
    c. This work will connect with the Strengthening Communities workstream of the Whole Essex Community Budgets programme to build community capacity to keep people safe, well and integrated within the community.
    d. The Supporting Resilience draft strategy for adults will be central to this approach.
- **Dementia.**
    a. Essex has a joint Dementia Strategy which has recently been signed off by the CCG's and three local authorities and 2 Mental Health Trusts.
    b. For 13/14 the focus will be on early intervention and demand management, to [for example] improve identification of people with dementia through early diagnosis and improved access to memory assessment clinics and providing support and information following diagnosis.

- **Functional Mental Health**
    a. Determine how older adults with functional mental health needs will be supported jointly by ECC and the CCG's
    b. Identification of Older adults who are at risk of developing mental health issues; e.g. people who are socially isolated, those who are bereaved and ensuring older adults with mental health needs have access to "mainstream" support for older people.

c. Identify mental health factors (e.g. depression) which are specific to older People and the strategies to manage these.
d. Develop support options for those at risk of developing mental health issues
e. Ensure that older people have equal access to mental health Services for working age adults and ensure that reasonable adjustments to WAA services are made to ensure that these are accessible for older adults. Services may include: IAPT, Crisis intervention and Home Treatment
f. Continue review of the Older Adult Mental Health teams to develop an outcome model supported across health and social care economy.

- **Falls Prevention**
    a. A joint Falls Prevention strategy will be developed in 2013/14 between ECC and CCGs, underpinned by Public Health support and advice. A joint Falls prevention pathway will be developed based on best practice advice and learning across Essex

- **Continence Management**
    a. Incontinence is one of the highest triggers for carer breakdown and admission to residential and nursing care. Additionally there is a high number of older people presenting at A&E with Urinary Tract Infections. Approximately 43,000 people in Essex per year have a bladder problem at least once a week. The current picture across Essex is that of product distribution rather than prevention and early intervention, plus a range of health and social care interventions that are not integrated around the client.
    b. In 2013/14 a continence management strategy will be developed, leading to a joint service specification with clear outcomes, to be jointly commissioned in 2014/15.

- **Support for carers**
    a. Carer breakdown is a main trigger for admission to hospital/residential and nursing care.
    b. Integrated Plans to support implementation of the Essex Carers strategy and weaving requirements into contracts.
    c. There is a range of Carer support arrangements in place across the county. The North Essex CCG's – carer befriending scheme, hospital link worker, Macmillan carer service, carer wellbeing checks (not universal coverage)
    d. South Essex CCG's – carer recognition workers in primary care and secondary care settings, who care project, Carer champions.
    e. In 2013/14 it is proposed to develop the business case for improved carer support and commission jointly between ECC and the NHS, for implementation in 2014/15.

- **Urgent Care Pathways - crisis avoidance and crisis response, long term conditions**
    a. A variety of different models are in operation across Essex.
    b. An evaluation is underway to identify best practice to reducing inappropriate admissions and keeping people at home independently, including information sharing, the outcomes of which will be shared systematically across Essex in 2013/14.
    c. Analysis of the care economy is needed to better understand trigger points to shift support from reactive to proactive.

- **Support for professional carers to raise standards in care homes, linking with providers of community services.**
    a. High numbers of people present to A & E from residential and nursing homes.
    b. In 2013/14 ECC and CCG partners will work with care homes to reduce falls and improve experience at End of Life through the My Home Life Programme.
    c. Benefits would include reducing admissions to acute hospitals from residential and nursing homes.

- **End of Life Care**
    a. 70% of people say they would prefer to die at home while currently 58% of people die in acute hospitals. Much progress has been made across Essex over the last few years but still a high number of people are dying in hospital.
    b. In 2013/14 ECC and CCGs will develop more integrated approaches and establish common areas to join up and improve End of Life care and support so that all persons expressing a preference to die at home are enabled to do so in all but exceptional circumstances.
    c. Changing culture and removing stigma around death – getting people to start talking about death.

- **Continuing health care - children and adults**
    a. In 2013/14 partners will review Continuing Health Care arrangements and processes on a county-wide basis.

The County Council will be looking to use a significant proportion of the S256 transfer funding from the NHS for Social Care sustainability to fund demand management schemes supporting a range of the above priorities for joint NHS and Adult Social Care benefit.

The Frail Elderly are one of the CCGs 3 local priorities for 2013/14 in addition to the nationally mandated priorities for the NHS.

The CCG and ECC partners have agreed to adopt the National Voices narrative statement of person-centred coordinated care as a working definition for the emerging vision.

There is also an emerging commissioning vision of a single budget enabling joint outcome-based specifications for the health, care and support market to respond with integrated service propositions (prime contractor).

In the context of the strategic framework, local priorities have been identified for 13/14 as:

- **Dementia strategy implementation.**
    - Following public consultation the Essex Southend and Thurrock Dementia Strategy was agreed and signed off by the previous 2 PCT clusters, 2 Mental Health Trusts and Essex, Southend and Thurrock local Authorities in November 2012.
    - A key focus of the strategy is to increase uptake of early intervention services for people with dementia and their carers that support independence and ensure service pathways incorporate the appropriate range of interventions throughout the dementia journey. These include commissioning the voluntary sector to provide support to people in the community and at first diagnosis within Memory Assessment Services.
    - The strategy recognises the contribution that the NHS QIPP agenda will make in ensuring that the Dementia Strategy can deliver services that meet demographic demands, that services are cost effective and that planning is integrated. Implementation plans are being developed with partners to improve outcomes for people with Dementia and manage demand on statutory services.
    - There are number of examples of commissioning services jointly to deliver the outcomes of both the National and Essex Dementia Strategies. These include:-

        - Dementia Support Services within Memory Services. These are jointly commissioned services provided by specialist voluntary organisations (Alzheimer's Society and Colchester Mind) to provide sensitive, responsive and individualised information, signposting, guidance and support to all people newly diagnosed with dementia, and their families and carers, to enable them to manage the impact of assessment and diagnosis of dementia on their lives.
        - Working with Alzheimer's Society as well as the MH Trusts who provide a variety of 'Dementia Cafes' across a number of localities.
        - Arrangements in South Essex to jointly fund a Dementia Support worker within the Community.
        - We are working with partners this year to procure the following services as we move from grant funding to commissioned services with the 3rd Sector. These services include, Peer Support, Dementia Cafes, Dementia Support Services and Advice, information and awareness raising. Procurement is underway with an expectation that contracts will be in place by the 1.4.13.

- **Review scope to accelerate Assistive Technology.**
  The population of Essex is growing. At the same time, the expectations and needs of the people in Essex continue to rise and technological innovation continues to increase the possibilities to meet these expectations in new and more effective ways.
  When used to its full potential to the point where AT is adopted as routine to support care needs, the use of simple to use devices can play a major role in improving safety and quality of life for people who, through its use can lead their lives with greater choice, independence and personal control allowing people to have more choice and say in their own care arrangements.
  Used wisely, we know that AT offers local care partnerships an opportunity for transformational change in the way customers and their carers receive support, and in the types of support that can be offered and providing a more joined up, whole systems approach to health and social care delivery.
  Assistive Technology is very much seen as an 'enabler' to achieving a range of high level ambitions for both Health & Social Care which will be integral to the delivery and action plans coming out of the CCG's.

  The actions and activities that will enable ECC to review the scope to accelerate Assistive Technology (AT) can be described in 3 key areas;

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

  Appendix 6 describes the ECC approach to AT development in more detail.

- **SPOR arrangements.**
  - Evaluate and review to develop unified assessment processes.
  - Review potential for and plan unified single point of access for urgent care, incorporating social care emergency duty, Social Care Direct and 111.
  - Plan unified SPOR integrated with Intermediate Care via joint contract with single provider.

- **Map preventive services**, engaging with District and Borough Councils, collating risk indicator information from existing sources (e.g. Meals on Wheels, Mosaic data, care providers, OP not engaging with services).

- **Plan integrated Continence pathway.**

- **Plan integrated preventive support strategy,** including building on current Befriending service arrangements.

- **Review Continuing Care processes and arrangements.** ECC wish to agree a pan-Essex approach to reviewing Continuing Health Care processes and arrangements.

- **Review procurement pipelines** to spot opportunities for joint commissioning approaches.

- **Develop integrated information sources** for citizens to access – common directory of services.

- **Scope potential for MDTs**, including SWs, based around GP Practice clusters.
- Secure agreement to the draft joint Carer's strategy & commissioning intentions.

Draft priorities for 2014/15

- Review Equipment contract with view to jointly commissioned service.
- Implement Integrated Continence pathway.
- Implement integrated preventive support strategy.

2.6.2 Children's Services

Children's services, including CAMHS, will be commissioned jointly by ECC and CCGs on either a CCG level or North Essex/South Essex system or Essex-wide basis, informed by the JSNA and a strategic review of CAMHS.

There is agreement in principle to commission some services jointly at system level (North/South or Essex wide to be considered as options), e.g. Joint CAMHS & Behaviour Tier 1-3 services, children with complex care needs and disabilities and safeguarding and provision/statutory duties for Looked After Children and Care Leavers.

There is agreement to commission some services jointly at CCG level (e.g. Families with Complex Needs, Maternity/Early Years).

Families with Complex Needs are one of the CCGs 3 local priorities for 2013/14 in addition to the nationally mandated priorities for the NHS. ECC wishes to see CCGs commit to the implementation of the Community Budgets FCN business case in 2013/14.

The priorities for the 2 South Essex CCGs of B&B and CP&R are outlined in the table below:

Children's services workshop 21 January 2013, South Essex (ECC,B&B CCG, CP&R CCG)	**Implement 2013/14**	**Plan 2013/14**	**Implement 2014/15**	**Plan 2014/15**	**Implement 2015/16**
PRIORITY	**South Essex**				
1. Families with Complex Needs - CCGs to contribute to 8 Family Solutions teams within their commissioning intentions.	y	y	y		
2. CAMHS - integrating Behaviour services and commissioning across tiers 2 & 3. CCG's to continue to support the CAMHS gateway and posts in tier 2. Review to include eating disorders.	y	y	y		
3. Maternity and Early Years- Improved links and information sharing and joint working by maternity, health visitor/MESCH/FNP services with children's centres and other early years services	y	y			
4. Maternity and Early Years- joint focus on breast feeding	y				
5. Early Years- review Children's Centre contracts for re-commissioning 14/15 and align maternity and health visiting with this		y	y		
6. Support for children in and leaving care - Improve the quality, speed/priority and cross County consistency of health and dental assessments and treatment - embed in main contracts without further charge to ECC.	y	y	y		
7. Select provider for foster/adoption medical advisor	y				
8. safeguarding - Health providers to contribute to Assessment, Planning and Review activities and engage as active	y				

members of Core Groups for Children In and Leaving Care and Children on a Protection Plan as required and that this is embedded in the main contracts and jointly performance managed.					
9. safeguarding - Health providers to provide interventions for Children In and Leaving Care and Children on a Protection Plan including to improve parenting skills	y				
10. Early help processes - Providers to help develop and then use agreed referral and assessment tools and participate in joint training.	y				
11. Continuing care - Continue joint agency panel arrangements to plan and fund the care packages for children with complex and specialist care needs. Plan pan-Essex approach and roll-out pan-Essex approach in 15/16.	y	y	y	y	
12. Children with Disabilities and Special Educational Needs. Scope Speech + language OT-move to more integrated provision + commissioning with joint spec in 14/15		y	y		
13. Children with Disabilities and Special Educational Needs. Review equipment contract [with adults.]	y		y		
14. Improved CAMHS T3 provision for Children In and Leaving Care.					
15. improved CAMHS T3 provision for Children on a Protection Plan					
16. re-tender CAMHS advocacy					
17. Safeguarding. Continue clinical network in 13/14 and review costs. WECCG to	y				

host.					
18. Safeguarding. Develop new spec for network				y	y
19. System assurance around partnerships, joint commissioning /contracting / data + performance management		y	y		
20. Domestic abuse - Link to Winterbourne. Engage stakeholders + review business case + review interfaces involving key stakeholders across children + adults		y			

Please see Appendix **4** for the ECC Schools Children and Families commissioning priorities.

2.6.3 Learning Disability

The CCG accepts the priority this holds for ECC as a demand management pressure and the benefits in developing an All Age approach to Commissioning.

There is recognition that there is mutuality in commissioning priorities and a strong benefit in developing a single specification to address an emergent contractual opportunity within the next 24 months.

The planning process has clarified system leadership within CCG's on North and South basis and EEC has tabled its offer to be the lead commissioner, with access to specialist NHS commissioning advice and support from the NHS CSU.

The proposed joint vision is that people with learning disabilities will have improved health and wellbeing through:

1. Making healthy choices and adopting healthy lifestyles
2. Having equal access to primary health services
3. Maintaining and improving their physical and mental health
4. Learning to manage their own health and care needs.

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

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

The following draft priorities are proposed:

Final Delivery Milestones		**Outcomes**
1. Improving services for young people and adults with a learning disability	• Establish a South Essex Winterbourne View Implementation Group jointly with 3 local authorities across children and adults services • Implement the DH requirements	• Fewer people are in health funded in-patient services with clear move on plans for those still in these services.

and/or autism whose behaviour is challenging	within timescales, including local registers and person centred support/move on plans for everyone in health funded in-patient services. • Move people onto appropriate community based, local services wherever possible • Agree models of care and joint health and social care pathways for this group of people • Draw up and implement a joint health and social care commissioning and procurement strategy • Achieve a partnership agreement with ECC for a pooled budget for this group of people. • Ensure there is monitoring and evaluation of the outcomes and benefits for people. • Consider the benefits of an Essex wide approach and take forward as appropriate.	• Different models of services are being jointly commissioned to maintain people in community settings in local areas. • Pooled budgets are in place. • People who have moved on from in-patient services have improved outcomes in health and quality of life. • Some people are using personal health budgets
2. Improving access to mainstream services	• Using the 2012 Learning Disability Health Self Assessment and Improvement Plan, ensure all providers (acute, community, mental health, primary care and third sector) have and are implementing robust plans to improve the quality of care for people with a learning disability • All providers can demonstrate they are making reasonable adjustments. • Undertake the learning disability health and social care joint self	• People with a learning disability are identified in mainstream health service patient information systems • People with a learning disability have improved health and a reduction in early mortality. • Improved experience of care • Increased value for

	assessment in 2013 with the involvement of people with a learning disability and family carers.	money through greater efficiency.
3. Improving the health of people through health checks and health action plans	• Continue implementing a DES or LES for learning disability health registers and annual health checks. • Using the 2012 Learning Disability Health Self Assessment and Improvement Plan, work with GPs and specialist learning disability health services to deliver more health checks which are of a high quality and are linked with Health Action Plans. • Specialist learning disability health services and social care services are supporting people to complete and use their Health Action Plans.	• Everybody is offered a health check • 90% of people on a DES register has a health check and a health action plan • 100% of people with profound needs, from BME groups or with Downs Syndrome has had a health check and has a health action plan. • People with a learning disability have improved health and a reduction in early mortality. • Improved experience of care
4. Agreeing and implementing a Learning Disability Health Strategy	• Develop and consult on a South Essex Learning Disability Health Strategy with clear deliverables. • Ensure this is consistent and joined up with the Council Learning Disability Strategy.	• An agreed health strategy providing clear strategic direction to improve learning disability commissioning for the improved health and well being of people with a learning disability and family carers.
5. All age commissioning approach	• Work with our local authority partners to plan for the introduction of a single birth to 25 assessment process and individual birth to 25 Education,	• An agreed pathway and single Education, Health and Care Plans are in place to deliver a

	Health and Care Plans through the Children and Families Bill. • Link this with the Winterbourne View work on joint pathways and joint commissioning	smooth transition from children's to adults health, education and social care services. • The pathway and care plans put young people and their families at the centre of planning for the future. • Fewer young people are in health funded in-patient services.

2.6.4 Mental Health

Mental Health services for Adults will be commissioned jointly by ECC and South Essex CCGs on a South system basis. This will be overseen by a South Essex Mental Health Joint Commissioning Board comprising representatives of the four CCGs and Directors of the three local authorities in South Essex.

The South Essex system partners have an agreed outcomes framework that was co-produced in partnership with people who use services and providers of statutory and non- statutory mental health services. This sets out the vision that services will support the following health and social care outcomes for people in south Essex:

- 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.

This is supported by a joint mental health commissioning strategy which has been developed through extensive consultation and identifies the following priorities:

1. Improve the confidence and capability of GP's and practice staff to recognise, assess, support and refer people with mental health problems.
2. Improve the gateway into services so people are directed to the right support at the right time.
3. Improve primary care and preventative mental health services so more people are supported without the need to be in secondary care.
4. Focus secondary care on providing intensive, specialist support which improves recovery, personalisation and choice, so fewer people need residential care.

5. Focus secondary care on providing intensive, specialist support which improves recovery, personalisation and choice, so fewer people need residential care.
6. Improve crisis responses so that fewer people need inpatient care.
7. Focus on developing the usage of alternative providers and self-management where it is safe and appropriate to do so.
8. Focus on meeting the needs of higher risk groups who may have specialist needs.
9. The strategy provides a timeline for working with partners to implement the new strategy over the next 3 – 5 years. This will involve a process of refining models, piloting, reviewing and implementing the changes.
10. The strategy shows how we will commission the delivery of the strategy through co-ordinated health and social care commissioning arrangements.
11.

Link to the strategy – www.southessex.nhs.uk/mentalhealth

Essex County Council and Castle Point & Rochford CCG have agreed to develop from lead commissioning to joint commissioning across as many partners in the South system as possible (note there are 4 CCGs and 3 LAs in the system).

The partners are committed to developing a single plan for health and social care, incorporating QIPP and Council efficiency measures as well as development priorities and strengthened governance arrangements to secure joint commissioning.

ECC agrees that joint commissioning in Adult Mental Health should be on a north and south Essex systems basis. ECC understands the lead CCG commissioner in north Essex will be North East Essex CCG and Castle Point and Rochford CCG in south Essex.

The key milestones for the Integrated Plan are outlined in the table below:

2013/14	2014/15	2015/16
1. Strategy (SE MH JCS) functional MH Formal consultation Establish 3 workgroups/task and finish Piloting new model of care Activity modelling and further data analysis Essex wide dementia strategy Identify where else strategies need to be aligned – DAT; CAMHS; Specialist commissioning; carers	Implementation and roll out. Further develop older adult CMHT model Implement agreed strategy outcomes across Essex Southend and Thurrock Review position in relation to	Single strategy with 3 local delivery plans. incorporates adults and OAMH (query CAMHS need to make links) age inclusive approach Implement model for older adults that supports an age inclusive service Review and joint market strategy with joint procurement Review outcomes against each organisational Action Plan

(bid for part of 6m to support this)	whole person provision	Review commissioning approach
2. **Commissioning integration**. Governance established. Marks diagram Formalising Joint Commissioning board ToR and delegated authority Formalising virtual team under a memorandum of agreement Jointly plan commissioning cycle	Review and sign off formal arrangements. Jointly appointed performance, information and data management commissioning post (draws on CSU/ECC CSU) Clarify where a joint commissioning team buys business support from Co-location	Single team led by health
3. Outcomes framework Formal agreements via different governance bodies Address silos (QIPP/CQUIN) by using the OBA framework to agree QIPP/CQUIN/ Accommodation strategies as part of this framework) over next 6 weeks Adopt OBA as framework	Develop as part of commissioning cycle to include commissioning intentions Consolidate work around QIPP/CQUIN Local authority efficiencies	Outcomes based commissioning
4. Contract and partnership agreements Align commissioning cycles	Review position on partnership agreements and how they align with CCG commissioning intentions	Single contract. Joint Market testing strategies where appropriate
Pooled budgets Financial mapping and analysis of allocation across pathways and recognise other financial contributions including public health	Agree models of joint or pooled budgets and test risk/gain share agreements	Joined up/aligned or Pooled budget

While Dementia care and support is covered in the section on Frail Older People, further discussion is required regarding Older Adults with functional mental health needs and how they will be supported jointly by ECC and the CCG.

During 2013/14 ECC and CCG partners will determine how older adults with functional mental health needs will be supported jointly by ECC and the CCG within the frailty pathway

Partners will continue to review the Older Adult Mental Health service delivery model.

2.7 Enablers to Integrated Commissioning

The following enablers inform discussions between ECC and CCG to deliver successful integrated commissioning plans

A. Governance

B. Finance

C. Information sharing

- We will seek to produce joint intelligence that enables effective commissioning decisions.
- We will seek to operate a shared consent model that allows the effective sharing of information between organisations.
- We will seek to work collaboratively between organisations to meet our requirements under the Data Protection Act and the Freedom of Information Act.

D. Co-location

E. HR

F. Procurement and contracting (lock-in to partnership)

G. Technology.

- We will seek to use technology to integrate care pathways between organisations that are involved in the individuals plan.
- We will seek to use technology as an effective communication tool between practitioners
- We will seek to use technology to provide individuals access to their own information, give views and opinions and engage with providers.

H. Information Management

Practical Options

- Use of secure email – particularly focused at hospital discharge, multi-disciplinary referrals and Continuing Health Care arrangements
- Encryption services – to facilitate secure email with citizens, patients, carers and providers
- 'Adapters' – software that sits between systems and allows for documents and information to be recognised and used by the different IT systems
- Increased access to view or contribute to current or developing systems

- Increased sharing of a common IT system across organisational boundaries including allowing partners access to IT systems
- Messaging between IT systems (interoperability)
- Area based information hubs or clinical portals which draw information from different sources and allow controlled access to care and health professionals
- Master Data Management, including the sharing of common data between organisations.
- Citizen Portals allowing client access and control of who they share their care records, assessment and care/support plans with. Increased potential to keep carers, family and care providers informed and up-to-date

It is envisaged that a Memorandum of Understanding will be agreed between the CPRCCG and ECC in the near future and a commitment to look at revised joint commissioning arrangements will be included as part of this. The Local Authority will review their commissioning arrangements over 2012/13. Both Castle Point Clinical Commissioners and ECC are clear that the effective management of pay costs and other corporate expenditure will require innovative solutions to running costs associated with physical infrastructure and joint working. Both parties are committed to exploring the possibilities as part of the local authority's review (this includes Community Budgets Project unique to Essex County Council).

2.8 Public Health

The CCG will be worked with colleagues in Essex Local Authority to scope an opportunity to secure a public health resource once this function transfers to local authorities from April 2013. The CCG will be involved in designing a future operating model for public health that will support us to deliver this Integrated Plan and our Health and Wellbeing Strategy.

It has been agreed by all parties that Castle Point & Rochford will share a Director of Public Health and a specialist public health function, although the local authority will retain a separate public health commissioning resource. The CCG will begin to work under these arrangements from October 2012 in shadow form ahead of the transfer of public health to the local authority in April 2013. The CCG Board has a named Public Health Consultant as core member.

In 2013/14 the Essex-wide priorities for review and development of plans/specifications for procurement in 2014/15 are in

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

2.8.1 Public Health commissioning

The following summary of activities, impacting on the health status of CCG populations, will be funded by the ECC Public Health budget in 2013/14. *See ECC 6th Plan for more detail*.

- **ReachOut**
  - Proven prevention & early intervention model designed to reduce inequalities in health through identification of households in crisis or pre crisis.
  - During 2013/14 procurement will be worked up to enable roll out to deprived areas of Essex, including Harlow, Basildon and Castle Point scaling up innovation.
  - Approximate costs to ECC are £600K over 3 years through PH budgets.

- **Mental Health Casework Project**
  - Specialist welfare rights advice to people with severe & enduring mental illness. Currently operates in Tendring, and plan to scale up & roll out to Tendring, Harlow, Basildon and Colchester.
  - Approximate costs to ECC are £480k over 3 years, funded by Public Health.

- **Physical Activity**
  - To target those /at risk of being on a social care caseload, as well as clinical selection criteria, for whom evidence shows benefit from physical activity as part of condition/circumstance management.
  - Cost of £610,000 planned from PH budget.

- **Obesity and Weight management**
  - We will continue to commission a range of interventions aimed at reducing the prevalence of obesity among the population and delivered through a variety of community based providers offering targeted approaches for both individuals and families.
  - Resource implication - £800,000 planned from PH budget.
  - Where programmes are targeted at management of those with existing health problems, i.e. secondary prevention, Public Health wish to discuss with CCGs the appropriate source of finding for services such as for a community diabetes service.

- **Reducing smoking prevalence and tobacco control**
  - During 2013 commissioners will re-design the stop smoking service specifications towards a single tobacco control service.
  - Resource Implication £2,380,000. Planned from PH budget.

- **Increasing the prevalence of breastfeeding at 6- 8 weeks**
  - Through the commissioning of high quality effective support services an increase in duration of breastfeeding should result in a reduction in admissions for

selected conditions which should be realised in year with longer term benefits in terms of reductions in chronic conditions into adulthood.
    - Resource implications £700,000 (approx.) planned from PH budget

- **Improving sexual health**
    - From April 2013 Local Authorities will be mandated to commission confidential, open-access STI testing and treatment services for all persons present in their local area, without charge for any STI treatment, or supply of any drugs or medicines for STI treatment.
    - In addition they will be mandated to commission, open-access contraceptive services for the benefit of all persons of all ages present in the area, including under 16s, and without charge for the provision of the full range of contraceptive methods (but not including sterilisation and vasectomy).
    - Resource Implications £11,000,000 (cost of full sexual health commissioning offer currently)
    - To respond to the statutory requirements in an effective way, a Sexual Health pathway redesign is targeted for 2014/15.

- **NHS Health Checks**
    - The commissioning of the NHS Health Checks programme is a mandated requirement for Local Authorities with effect from 1st April 2013. The NHS Health Checks programme provides systematic lifestyle screening for eligible patients aged 40 – 74 years once every five years.
    - We will continue to commission the health checks programme primarily through primary care but with additional capacity from community based providers to maximise uptake especially among hard to reach communities. .
    - The total resource implication is £2,419m. Funded via PH budget.

- **Identification and Brief Advice (IBA)** services across Essex in a range of appropriate settings and as part of the Health Checks agenda in Primary Care.
    - Current contracts and agreements in relation to the Health Checks agenda will be reviewed by Public Health.
    - To deliver services to reduce harmful and hazardous drinking patterns in the population thereby contributing to improved health and reduced alcohol related hospital admissions

- **Primary care prescribing interventions** to dependent opiate users referred from specialist prescribers (Shared Care) in partnership with specialist drug treatment providers.
    - To achieve a reduction in illicit drug use and improvements in associated health and social functioning issues (Crime, unemployment, housing etc.)

- Cost of £200,000 annually from PH ECC Budgets and contracted with GPs.

- **Atrial Fibrillation management**
  - This was a new quality measure for delivery of primary care from 12/13. Whilst levels of management are overall relatively good in Essex there is considerable variation across practices. We plan to work with primary care to further develop the implementation of this measure.
  - Resource implication is 200k in total. Note that plan is for non-recurrent maybe one or two years maximum. Planned from PH budget
  - Delivery of AF management is reliant on medicines management by the NHS. Reductions in stroke will have benefit to the NHS in terms of fewer admissions and rehabilitation.

ECC wishes CCGs to consider funding on a partnership share basis for the following activities.

- **Essex County Traveller Unit (ECTU)**
  - Early intervention and prevention service for Gypsies and Travellers, contributing to improvements in child health outcomes, management of low term conditions, healthy lifestyles and health intelligence gathering to inform future service need.
  - The cost is £71,012 per year and ECC is requesting each CCG to fund a proportional part.

- **Alcohol Liaison Nurse Specialist (ALNS)** provision in acute settings to support hospital staff to identify, manage and support problematic alcohol users.
  - The intention will be to integrate this service within the prescribing contracts held by ECC with the two Mental Health Trusts, ensuring provision is not based upon an individual but the service is a core function of the contracted service. A reduction in alcohol related hospital admissions is expected.
  - The initial cost associated with the ALNS provision in a number of areas across the Essex is approximately £70,000 per acute setting. ECC is requesting each CCG to fund a proportional part.

- **Senior Health Checks**
  - During 2013/14 and 2014/15, Senior Health Checks will focus on finding new cases of previously undiagnosed diabetes, cardiovascular disease (CVD), and chronic kidney disease (CKD) among older adults aged 75-84, followed by evidence-based treatment.
  - Investment will be required from both the NHS (£470k over 5 years) and Public Health (£331k over 2 years). Up to 4,130 new diagnoses of long term conditions

or of high vascular risk could be made, and up to 370 emergency health events could be prevented or postponed over the next 5 years.

- It is estimated that a net saving to the care economy of up to around £2.3million could be made over 5 years. These savings are likely to accrue to NHS, Social Care and private individuals in a ratio of roughly 3:1:1.

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

- Across Essex where this leads to optimal economies of scale.
- Commission jointly with partners at a local level where it makes more sense,
- Partner with Public Health England for specific programmes including screening**.**

2.9 Specific funding Streams

2.9.1 Section 256 Sustainability Funding

The initial proposals for the use of sustainability funds transferring from the NHS to ECC, which have yet to be agreed between the NCB- LAT, ECC and CCG lead Commissioners, are:-

- Fund a jointly appointed / integrated ECC Commissioning Lead within each CCG
- Provide CSU and Project Management capacity for the development of integrated specifications and the delivery of plans
- Resources for mutually beneficial demand management schemes.

2.9.2 NHS Transformation funding

The 2011/12 Operating Framework required 2% of recurrent resource to be held by the SHA/LAT for use non-recurrently to support transformation. This arrangement remains in place inviting proposals for the use of the transformation fund from CCGs and Providers in line with the criteria stated and set out within the Integrated Plan:

2.9.3 Section 256 Reablement funding

In accordance with 2006 Act regarding the empowerment of section 256 funding CPR CCG can agree to make payments to the organisation (in this case Essex County Council) to contribute towards a variety of projects for the provision of Reablement to the CP&R population.

The funding is used to facilitate a seamless service for patients to promote on-going recovery and independence and to prevent avoidable hospital admissions. The details of each project for 2013/14 are provided in table below for the agreement of CCG Board in March. The use of social care funding will be used to secure a dedicated social care professional and continuing health nurse coordinator/assessor to ensure CHC assessments are undertaken jointly. This is in

line with national framework for CHC health care. This specific project has specific key metrics and performance targets.

ECC provide operational management of the project(s) and shall meet at such intervals agreed to review the projects in accordance with DOH and CCG guidance. Similarly any information the CCG may require and may reasonably request will be provided. Any complaints in relation to the project(s) are notified to the nominated officers who in turn agree the appropriate course of action.

The schedule in the table below details the projects as agreed at the commencement of the CCG/ECC agreement but it is also agreed that the specific details given below may be amended at any time by written agreement between the nominated officers.

Table: Proposed Schedule of Projects for Reablement Funding 2013/14

Details of Reablement Project 2013/14	Estimates of Potential Impact	£904k	Outcome measures.
Re-tender of Reablement service and transformation to The Essex Reablement Model (TERM)	Reduction in admission and re-admissions to hospital. Reduced length of stay. Reduction in ongoing care packages	£452k	10% reduction in Acute Admissions following reablement.
Single Point of referral	Reduction in placement delays from hospital. Improved discharge planning. Reduction in hospital admissions	£160k	10% reduction in acute admissions through more responsive community service. Integrated working between ECC and CCG leading to better outcomes for patients
Dedicated SPT worker	Reduction in placement delays from hospital	£30k	Contribute to reduction in delays by 50%
2 Social Work posts for discharge from hospital, DAU, Princess Anne ward & Rosedale	Improved discharge planning. (Review in 6mths. with reference to implementation of other projects)	£80k	Reduction in admissions to Hospital. Avoid approximately 50% of delays. Eventually move to SPOR.
Dementia bed project	Reduced length of stay for patients with dementia. Improved outcomes for people with dementia in specialist reablement unit	£40k	10% reduction in admissions to hospital.
Consultant to take forward South Essex integrated intermediate care strategy crisis response and SPOR	Modelled on successful pilot of SPOR in SBC	£42k	Increase in transition period to set up of new service
2 GP MDT Workers		£50K	To maintain participation and joint working with GP's in order to provide early intervention and sign post appropriately.
Contract Home from Hospital service	For vulnerable people returning home on the first day of discharge from acute or community hospital care	£50k	To ensure clients are going home to Heat, Light & Food and a suitable environment before the ongoing care package is provided. To avoid hospital readmission

SECTION 3: COMMISSIONING TO IMPROVE QUALITY

3.1 DELIVERING CCG STRATEGIC PRIORITIES

As Section 1 set out, the CCG has identified priority areas that it will target its efforts on in order to improve the quality of care and patient outcomes. To deliver the strategic aims identified the CCG has planned the actions it needs to take across the strategic planning period. These actions can be broken down into those that are planned for implementation in the year of transition (12/13), those commissioning intentions planned the following year (13/14) to build on the foundations laid, and the medium term strategic plans covering a the next five years. The section below sets out how we will deliver change in each of these three phases of implementation.

This includes project and QIPP plans in year 1 (Section 4); headline commissioning intentions in year 2, and a focus on high-level programmes covering the entire period to 2014/15.

The CCG leadership team has established clear strategic ambitions in each of its strategic priority areas which are aligned to National Outcomes Framework.

These are summarised below and included in the tables in subsequent pages.

1. **Active Support for Self-Management -** Self-management support can be viewed in two ways: as a portfolio of techniques and tools to help patients choose healthy behaviours; and a fundamental transformation of the patient–caregiver relationship into a collaborative partnership.
2. **Primary Prevention -** Taking action to reduce the incidence of disease and health problems within the population, either through universal measures that reduce lifestyle risks or by targeting high-risk groups.
3. **Secondary Prevention:** - Systematically detecting the early stages of disease and intervening before full symptoms develop – for example, prescribing statins to reduce cholesterol and taking measures to reduce high blood pressure.
4. **Managing Ambulatory Care Sensitive Conditions -**Ambulatory care sensitive (ACS) conditions are chronic conditions that include congestive heart failure, diabetes, asthma, angina, epilepsy and hypertension. Actively managing patients with ACS conditions – through vaccination; better self-management, disease-management or case-management; or lifestyle interventions – prevents acute exacerbations and reduces the need for emergency hospital admission.
5. **Improving the Management of patients with both mental and physical health needs -** Developing a more integrated response to people with both mental and physical health problems, in particular supporting people with common mental health problems (such as, depression or anxiety) alongside a physical long-term condition.
6. **Care Co-ordination through integrated health and social care teams for frail elderly and children/young people -** Creating patient-centred care that is more co-ordinated across care settings and over time, particularly for patients with long-term chronic and medically complex conditions who may find it difficult to 'navigate' fragmented health care systems.
7. **Improving Primary care Management of End-of-life Care** - Within primary care, improving the systematic identification of patients who are at the end of life, and then

providing the appropriate support; in particular, improving the co-ordination of care, continuity, quality of communication, and the provision of bereavement care.

8. **Effective Medicines Management -** Medicines management supports better and more cost-effective prescribing in primary care, as well as helping patients to manage medications better. Good medicines management can help to reduce the likelihood of medication errors and hence patient harm.
9. **Managing Elective Referral Activity -** Managing elective (planned) hospital activity by systematically reviewing and auditing referrals with a view to benchmarking against other practices and improving referral quality and by ensuring patients are fully involved in decision-making.
10. **Managing emergency activity – urgent care – focus on frail elderly -**Developing a more integrated approach to urgent care for patients who have an injury or illness that requires immediate attention but is not serious enough to warrant a visit to an accident and emergency department (A&E) through better co-ordination of the range of services available and sharing of clinical information across different agencies.

These ten priorities inform QIPP planning and CCG commissioning operational plans for 2013/14

3.2 PLANS TO MEET CORE RESPONSIBILITIES IN 2013/14

Appendix 5 summarises CCG plans to enhance quality and deliver QIPP in 13/14 linked to the above strategic priorities and our CCG intentions for 2013/14 including lead responsible for each workstream.

3.2.1 Performance

Performance targets have been delegated to Castle Point and Rochford CCG. Since this time the emerging CCG in Castle Point & Rochford has retained a clear oversight of performance against national targets through the Castle Point Clinical Commissioning Governing Board and respective locality groups.

Performance reports – including all headline and supporting measures – have been a standing item throughout the period of delegation to the CCG operating as a sub-committee of the PCT Board.

Since July 2012 the CCG has developed its governance structures in preparation for authorisation to focus on all aspects of CCG and provider performance in an integrated way. In October 2012 the CCG has established a Quality and Governance Group (board subcommittee), which will focus on domains of quality; safety; performance; QIPP and finance in an integrated way. This group and the CCG will be presented with an Integrated Performance Report to enable it to identify key areas of risk and to plan and oversee mitigating actions.

The Quality and Governance Group focuses on holding programme leads and responsible directors to account for performance against national performance measures and for the delivery of 'turnaround' in performance measures falling below target.

The CCG will work with the Essex Commissioning Support Unit to ensure that all integrated performance reports can be broken down a) at locality/borough level, b) at practice level.

3.2.2 CCG Performance Priorities 2012/13

Castle Point & Rochford has performed well against most of these key measures in 2011/12 and continues to maintain this into 2012/13, as shown in Table 1 below. Governance arrangements in place locally will allow clinical leads to retain a firm grip on performance in these areas ahead and beyond authorisation.

Table 5.
Performance for South East Essex as at September 2012 ***(latest position to be added for final submission)***

National Quality Measures:		Period	Standard / Plan	South Essex		NHS South East Essex	
Preventing people from dying prematurely	Ambulance Red 1 (8 mins)	Jul-12	80% by year end	✗	73.0%		
	Ambulance Red 2 (8 mins)	Jul-12	75%	✓	77.2%		
	Ambulance Cat A (19 mins)	Jul-12	95%	✓	95.1%		
	Cancer						
	- 31 day first definitive treatment	Jul-12	96%	✓	98.8%	✓	97.6%
	- 31 day subsequent treatment - surgery	Jul-12	94%	✓	95.0%	✗	88.2%
	- 31 day subsequent treatment - drug	Jul-12	98%	✓	100.0%	✓	100.0%
	- 31 day subsequent treatment - radiotherapy	Jul-12	94%	✓	97.6%	✓	97.7%
	- 62 day standard	Jul-12	85%	✓	87.9%	✓	87.2%
	- 62 day screening	Jul-12	90%	✓	100.0%	✓	100.0%
	- 62 day upgrade	Jul-12	No standard		77.8%		83.3%
Positive experience of care	- 2 week wait	Jul-12	93%	✓	94.1%	✓	94.3%
	- Breast symptom 2 week wait	Jul-12	93%	✓	96.4%	✓	96.1%
Enhancing quality of life for people with long term conditions	Mental Health						
	Early intervention in psychosis (YTD)	Q1 12/13	vs Plan	✗	20	✗	8
	Crisis resolution - home treatment episodes (YTD)	Q1 12/13	vs Plan	✓	312	✓	142
	CPA follow up - 7 days	Q1 12/13	95%	✓	98.0%	✓	98.0%
	IAPT (percentage entering treatment vs need)	Q1 12/13	vs Plan	✗	2.9%	✗	3.0%
	IAPT (percentage moving to recovery)	Q1 12/13	vs Plan	✓	62.8%	✓	65.0%
Ensuring that people have a positive experience of care	Inpatient experience (weakest provider)	2011/12			74.6		
	RTT admitted	Jun-12	90%	✓	93.1%	✓	94.1%
	RTT non-admitted	Jun-12	95%	✓	97.9%	✓	98.5%
	RTT incompletes	Jun-12	92%	✓	95.3%	✓	97.1%
	Diagnostics - 6 weeks+	Jul-12	<1%	✓	0.2%	✓	0.2%
	A&E total time (weakest provider, quarter to date)	02-Sep-12	95%	✓	95.5%		
	Mixed-sex accommodation	Jul-12	0	✗	2	✗	1
Safe environment and protecting from avoidable harm	MRSA (YTD)	Jul-12	vs Plan	✗	6	✗	4
	MRSA plan	Jul-12	Plan data		4		2
	C. *difficile* (YTD)	Jul-12	vs Plan	✓	44	✓	23
	C. *difficile* plan	Jul-12	Plan data		57		27
Improving public health & well being	Smoking quitters (YTD)	Q4 11/12	vs Plan	✓	6,246	✓	2,905
	Smoking quitters plan data	Q4 11/12	Plan data		6,049		2,904
	Health checks (offered YTD)	Q1 12/13	vs Plan	✗	3.7%	✗	5.6%

Clinical commissioning leads have reviewed CCG performance at the end of 2012/13 and identified a number of priorities and challenges for 2013/14 for both acute and non-acute performance measures.

Provider performance against key performance indicators is outlined in Table 2 below and highlights performance issues at Southend University Hospital NHS Foundation Trust relating to 62 day cancer waits and MRSA. The CCG will continue to work with Southend CCG (SUHFT Contract host) to ensure that performance improves in these areas. In addition to this the CCG is closely monitoring A&E performance at Southend Hospital, as performance is only just above target in this area. A robust system Winter Plan has been developed to ensure that performance is maintained through winter pressures.

Table 6.

National Quality Measures:		Period	Standard / Plan	Southend University Hospital NHS FT	Basildon & Thurrock University Hospitals NHS FT	South Essex Partnership NHS FT
Preventing people from dying prematurely	Cancer					
	- 31 day first definitive treatment	Jul-12	96%	✓ 99.5%	✓ 100.0%	-
	- 31 day subsequent treatment - surgery	Jul-12	94%	✓ 95.5%	✓ 100.0%	-
	- 31 day subsequent treatment - drug	Jul-12	98%	✓ 99.0%	✓ 100.0%	-
	- 31 day subsequent treatment - radiotherapy	Jul-12	94%	✓ 97.8%	-	-
	- 62 day standard	Jul-12	85%	✗ 83.9%	✓ 93.4%	-
	- 62 day screening	Jul-12	90%	✓ 100.0%	✓ 100.0%	-
	- 62 day upgrade	Jul-12	No standard	75.0%	60.0%	-
Positive experience of care	- 2 week wait	Jul-12	93%	✓ 96.1%	✓ 93.2%	-
	- Breast symptom 2 week wait	Jul-12	93%	✓ 97.0%	✓ 96.1%	-
Enhancing quality of life for people with long term conditions	Mental Health					
	Early intervention in psychosis	Q1 12/13	vs Plan	-	-	45
	Early intervention in psychosis plan		Plan data	-	-	N/A
	Crisis resolution - admissions gatekept	Q1 12/13	95%	-	-	✓ 99.4%
	CPA follow up - 7 days	Q1 12/13	95%	-	-	✓ 98.0%
Ensuring that people have a positive experience of care	Patient experience (PF score for MHTs)	2011/12		74.6	75.4	Under review
	RTT admitted	Jun-12	90%	✓ 95.1%	✓ 91.8%	No data
	RTT non-admitted	Jun-12	95%	✓ 98.6%	✓ 95.3%	✓ 100.0%
	RTT incompletes	Jun-12	92%	✓ 97.3%	✓ 92.4%	✓ 100.0%
	Diagnostics - 6 weeks+	Jul-12	<1%	✓ 0.0%	✓ 0.0%	No data
	A&E total time (Quarter to date)	02-Sep-12	95%	✓ 95.9%	✓ 95.5%	✓ 100.0%
	Mixed-sex accommodation	Jul-12	0	✓ 0	✗ 1	✓ 0
Safe environment and protecting from avoidable harm	MRSA (YTD)	Jul-12	vs Plan	✗ 2	✓ 0	-
	MRSA plan	Jul-12	Plan data	1	2	-
	C. *difficile* (YTD)	Jul-12	vs Plan	✓ 4	✓ 11	-
	C. *difficile* plan	Jul-12	Plan data	11	14	-
	VTE	Jul-12	90%	✓ 94.3%	✓ 97.3%	-

Other non-acute performance concerns are highlighted in the table below (only C&B and LD Health Checks are broken down to CCG level, all other performance is currently at SEE PCT level):

Target	Current Performance	What we have done in 2012/13	What we will do in 2013/14
Coverage of NHS Health Checks – Offered (25,600)	5,668	Ensured that NHS Health Checks programme is supported by healthy lifestyle initiatives and treatment i.e. weight management, smoking cessation, physical activity, NHS Health Trainers. Service specification for a community/workplace outreach service to provide NHS Health Checks in our most deprived MSOAs, areas of highest CVD prevalence and for routine and manual workers to address health inequalities has been prepared and sent to providers. Population based targets calculated and sent to practices. Clinical admin training ongoing.	MNA to meet with PH Team to develop action plans
Coverage of NHS Health Checks Received (15,372)	2,699		MNA to meet with PH Team to develop action plans
LD Health Checks (421)	31	Arrangements established to cover patients of practices not participating in the DES.	MNA to add
Choose and Book (% Useage TBC)	CP&RC&B.pptx	Sara Tindell, Performance and Corporate Services Manager appointed as CCG lead for Choose and Book. Practice useage of Choose and Book	MNA to add

		presented to Locality Group members as a standing item within the CCG Performance report and shared at the Public Board meeting. Additional Choose and Book training and support provided to those practices with poor uptake rates.	

Target	Current Performance	What we have done in 2012/13	What we will do in 2013/14
Childhood Immunisations: Age 2 MMR (95%)	89.9%	Public Health Nurse to continue to monitor monthly COVER, waiting lists and suspension lists and identify and assist practices to improve using active patient management model. Share data with CCGs to consider whether practices can work collaboratively to improve uptake. MMR LES in Place and practice level action plans developed with those practices that have a low uptake of MMR vaccine.	MNA to add
Childhood Immunisations: Age 5 MMR (95%)	TBC		MNA to add
Cervical Screening (80%)	79%	Project initiated with general practice to improve identification of eligible population. Work is underway with 3 local practices. Non-attenders mapped for segmentation work.	MNA to add
Winter Flu Vaccination – 65 years and above (75%)	To be added	Targeting practices with low uptake to offer support to increase the coverage of flu immunisation. In 2012/13 there will be a particular focus on the at risk groups, including asthma and COPD patients. Engaging with adult social care, older peoples groups, LTC support groups and social housing organisations to develop a mechanism to disseminate messages and encourage uptake. Specialist nurses and adult community nurses including advice and information on flu vaccination at all routine appointments in flu season. Expanded upon our flu immunisation and Winter Warmth letters/campaign to include other health messages. Continuing to proactively manage	MNA to add
Winter Flu Vaccination – at risk groups (70%)	To be added		MNA to add

		outbreaks of influenza – like illness in nursing and residential homes with anti-viral prophylaxis. Working with providers to increase vaccination uptake by frontline staff by ensuring high level organisational support for the programme, good communications and accessible vaccination clinics. Flu immunisation delivered from, a hospital setting for pregnant women and children with chronic Conditions.	
SEPT Pressure Ulcers (0)	 Copy of Pressure Ulcers New SEPT-CHC	£90k of 2% transformation fund set aside by the PCT to support elimination of avoidable pressure ulcers. Standard clause included in contracts provided by the SHA included in contract negotiations and included within CQUIN. Action plan from Intensive Support Team visit currently being implemented. Local communication plan in place and in line with the SHA plan.	MNA to add

3.3 PROGRESS AGAINST QIPP DELIVERY IN 2012/13

Commissioning priorities in 2012/13 have focused on reducing outpatient referrals and unplanned admissions and associated spend and reducing prescribing expenditure.

Referral management: The CCG has agreed that Specialty Peer Review is their preferred approach to Referral Management. Peer Review has been in operation since May 2011 targeting key high referring specialties and practices. In January 2013 the CCG appointed a GP lead for referral management who is visiting practices and developing communications all aimed at improved referral management.

Prescribing: The CCG have appointed three GP clinical leads for prescribing. The Medicines Management team leads have already carried out the 1st series of practice visits to set out QIPP requirements and associated Prescribing Incentive Scheme targeting the high spending practices and it is anticipated that this approach will deliver substantial savings for CCG moving forward.

Unplanned Care: The CCG in partnership with Essex County Council have supported and delivered the roll out of the health economy wide schemes that focus on the frail elderly and management patients in community. This includes Single Point of Referral (SPOR); access to

intermediate care beds; access to Community Geriatrician; community and practice level MDT, and risk profiling to identify vulnerable patients. We have worked closely with providers to understand the current patient pathways through the unplanned care system, with a view to redesign services further to deliver efficiencies and through pro-active interventions avoid unnecessary acute admissions. These initiatives will continue to be embedded into 2013/14.

Other Areas (some of which benefit for Essex County Council Integration):

Befriending Scheme: Working in partnership with local voluntary sector delivered joint scheme aimed at using volunteers to visit vulnerable adults in Castle Point area. In Dec 2012 the board agreed to extend this scheme into Rayleigh / Rochford localities. This scheme can be specifically linked to Essex County Council 'Strengthening communities' workstream.

Community Paediatric Service: The CCG in partnership with Essex County Council initiated discussions with provider organisations regarding specific pathways within paediatrics, focusing on shifting activity into a community setting, developing primary care provision through structured support and education and reducing follow up rates.

Dermatology: The CCG began the development of a community based dermatology service that works in partnership with primary care to avoid acute activity, utilising innovative modern technology such as virtual consultations.

MSK: Appointed GP clinical lead for MSK and will ensure CCG takes a lead role in delivering MSK QIPP agenda. This includes the pilot of refined Lower Back Pain pathway. The GPs through their involvement with MSK Project Board will also inform deliberations in partnership with Southend Hospital regarding moving to an Integrated Pathway Hub model for MSK in South East Essex.

Intermediate Care Beds: A key are of integration with Essex County Council. Following a formal procurement process led by Essex County Council, the 10 rehab beds previously located at Parklands Nursing Home in Benfleet, has been relocating to Rosedale Court Nursing Home in Rayleigh. This is a phased transition with ECC working in partnership with the CCG and SEPT Community services.

Medical Cover for Rehab Beds: During recent Practice visits, the issue of providing GP cover to the 10 rehab beds was raised on several occasions. Although these residents are classed as 'temporary residents' with the nearby Practices, the acuity of the patients is impacting on the time commitment and prescribing budgets of these Practices. Options are currently being discussed to formalise an arrangement for such GP provision to these beds, with appropriate remuneration. A commissioning proposal will be submitted to the LCGs in January 2013.

NHS 111 and Out of Hours: CP&R CCG has provided Senior Commissioning and Clinical leadership with this health economy-wide procurement.

SHA Stroke Services Review/Reconfiguration: An SHA review of stroke services is currently underway throughout the NHS Midlands & East region. The review is comprehensive,

encompassing every aspect of the patient journey from Primary Care to end of life with the aim of making step change improvements in the quality of stroke care and resulting outcomes. Essex County Council will also be interested in the proposals as they emerge for consultation in February 2013.

The provision of stroke services in Essex is expected to change considerably following the recommendations of the review; the implementation of a 'hub and spoke' model looks inevitable. The CCG will be fully engaged in this process through its involvement in local Cardiac and Stroke Network

Ophthalmology: There has been considerable development in Ophthalmology in the early months of 2012/13.

- Consult to Consultant referrals – the issue of excessive consultant to consultant referrals has been addressed through contract management and the Trust have agreed to a new protocol which is now being circulated for consultants to implement.
- Generic ophthalmic pathway – Meeting shave taken place with all stakeholders to review current over performance of the Trust and sustainability going forward. A collaborative co-managed care pathway is being proposed for both Outpatients and follow ups.
- Primary Care Triage and treatments -

Dietetics: An options paper was submitted to both LCG's for review and discussion with regard to provision of dedicated service for South beast Essex CCGs.

New Emerging Commissioning Proposals Commissioning Proposals: The following commissioning proposals are being submitted to the Locality Groups for review:

- Deep Vein Thrombosis (DVT)
- Voluntary Management Scheme
- Non-Cancer Lymphoedema
- Intermediate Care Bed Provision – Reviewing future Options in partnership with essex County Council

3.4 ENABLING ACTIONS AND ADDITIONAL SERVICE DEVELOPMENTS

The CCG will oversee a number of programmes and initiatives to support the delivery of the goals set out in this Integrated Plan. The CCG will lead work to develop local models of care and infrastructure across the localities, will support more choice for patients and will work to develop the clinical competencies of the Castle Point & Rochford workforce (See organisational Development Plan). To supplement this, the CCG will continue to focus on developing its capability and capacity as an organisation and will retain an effective PMO function to ensure it continues to progress as planned.

3.5.1. Patient Choice

Castle Point CCG is committed to supporting patients to be involved in their care. We want to enable more patients to exercise choice about their care more of the time. In an environment where patients are able to exercise choice in relation to the services they use, providers are additionally incentivised to offer the best possible quality of care and patient experience. To begin to make this happen, the CCG will work to increase the extent to which patients have a choice of provider, location or treatment type by:

- Developing an extended range of community services as an alternative to hospital outpatient care
- Developing patient-centred planning as central to the model for Long Term Conditions services
- Using the Any Qualified Provider contracting approach to increase the range of providers in areas where this will improve the quality and responsiveness of care
- Developing good information for patients about local services and the options available to them. This workstream will be coordinated with Essex County Council.
- Promoting increased use of Choose and Book by Castle Point & Rochford practices, promoted via regular specialty-specific peer review sessions
- Increase the proportion of Personal Health Budgets offered to patients eligible for continuing healthcare
- Continuing to listen to patients' views in consultation room about the range and quality of local services and reflect these views and their choices in our commissioning intentions
- Supporting more services to support people to self-manage their condition. This workstream will be coordinated with Essex County Council.

The above ambitions in relation to extending choice are included within initiatives and programmes included in the CCG's Commissioning Intentions (see Section 2).

3.5.2. Programme Management Function

The CCG will operate with a management structure that includes a senior post-holder – Head of Performance & Corporate Services – responsible for overseeing the delivery of the Integrated Plan and the key outcome measures included in the CCG Strategic Framework.

The post-holder will report directly to the CCG Chief Operating Officer and assume responsibility for reporting progress on delivery of all facets of this plan to the CCG Integrated Governance and Performance Committee and to the CCG Governing Body.

For further details of *NHS Castle Point & Rochford CCG Organisational Structure & Governance Arrangements* please see *CP&R CCG Organisational Development Plan* document.

3.5.3. CCG Organisational Development Plan

As a new and emerging organisation, Castle Point & Rochford CCG will participate in planned programmes of development to support it and its clinical and managerial staff to manage the delivery of the Integrated Plan. The CCG Organisational Development Plan sets out our approach to achieving this.

The Organisational Development Plan includes five key priority areas of work linked to authorisation criteria to develop the CCG so that it is:

1. Clinically-led at all levels of the organisation
2. Customer-focussed in respect of its members and stakeholder
3. Able to function effectively in collaboration with partners
4. Able to effectively manage communications with patients, members and stakeholders
5. Competent and capable of delivering its goals

For further details see *NHS Castle Point & Rochford CCG Organisational Development Plan*.

3.5.4 Primary Care Development

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

The CCG would like to commission a project looking at primary care quality and their capacity to deliver this Integrated Plan and achieve improvement in the outcome indicators. This work would be completed during 2013/14 to inform a longer-term strategy to improve primary care quality and reduce variation in patient outcomes across the borough.

The intention is that our CCG would invest in a programme of targeted primary care development to support the delivery of the Integrated Plan and the outcomes included in the CCG strategic framework. The purpose of this development programme is to:

- Support high quality care in primary care and community settings
- Improve the identification and management of a range of conditions
- Provide more care closer to the patient and by doing so decreasing reliance on acute hospital care.

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

- Early identification and accurate diagnosis of long-term and other priority high prevalence conditions
- Enhanced ability to manage long term conditions, to avoid hospital referral and support better patient outcomes

- Medicines management knowledge in order to provide quality, cost-effective prescribing and support
- management of patients in primary care where part of an agreed pathway
- Good understanding of agreed local pathways and local service configuration to enable referrals to be made to the right service for each patient's needs, at the right time

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

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

Section 4: Managing a financially sustainable Health Economy

4.1 Castle Point & Rochford CCG Financial Position

A Note on Financial Assumptions

This section has been subject to a refresh in February 2013. Castle Point CCG and Essex Commissioning Support Unit finance colleagues have helped complete a full refresh of the finance section following the publication of the NHS Planning Guidance 2013/14 and CCG 2013/14 financial allocations.

We provide a high-level model here and more detailed model in **Appendix 2**. Figures included in this section for 2013/14 onwards exclude those areas such as primary care, most property costs, and public health that will transfer to other parts of the NHS or to other organisations.
Figures included in this section are subject to revision

4.1.1 Finance Position 2012-2013

As Section 2 sets out, Castle Point & Rochford CCG has an ambitious plan to improve the quality of local health services, achieve better outcomes for patients and to reduce the health inequalities that exist in the localities. We are, however, acutely aware of that we have only limited resources to deploy in pursuit of achieving these objectives.

Demand for health services caused by population growth and demographic change costs more as do inflationary pressures such as the growing expense of new healthcare technologies. In short, our annual resource allocation already falls below the costs we will incur. So to support a sustainable health economy and operate as a financially responsible commissioning organisation, we will need to reduce unnecessary costs where these do not impact frontline services. We will also need to commission models of care and clinical pathways that are increasingly efficient.

This section and tables sets out our headline strategic financial plans and assumptions, which allow us to model the resources available to us to deliver our strategic priorities.

Financial Plan for 2013-14			Programmes £000's R	£000's NR
Recurrent Allocation			-188,188	
Growth at 2.3%			- 4,328	
Notified recurrent Allocation			-192,516	
Application of funds				
Outturn				
	Acute	121456		
	Mental Health	21071		
	Community	10695		
	Continuing care	9413		
	Primary care	28119		
			190,754	
Non- recurrent expenditure CQUIN			- 3,828	
Recurrent expenditure			186,926	
2% headroom (statutory requirement)			3,850	
Tariff Deflator 1.3%			- 1,962	
Activity growth				
	Demographic	1112		
	Demand	3349		
			4,461	
Investments				
	Recurrent	5958		
	Non-recurrent			1,000
			5,958	
Non-recurrent expenditure CQUIN			3,245	
Total planned expenditure			202,478	1,000
GAP			9,962	1,000

Appendix 1 - Castle Point and Rochford & Rayleigh

2012/13 Financial Reporting - Month 9		South Essex Cluster							
		Year to Date			Opening	Full Year Forecast			Previous month FOT
		Plan	Actual	Variance	Plan	Plan	Forecast	Variance	
		£000	£000	£000	£000	£000	£000	£000	£000
Acute Activity									
	NHS acute providers	73,240	80,281	7,041	88,868	98,061	107,042	8,981	7,710
	NCAs	969	908	(61)	1,270	1,292	1,211	(81)	70
	Ambulance	4,451	4,563	112	4,864	5,935	6,083	149	222
	Other providers	6,556	7,101	545	8,215	8,735	9,468	733	931
		85,216	**92,853**	**7,637**	**103,217**	**114,021**	**123,803**	**9,782**	**8,934**
Mental Health & LD									
	SEPT contract	14,436	14,416	(20)	16,318	19,248	19,221	(27)	(27)
	Other MH & LD	948	831	(117)	2,275	1,264	1,108	(156)	(172)
		15,384	**15,247**	**(137)**	**18,593**	**20,512**	**20,329**	**(183)**	**(199)**
Community Health									
	SEPT/NELFT contract	7,808	7,553	(255)	7,962	10,410	10,071	(339)	(337)
	Continuing healthcare	5,906	6,565	658	7,324	7,875	8,753	878	837
	Other community	1,319	1,230	(88)	1,548	1,758	1,641	(117)	(126)
		15,032	**15,348**	**316**	**16,835**	**20,043**	**20,464**	**421**	**374**
Medicines Management									
	GP prescribing	18,500	19,395	895	24,275	24,863	25,860	997	969
	Other meds management	2,048	993	(1,055)	1,573	2,757	1,324	(1,434)	(1,471)
		20,548	**20,388**	**(160)**	**25,847**	**27,621**	**27,184**	**(437)**	**(502)**
Other Healthcare Services		**3,615**	**3,769**	**155**	**4,638**	**4,522**	**3,506**	**(1,016)**	**0**
Management costs		**988**	**989**	**0**	**633**	**1,625**	**1,625**	**0**	**(336)**
Total CCG		**140,783**	**148,593**	**7,810**	**169,763**	**188,343**	**196,910**	**8,567**	**8,271**
	South East Essex PCT	*140,783*	*148,593*	*7,810*	*169,763*	*188,343*	*196,910*	*8,567*	
	South West Essex PCT	*0*	*0*	*0*	*0*	*0*	*0*	*0*	

This position is before the deployment of the 1% contingency which will be returned to the CCG in year and any other QIPP reserves or general reserves currently managed by the PCT. This also assumes that only 60% of the QIPP schemes are achieved in the acute sector and prescribing has achieve its growth but with a 5% growth in prescribing costs.

4.1.2 Financial Assumptions

The CCG are making the following financial assumptions:

- The allocation that was split out from the NHS South Essex PCT cluster has been the original level of resources. No additional resources from reserves being currently retained by the PCT has been taken into account for individual CCGs.
- The 1% top slice to the PCT has not been returned to CCGs and will continue with the NHS Commissioning Board.
- That current levels of resource split with public health and other organisation have not changed since the assumptions from the start of the year.
- That any transfer to CCG of responsibility of services comes with the resources able to fund the service.
- The budgets have been set on current projections of outturn based on month 6 projected outturn.
- The efficiency savings identified by the Department of Health continues for the next two years.

- Growth is as stated in the assumption from the Operating Framework and previous plans in the PCT. These growth assumptions will be revised once the allocation assumption and the operating framework is published.
- Continued growth within the acute sector of 2% for the next financial year.
- Growth within the prescribing arena continues as per current trends.
- Pressure and priorities identified in the Operating Framework will continue, this will be revised once published but will include Mental Health strategy and 111/Out of Hour services.

4.1.3 Financial Case for Change

The challenge for QIPP in 2012/13 assuming no additional resources being related to the CCG will be £15m. This can be broken down

- Keeping all growth in provider services care to 0% - **£4,461k**
- Continuing with the legacy QIPP schemes and Prescribing achieving the full potential of these schemes as currently assumes 66% achievement - **£4,510k**
- Agreeing acute contractual changes and risk share **£6,026k** .
- The CCG will be developing a full list of prioritised schemes for 2013/14 over and above the legacy schemes already in train in effort to improve position event further. (See section 4)

4.2 Essex County Council - Financial Position

4.2.1 ECC – Financial Outlook

Local government faces central government funding reductions of nearly 30% over the 4 year period to 2015 and further reductions are expected in the next Comprehensive Spending Review. As a result of this reduction in funding, ECC is forecast to shrink from being a £930M organisation in 2012/13 to an £850M one by 2016/17 (excluding new responsibilities and funding arrangements around Public Health and Learning Disability Grant). The gap between available budget and demand for ECC services is forecast to be £200M by 2016/17.

Over the last 4 years Essex County Council has embarked on an ambitious transformation programme and achieved savings of £300M per annum by 2013. This is one of the largest savings targets of any local authority in the country.

However, the major challenge ECC faces is not simply one of reductions to funding levels, but inflation and demographic pressures. The Council faces demographic pressures and increased demand for services, particularly in the Adult, Health and Wellbeing service area including Learning Disability, Physical and Sensory Impairment, Older People and Mental Health services. These services alone represent close to half of ECC's controllable budget. The risk is further exacerbated given the enormous efficiency savings and demand pressures within the health

system. It will be imperative that we work with health partners and build on the Whole Essex Community Budgets work to date, to address the common issues we face.

An overview briefing paper of Essex County Council Expenditure Analysis was provided to CCGs in mid February.

4.2.2 ECC Transformation Programme

The profile of the financial gap for ECC over the years to 2017 is:

- 2013/14 - £5M
- 2014/15 - £77M,
- 2015/16 - £137M
- 2016/17-£195M

In order to deliver efficiencies of £200M per annum by 2016/17 the County Council has agreed a Transformation Mark II programme. The programme will continue the council's transformation into a commissioning-led council, separating explicitly strategy and commissioning from operations.

In re-structuring the council, the statutory roles of the Director for Children's Services (DCS) and Director for Adults Social Services (DASS) have been combined. The combined post-holder of DCS and DASS is the principal Commissioner for People Services.

Section 5: QIPP Challenge Castle Point & Rochford CCG (2013/14)

5.1 Overall Savings Plan

Appendix 5 sets out the current list of prioritised QIPP schemes for 2013/14 including savings targets that have been agreed for Castle Point and & Rochford CCG. These include all legacy 2012/13 schemes that are expected to impact on the CCG next year

5.2 Prescribing

This work stream aims to step up efforts to ensure that practices deliver the most cost-effective prescribing, based on current guidance and known good practice.

The range of variation in cost per ASTRO-PU across the PCT is currently between £12,160 and £30,722 (excluding the Victoria Surgery), with the PCT average being £23,215 (below the national average of £24,638). Rayleigh & Rochford CCGs spend less than the PCT average on prescribing with CCG costs per ASTRO-PU £21,130 respectively.

Although the CCG average cost per ASTRO-PU is below the PCT average, there is significant variation in prescribing costs between practices (Rayleigh & Rochford - £16,737 to £23,903). Grouping practices into three groups based on population demographics showed no relationship between population type and prescribing spend. It therefore appears that the differences are more likely associated with prescribing behaviour. Experience from the medicines management team at the PCT backs this up and in recent years some practices have moved from being amongst the highest cost per ASTRO-PU to amongst the lowest.

Given the current financial situation for the CCG we consider that prescribing should be a top priority in the QIPP programme as it is one of the areas where GPs have direct control over resource use. If the range of variation was reduced significantly to match the lower spending practices, the opportunities for savings would be significant:

Although these scenarios are probably over-ambitious, they demonstrate the significant potential that is available if GPs were to commit to prescribing differently, based on advice from the medicines management team.

We consider that a more realistic target may be between £750-850k depending on the level of resource required to support the changes. We propose that a sliding scale of practice level savings targets is introduced in order to reflect the level of savings opportunity that might be available.

The prescribing plan sets out the actions that would be required to develop and implement a scheme to reduce prescribing spend. Key aspects of this would need to be:

- An appropriate incentive scheme to reward all practices for significant reduction in prescribing spend
- Additional pharmacy support to help practices identify the best way to improve cost-effectiveness
- Development of practice level prescribing plans with clear targets overall and on key drugs

- Regular performance monitoring at CCG Board meetings
- Provision of necessary data
- Supporting material for patients

5.3 Planned Care

EFFECTIVE REFERRALS – PEER REVIEW

There is currently significant variation in referral patterns across the CCG and wider cluster populations. There are various methods available for tackling such variation using referral management techniques. The CCG has opted to maintain a system of peer review for referrals rather than developing a referral management centre.

There is good evidence to suggest that well organised peer review can be very effective in reducing variation in referrals and ultimately reducing overall referral rates. The system being applied across localities has already demonstrated some significant success.

Savings associated with reducing outpatient referrals:

- Cost of the First Outpatient Appointment
- Cost of subsequent outpatient procedures (to a lesser extent)
- Cost of procedures (to a lesser extent)
- Cost of Follow-ups

The cost of all GP referred outpatient activity (excluding ophthalmology and all outpatient procedures) for the CCG in the twelve months to the end of October 2012 was around £4m, with around £2.3m in First Attendances and £1.4m in follow ups.

Given that all CCGs are currently working to reduce referrals this average is likely to fall in 2013/14. It therefore appears reasonable to aim for a target reduction of around 10-12% to continue in 2012/13. The peer review process has been formalised and agreed within the CCG.

Appointed a dedicated GP lead for Referral Management to provide expert clinical leadership and providing specific targeted support to higher referring practices will also enhance the process that is used in the CCG.

The £XXXk savings is gross and should deliver with a margin of safety the required net savings of around £XXXk as outlined above, once costs for the scheme have been considered.

In order to support the peer review process and to enable practices to target their efforts we will provide practice level target savings at specialty and HRG levels.

OPHTHALMOLOGY TRIAGE

The CCG has identified that there is scope to reduce significantly the level of ophthalmology referrals, through the introduction of a referral triage system. Currently 31% of referrals are coded as 'other' and these will be mainly from optometrists. It is considered that the current quality of referrals from optometrists and GPs could be improved and may benefit from a simple triage system to reduce the number of referrals.

The details of how this model might work are being developed at present and the potential savings, which are relatively modest are outlined below.

	Current Spend	**% saving**	**£ savings**
GP and 'other' referred First Outpatient Attendances (FOAs)	258	15	38.7
Current spend on GP and 'other' referred Follow-ups	200	10	20
		Total	£58.7k

These are initial estimates and do not take into account the cost of delivering the service or the knock on effect in the reduction of elective procedures. However, in order for a triage service to be viable it is likely that it would need to be combined with Southend CCG and would need to cover all GP and optometry referrals.

Overall savings may also be reduce by the impact of changes in PbR coding which will allow more outpatient appointments to be coded as outpatient procedures. The impact of this has not yet been tested.

SHARED DECISION MAKING

In order to support a reduction in referrals we propose that the CCG implements a programme to promote the use of Shared Decision Aids. There is good evidence to suggest that these:

- Improve patient experience by ensuring that patients have all the necessary information they need in order to make an informed decision about treatment
- Reduce uptake of various procedures where the benefits are less clear cut and where there may be risks associated with the treatments.

NHS East of England (Now NHS Midlands and East) undertook a programme to develop a range of decision aids which are now freely available for patients to use on the NHS Direct website (www.nhsdirect.nhs.uk/decisionaids) for the following procedures:

- Advanced kidney disease – planning for end of life
- Benign prostatic hyperplasia
- Cataracts
- Localised Prostate Cancer
- PSA Testing

- CVS and Amniocentesis
- Breast Cancer
- Knee Arthritis
- Osteoarthritis of the Hip

Rolling out wider use of these tools may be particularly helpful in this CCG due to the demography of much of the population (low deprivation, affluent well educated older people).

Whilst savings associated with implementation of these is hard to quantify the evidence from application elsewhere suggests that it should be worthwhile. We will undertake some further analysis to establish what likely opportunities might be associated with this, based on some assumptions as seen elsewhere in the world when these tools have been used.

CONTRACT LEVERS

The PCT is pursuing a range of savings through current contract negotiations, which should be concluded in the next few weeks. This includes:

CONSULTANT TO CONSULTANT REFERRALS

Audit of Consultant to Consultant referrals with a view to agreeing reductions and/or acceptable ratios against baseline of all referrals

PROCEDURES OF LIMITED CLINICAL VALUE

The PCT has already produced a revised range of procedures of limited clinical value. Procedures on this 'Low Priority' list should either not be carried out at all or only in certain circumstances where clear criteria are met.

The CCG currently has a relatively high spend on these procedures with high rates (see next page for details) for:

- Carpal Tunnel
- Wisdom tooth extraction
- Tonsillectomy
- Trigger Finger

In view of this the CCG needs to take action in two ways:

- Ensure that all referrals are made in line with current guidelines for these procedures (including promotion of the guidance and targeted peer review where necessary)
- Engage with the contracts team to ensure that the procedure for checking that the relevant criteria were met is being adhered to prior to payment.

5.4 MSK

Southend CCG is leading a piece of work to develop an 'Integrated Pathway Hub'. This would see all resources being pooled for:

- Elective and non-elective secondary care inpatient, day case and outpatient treatment for T&O , rheumatology and pain
- Orthotics
- Community and secondary care physiotherapy
- Secondary care falls service
- Fracture liaison service recently commissioned

The reasons for the new approach are as follows:

- Difficulty reaching national 18 week targets for T&O – SUFHT report that this is predominantly around Spinal procedures
- For 10/11, the spend for T&O outpatients in South East Essex was £6,471,564 circa 32% higher than the national and 37% higher than East of England average. (NHS comparators)
- Spinal consultants at SUHFT report that a high percentage of patients seen by them do not need surgery and so are referred onto physiotherapy.
- Spinal surgery activity for SEE is around 28% above the national and East of England average. The cost however, is 17% above national average and 25% above EoE average, (NHS comparators 08/09). Although the majority of the activity pertains to T&O, around 37% is associated with Pain services. SUHFT have recently taken on a third Spinal Consultant which although may assist in achieving the 18 week target, could further increase the volume of surgery.
- Overall T&O conversion rates are within contractual agreements, however, conversion rates for spinal are low and spinal intervention rates are nearly double the national average.

There are two main objectives for the project, which are:

1. Pilot the Keele Tool for stratification of lower back pain in primary care.
2. Develop a contract variation with SUHFT to provide an Integrated Pathway Hub

A number of practices in the CCG are taking part in the pilot and the projected savings are currently :

		6	months	
RR MSK programme budget		£5,853,486		PCM
efficiency	5%	£292,674.28	£146,337.14	£24,390
	7%	£409,744	£204,872	£34,145
	10%	£585,349	£292,674	£48,779

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	TOTAL
5%	£588	£588	£588	£588	£588	£588	£24,978	£24,978	£24,978	£24,978	£24,978	£24,978	**£153,393**
7%	£588	£588	£588	£588	£588	£588	£34,733	£34,733	£34,733	£34,733	£34,733	£34,733	£211,928
10%	£588	£588	£588	£588	£588	£588	£49,367	£49,367	£49,367	£49,367	£49,367	£49,367	£299,730

We are currently working through the detail to ensure that actions required at practice level are delivered.

5.5 Unplanned Care

Unplanned acute care comprises £28.8m (17%) of Castle Point and Rayleigh & Rochford CCGs' allocations.

Potential for savings:

The PCT benchmarking (using crude population) shows both Castle Point and Rayleigh Rochford at 80 cases per 000 population are slightly below the S E Essex average use of unplanned care at 83 cases per 000 population and are slightly higher than the Essex average of 77 cases.

The weighted population equivalent comparison shows Castle Point at 80 cases which is below both the S E Essex figure of 83 cases and the Essex figure of 81 cases. Rayleigh Rochford is slightly above the weighted average at 85 cases versus S E Essex 83 and Essex at 81.

The detailed benchmark analysis (on weighted population) identifies opportunities to:

- Reduce admissions and improve care by meeting patients' needs closer to home in general practice or community settings.
- Reduce excess bed day costs.

The benchmarking groups the practices into three categories (Older; Average; Low Deprivation) and sets separate national benchmarks for each category. The analyses are at practice level and the targets will be set out in detail at practice level.

That analysis identifies that approximately £2.7m (10.3% of unplanned care costs) would be saved if each category of practices reduced unplanned care to their national benchmark.

The potential is slightly lower for Castle Point at 9.5% opportunity and higher at Rayleigh Rochford at 11.5%.

It is important to note that a significant proportion of the short length of stay cases have already been reduced by previous initiatives. The longer stay cases (2 days and above) will be more challenging to address.

Proposed saving target:

The CCG has agreed a target saving of £762k in unplanned care which represents 2.7% of the budget. That target is realistic at about a third of the benchmark opportunity given that the shorter length of stay cases has already been reduced.

There are several PCT QIPP schemes that will add to this target:

1. A&E - Admission avoidance / Gateway Schemes
2. Admission avoidance car (Ambulance Trust Initiative)
3. *Community Geriatrician (Frail Elderly Care)
4. *Community MDT (Frail Elderly Care)
5. *One Care Home / One Practice

* Essex County Council will be involved in these projects which relate to integration of services.

Those QIPP projects each have their own templates and a summary template sheet will draw the key metrics together to fulfil the overall target.

The CCG propose to address the target by:

1. Community Service signposting to make best use of existing community services - an essential element of all these projects is effective liaison with Community Services to ensure GPs and patients can efficiently access those services that have already been developed in the community as an alternative to acute hospital admission.
2. Early identification of inpatients likely to exceed trim points, becoming long-stayers incurring excess bed day costs. The tracker nurse, working with discharge teams would target those potential long-stayers to ensure there were no organisational delays or lack of clinical input which would lead to stays beyond trim point.
3. Community services review – ensuring that the community services that have been developed to provide care closer to home are focussed on the most effective way to reduce inappropriate admissions. The first steps of this will be to review the last two years' plan developments with the community provider to review impact and agree retargeting where appropriate. This review would also cover examination of duplication of services within the provider and across the community and acute providers.

Review of LTC case management arrangements – to ensure that suitable patients are being identified and supported as much as possible.

FRAIL ELDERLY

The Frail Elderly programme forms part of the wider model for Unplanned Care in South East Essex. The programme focuses on the improvement of services in the community and primary care that reduce the risk of patients exacerbating and requiring acute intervention. Furthermore, the programme will ensure that if a patient does exacerbate and require additional input, appropriate care packages will be able to be easily sourced and provided in a domestic or community setting.

This aims to improve the quality and appropriateness of care offered to patients (as long term outcomes are better when patients are managed close to home where they can be) and reduce the spend on unplanned care as alternatives in Primary, Community and Social Services offer better value. In addition, where patients need is appropriately managed in the community the longer term costs for caring for the patient are lower.

The project has three elements – Community Geriatrician; Intermediate Care and Single Point of Referral (SPOR) which are summarised as follows:

- Community Geriatrician

There has been a consistent view across South East Essex that to appropriately manage "high risk " elderly patients there is a need for senior clinical consultant leadership in the community to provide clinical support to GPs, the existing community teams , the intermediate care service and lead on a case management approach . It was felt that this approach would enable patients to be cared for in a community based setting of care rather that admit unnecessarily to acute settings.

The Community Geriatrician service will lead a comprehensive community MDT (which include Essex County Council Social Care input) with the aim to avoid unnecessary acute admissions and re admissions and ensure care be delivered as close to the home as possible. The aim is to improve the quality of care to older people in the community using a multidisciplinary team approach, led by a community Geriatrician providing the following benefits:

- Improving quality of care to older people in the community
- More effective management of patients in nursing and residential homes (high attendance and admission rate and high ambulance call out rate). This scheme would focus on those patients in care homes who meet the criteria and are deemed to be at highest risk of an acute admission
- Improved liaison and support to GPs
- Prevent inappropriate hospital admissions through better coordinated community care
- Reduce cost of inappropriate diagnostic tests (spiral of intervention)
- Reduce cost of inappropriate medication
- Decrease length of stay, improve bed utilization
- More cost effective model of care
- Intermediate Care

This scheme relates to the development of intermediate care services both to increase volume of intermediate care beds (up to 50 beds - utilising a closed ward in the hospital and spot purchasing other intermediate care beds dependent on need in the community). The need for additional Intermediate care beds is borne out by the Care of the Elderly Review 2009/10 and the fact there is a higher than average admission rate to DME wards in comparison with "peer" PCT areas. It should be noted that we currently commission a ward of 25 beds from the hospital (Princess Anne Ward) and are reviewing tenders for community provision of Intermediate Care beds. This additional capacity is intended to avoid acute hospital admissions and will contribute to the Community Geriatrician project (above). Its costs & benefits are subsumed in that project. All this work is carried through in partnership and working in collaboration with Essex County Council.

- SPOR

In collaboration with Essex County Council and Community health care provider, this project is a crisis health/social care response for patients over the age of 65 with the key client groups being GPs, care homes and Emergency Care Practitioners. The aim is to provide a comprehensive assessment of elderly patients within 2 hours following referral of elderly patients (who meet specific criteria) to prevent them from admitting to hospital inappropriately. The service is based around a rapid nursing response model and has direct links to social care teams in the area and team will undertake an assessment of the patient in their home and monitor the patient on a regular basis to ensure they do not admit to

hospital inappropriately. On average patients are on the caseload for 2 weeks. This scheme also provides direct assessment of patients in A&E settings as well as facilitating discharge from hospital to prevent unnecessary long lengths of stay. The scheme has been piloted in one part of SEE and will be rolled out across the locality during 2011/12. The key benefits from the programme include reduction in admissions and re-admissions to hospital for this age group, development of a comprehensive community care plan as well as providing direct input and expertise to those care homes where there is a high volume of emergency admissions. A single point of access has been developed for this programme and GPs, ECPs and Care homes can contact service directly. This scheme also underpins SEE (UPC3B) which aims to increase the number of frequent flyers who are case managed.

AMBULATORY CARE CONDITIONS

Analysis shows that that there are less potential savings for 'ambulatory conditions'[1] than for emergency spells as a whole. It seems likely that this is a group who have already received much attention in the past year, and probably linked to the decline in short-stay admissions. There were fewer short-stay spells and fewer spells for older people where an 'ambulatory condition' was the reason for admission than for all emergency spells. To us, this indicates targeting of short-stay spells for older people for ambulatory conditions.

Having said this, there are still a few conditions where potential savings might still be possible - the main possibilities being congestive heart failure, influenza and pneumonia and gangrene . But the overall potential savings are relative small, amounting to £150,000 if all such admissions could be avoided (which they cannot be).

In light of this it is suggested that a root cause analysis on the reasons for patients admitted in this category be undertaken to determine whether changes and local case management arrangements would further reduce these admissions.

The higher than expected admissions for gangrene could indicate that these are caused by poor management of diabetes and peer review of this area is proposed.

COMMUNITY SERVICES REVIEW

Community Service signposting to make best use of existing community services - an essential element of all these projects is effective liaison with Community Services to ensure GPs and patients can efficiently access those services that have already been developed in the community as an alternative to acute hospital admission. It is anticipated that Essex County Council will be also contribute to this workstream.

Early identification of inpatients likely to exceed trim points, becoming long-stayers incurring excess bed day costs. The tracker nurse, working with discharge teams would target those potential long-stayers to ensure there were no organisational delays or lack of clinical input which would lead to stays beyond trim point.

Community services review – ensuring that the community services that have been developed to provide care closer to home are focussed on the most effective way to reduce inappropriate admissions. The first steps of this will be to review the last two years' plan developments with

the community provider to review impact and agree retargeting where appropriate. This review would also cover examination of duplication of services within the provider and across the community and acute providers.

5.6 End of Life

End of life Community Case Management (life limiting diagnosis < 12 months) has been piloted within the Thorpe Bay area. The aim of the programme is to support patients on an end of life pathway to be cared for in the community and be supported and enabled to die at home should that be their preference. The focus of the programme is on active case finding end of life patients who will be placed on a register and have their care plans managed so that their needs are met in a community setting and not be admitted inappropriately to an acute setting during the last days of life. (It has been calculated that end of life patients admit at least 3 times to A&E during the last days of life at an average of £2,500 - £3,500 per spell). It is proposed that this be further extended to this CCG. Essex County Council will also be actively involved in this workstream.

The benefits expected will include

- Reduction in unplanned care admissions
- Reduction in unplanned A&E attendances
- Reduction in acute spend
- Increase volume of patients on an EOL Pathway who have their conditions managed in a community setting
- Increase in the volume of patients who die at home or in their location of choice.
- Decrease in the volume of patients who die in hospital
- Increase in volume of patients who complete preferred priorities of care documentation

Quantification of the benefits for this CCG still awaits agreement with the commissioning lead.

Section 6: Implementing the Plan

6.1 Governance & Delivery Arrangements for Implementing the Plan

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

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

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

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

- Two Locality Commissioning Groups
- CCG Executive Team

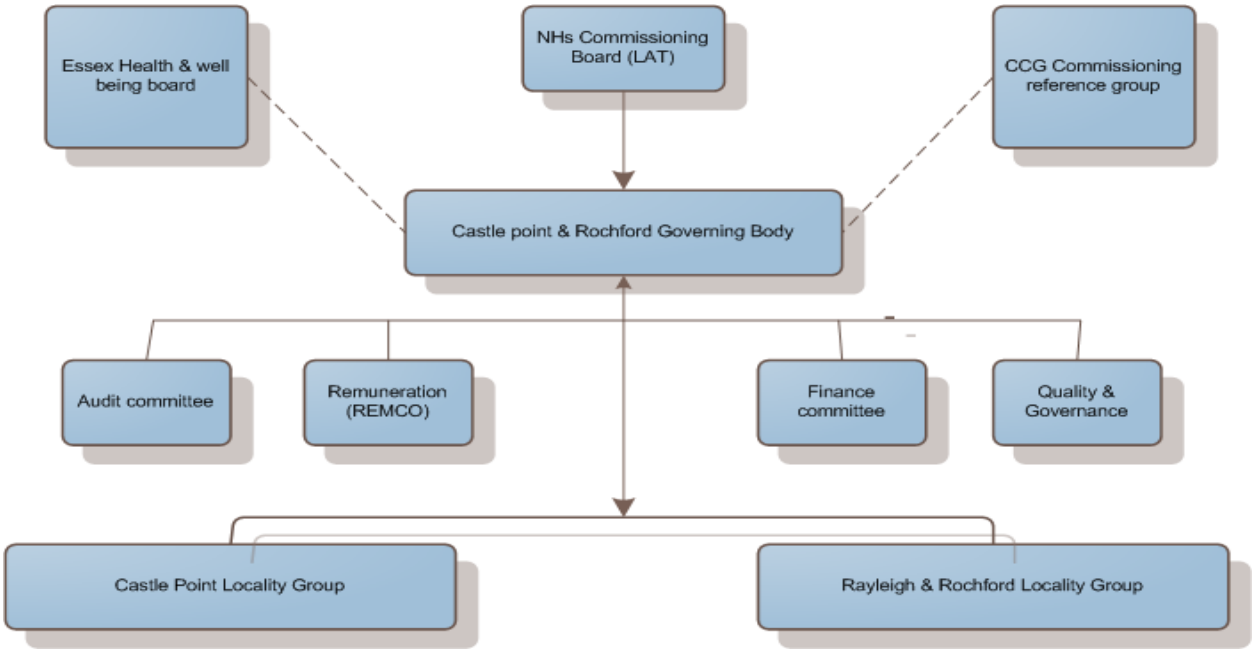
To review progress against the implementation of the Integrated Plan, the following committees and sub-groups will/have been established by the CCG:

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

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

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

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



In relation to the delivery of the Integrated Plan, the CCG Governing Body, its committees and sub-committees will assume the following responsibilities:

The Governing Body
This is the body with ultimate responsibility for the delivery of the Integrated Plan. The body will consider Integrated Performance Reports monthly to track the overall position against all aspects of performance, quality, finance and QIPP delivery. The Governing Body will delegate responsibility for implementation of the Integrated Plan to the Locality Groups and will delegate the responsibility for tracking performance against the Integrated Plan and the oversight of mitigating and remedial actions to the Quality and Governance Committee and its sub-groups.

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

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

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

Quality and Governance Committee:
Responsibility in relation to Integrated Plan: Oversees the delivery of all aspects of the plan.
Description: Monitors and provides the Governing Body with assurance on overall progress against the Integrated Plan, including all domains of finance, QIPP, performance, quality and

safety. The Committee maintains the CCG's assurance framework and risk registers. It will act to shape the management agenda for the locality CCGs.

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

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

Engagement and Patient Experience Committee (Commissioning Reference Group):
Responsibility in relation to Integrated Plan: Assuring that plan and work programmes engage with members of the public and patients.

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

Finance and Performance Sub-group
Responsibility in relation to Integrated Plan: Focussed group assuring full delivery of annual QIPP programme and financial responsibilities.

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

6.2 Governance & Delivery Arrangements for Implementing the Integrated Plan and Shared Priorities with Essex County Council

See Section 2.8 'Enablers to Integrated Commissioning'

6.3 Managing Provider Performance

The CCG attend monthly meetings with our main providers which provide the CCG with the opportunity to challenge and seek assurance from our Providers that they are delivering our key quality initiatives and are providing safe and effective quality care. A visiting regime is agreed to triangulate and coordinate all aspects of soft and real time intelligence. This corroborates the CQRG's evidence and allows clinical commissioners to observe real time patient care.

All providers within the South Essex area have achieved Foundation Trust status, therefore our on-going priority is both ensuring that our providers restore compliance with regulatory requirements and also delivering a significant programme to transform our community services.

Southend University Hospital NHS Foundation Trust (Acute and Community Services)

In December 2011, Southend University Hospital was found in significant breach of authorisation by Monitor arising from governance concerns relating to performance against C Difficile, cancer waiting times and CQC inspection findings, a summary of this is shown below:

Regulator	Issue / Concern (To be updated)
Monitor	Red rated for governance Trust in significant breach of authorisation.
Care Quality Commission	Judged improvements required against the following outcomes: • Outcome 4 • Outcome 6 • Outcome 14

6.4 Other Key CCG Duties

6.4.1 Safeguarding

Castle Point & Rochford CCG has laid the foundations for future clinical commissioners to take over safeguarding responsibilities from April 2013. Joint work continues with the Local Authority and all health providers (Acute Hospitals, Community and Mental Health Trusts) and partner agencies to promote and safeguard children's and adults' welfare by ensuring robust governance and organisational systems are in place to support quality safeguarding practices.

Safeguarding Children

Castle Point & Rochford CCG's priorities and governance arrangements support Section 11 of the Children Act. The CCG Lead Officer will deliver the Annual Section 11 Report directly to the Essex Safeguarding Children Network Board.

Castle Point & Rochford CCG's Designated Nurse and Doctor sit on the Executive and Main Provider Board of the Essex Children's Safeguarding Clinical Network (ESCCN) and available to provide provisional advice on safeguarding to the ESCCN.

A GP Clinical Lead has been appointed for Child Safeguarding and attends represents the CCG on the

ESCCN Board. The GP Clinical Lead liaises closely with directors within CCG, and the Designated Professionals for Child Protection to ensure robust understanding of safeguarding and partnership working.

Castle Point & Rochford CCG, along with other partner agencies, is represented on the South Essex Children's Clinical Advisory Group. Castle Point and Rochford CCG is signed up to the priorities and principles of the local South Essex Children's Plan.

Safeguarding Adults

Adult safeguarding is led operationally in the CCG by the Executive Board Nurse. Essex local authority's Safeguarding Adults Manager continues to provide a lead role around adult safeguarding to the CCG to ensure robust process are in place locally across organisations.

The CCG clinical lead for adults safeguarding is a member of the Safeguarding Executive Committee and also attends the Safeguarding Adults Partnership Board with the CCG Adult Safeguarding clinical lead.

The clustered PCT is leading the development of work with the CCGs to ensure the organisation is prepared to complete their safeguarding responsibilities. This work includes training, involvement in serious incident
reviews, close working with CCG clinical leads on commissioning assurance frameworks both for safeguarding and learning disabilities and developing robust assurance systems within all commissioning and contractual arrangements.

6.4.2 Equality Delivery System

The CCG is committed to promoting equalities across all of its activities. The Castle Point & Rochford Clinical Commissioning Group have worked to shape the local EDS and signed-off a plan for its implementation, which our Quality and Governance Committee will oversee.

A full description of our approach to assuring Equality & Diversity will be included in the *NHS Castle Point & Rochford CCG Equality, Diversity & Human Rights Strategy (to be developed)*.

6.4.3 Information Governance

The CCG has developed a robust approach to ensuring effective information governance across the organisation.

Full description of this is provided in the *NHS Castle Point & Rochford CCG Integrated Risk Management Framework* and *information governance self-assessment toolkit*.

6.5 Key Milestones

Headline actions for the delivery of QIPP in 2013/14 are set out in section 5 of this document. See Appendix

Section 7: Risk

The role of the CCG Board

- Ensuring there is an effective risk management system in place which is being continuously monitored and reviewed;
- Review of high level risks and approval of risk treatment plans;
- Review of effectiveness of internal controls (i.e., actions taken to manage risks to an acceptable level);
- Ensure that independent assurances are obtained around the robustness and effectiveness of the CCG's risk management processes (the Assurance Framework);
- From 2013/14 onwards, sign off Annual Governance Statement to accompany Annual Accounts.

The CCG will use the Assurance Framework which is the key toolkit for the CCG Board to manage risks. It ensures: that risks clustered around principal objectives; Controls (steps taken to manage/reduce the risk as far as possible) are in place; provide the assurances (evidence that those steps are working), and generate required action plans.

The CCG Board will focus on the GAPS in controls and assurances and agree anything else that can be done to manage the risk. Is there any more evidence the CCG can gather as to whether the controls are working or not working? Who is responsible for taking forward and by when?

Actions already in place include

- Risk Register has been in reviewed by the CCG Board every month since April 2012, based on PCT Risk Register format;
- Risk Register contains six high-level risks at the moment, mixture of strategic and operational risks;
- With effect from the version of the Risk Register being presented to the August 2012 CCG Board meeting, each risk is aligned to one of the six domains of the requirements for authorisation. These are essentially the CCG's strategic objectives during the transition period. Aligning risks in this way ensures that clinical and managerial effort is focussed on those risks with the greatest impact on the organisation's business;

To summarise the main areas of risk relevant to the Integrated Plan relate to:

1. The delivery of all CCG and provider quality and performance targets
2. QIPP delivery and financial control
3. Managing a rapidly changing local provider landscape
4. Organisational transition and delivering the CCG Organisational Development Plan

The ***NHS Castle Point & Rochford CCG Risk Management Framework*** provides a comprehensive account of how the organisation manages risk.

Next Steps in Managing Risk

- Agree process and timeline for updating and reviewing the Assurance Framework; keeping as streamlined as possible – **by end of September 2012**
- Make sure that the CCG Assurance Framework has picked up all the relevant risks from the PCT registers and reviewed the ratings – **by end of September 2012**
- Develop and sign-off CCG Risk Management Framework at Board-level - **Mid-October 2012**
- Be clear who is responsible for each risk – aspiration to have as many Clinical Leads as Risk Owners as possible in order to ensure that risk management is clinically led at Board-level. It is envisaged that this will become easier in the next few months as the CCG appoints Clinical Leads and senior managers – **by end of November 2012;**
- Consider separating out strategic from operational risks to form a Corporate Risk Register – **by end of December 2012**

Appendix 1 – CCG Membership

RAYLEIGH & ROCHFORD DISTRICT LOCALITY			
	No	Name	Pop
Clinical Leads - Steve Taylor & Dr Mike Saad	F81123	Lewis & Partners	18,487
	F81061	Conner S & Partners	7,046
	F81125	Cyrus C S & Partners	16,155
	F81065	Ramanathan S & Partner	4,529
	F81066	Kuriakose	5,721
	F81690	Singh B	2,913
	F81089	Freel J F & Partners	9,953
	F81007	Kothari C U & Partners	11,370
	F81675	The Practice Leecon Way	2,302
	F81704	Jayaweera A H I	3,071
	Y00984	Bajen JM & Partner	8,122
		LCG Total	**89,669**
CASTLE POINT LOCALITY COMMISSIONING GROUP			
Clinical Leads - Dr Sunil Gupta & Dr Kamdar	F81142	Patel R M & Partners	6,190
	F81096	Kamdar M K & Partners	11,374
	F81699	Suleman-Qureshi U	2,366
	F81205	Ghauri J B & Partner	3,626
	F81051	Chavda & Partners	7,529
	F81700	Rahman H U & Partner	4,140
	F81075	Lester M J & Partners	12,363
	F81667	Gardiner R A	3,171
	F81101	Khalil SM & Partners	6,342
	F81001	Hiscock S C & Partners	11,045
	F81739	Jena R & Partner	2,589
	F81032	Patel P A	2,353
	F81070	Brown B J & Partners	6,245
	F81618	Waiwaiku K N	3,691
	F81661	Sodipo JA	1,936
	F81740	Chaudhury	2,097
	F81713	Gill S & Partner	2,883
		Special Allocation Scheme	51
		LCG Total	**89,991**
CASTLE POINT AND RAYLIEGH CCG TOTAL			**179,660**

Appendix 2 – Complete Finance Summary

Appendix 2

Medium Term Financial Plan (Based on current allocations and DH return)

MTFP			2012/13 2.80%	2013/14 2.62%	2014/15 2.84%	2015/16 2.50%	DH return for 2011/12 spend uplift 2013/14
Allocation b/f			- 189.1	- 186.0	- 195.1	- 200.6	- 199.9
Additional allocation as advised (PCT held resources 12/13)							
QIPP Reserve							
Growth 12/13 for DH Return modelling							
Growth exc Management Allowance				- 4.87	- 5.54	- 5.02	- 5.24
Management Allowance				- 4.23			
Opening Recurrent Allocation			- 189.1	- 195.1	- 200.6	- 205.6	- 205.1
Funds on deposit							
Commitments b/f			191.9	193.4	195.1	200.6	193.4
Release of Development Fund spend in commitments							- 0.6
Dental costs							- 1.2
Nationally Defined NR Contingency Increase commited in year		2.0%	1.90	3.85	4.01	4.11	4.10
Local Contingency		1.0%		1.92	1.92	1.92	2.05
Reserves					-	-	-
Tariff Reduction Acute & NHS Providers		-4.0%	- 7.68	- 6.43	- 6.43		- 6.43
Tariff Uplift		2.5%	4.80	4.02	4.02		4.02
Acute	Growth	2.0%	1.60	2.40	2.40	2.40	2.40
Community	Growth	1.0%		0.11	0.11	0.11	0.11
Mental Health	Growth	1.0%		0.20	0.20	0.20	0.20
Prescribing	Growth	5.0%	1.45	1.37	1.37	1.37	1.37
Other	Growth	1.0%		0.04	0.04	0.04	0.04
Continuing Health Care	Growth	5.0%	0.70	0.43	0.43	0.43	0.43
Operating Framework Requirements			1.48	5.00	5.00	5.00	5.00
Running Costs				4.23			4.23
Known Investments/Commitments				1.78	-	-	1.78
Known Shortfalls							
Known Pressures							
FYE - Prescribing							
SEPT QIPP b/f							
QIPP Plan - Ambition							
QIPP Requirement			- 7.10	- 17.30	- 7.60	- 10.60	-5.8
Total Commitments			189.1	195.0	200.6	205.6	205.1
Net Position			- 0.0	- 0.0	- 0.0	- 0.0	0.0

National Operating Framework, East of England Pledges and Local Priorities

The NHS Operating Framework 2013/14 sets out the planning, performance and financial requirements for NHS organisations in 2013/14. Castle Point and Rochford CCG recognises these objectives as our key priority areas for 2013/14 and the actions being taken to implement these objectives are noted in the table below. Included within these priorities are the actions that the CCG plan to undertake to implement the NHS National Commissioning Board's ambitions for 2013/14 which are:

To be updated once further guidance is released

- Eliminating avoidable Grade Two, Three and Four pressure ulcers
- Making Every Contact Count
- Significantly improve quality and safety in Primary Care
- Ensuring radically strengthened partnership between the NHS and Local Government
- Create a revolution in patient and customer experience

National Priorities 2013/14 Insert updated tables

Appendix 4

ECC Schools Families and Children Commissioning Priorities

SCF Commissioning
Priorities for CCG Inte

Appendix 5

Proposed QIPP Schemes 2013/14 – Feb 2013

Project Name	High level summary of idea	Lead	Clinical Lead	Area	Estimated Savings
Community Dermatology Service (QIPP)	Transferring intermediate skin conditions to the community, procured via AQP	Hannah Wood	Dr Kash Siddiqui	Referral Management	
Deep Vein Thrombosis – Primary Care Pathway	Initial testing for a suspected DVT to take place at the GP surgery rather than at the acute.	Hannah Wood	Dr Kash Siddiqui	Planned Care	
Referral Management	Clinical referral management lead to work with all practices to audit and review data, design a web based referral source for all practices to access and to chair peer review sessions and ensure that outcomes are distributed to the CCG. Educational sessions to also take place to help reduce secondary care referrals	Liz Paddison	Dr Alan Kerry	Referral Management	
Unplanned Care	Implement schemes to reduce number of avoidable emergency admissions to acute. Includes: Practice based MDT, Community MDT, increased utilisation of Community Geriatricians, SPOR, Integrated Community Teams with enhanced rapid response, Int Care Beds, End of Life.	Matt Gillam	Dr Cyrus, Dr Mike Saad & Dr Roger Gardiner	Unplanned Care	
Planned Care	Implementation of contractual changes to deliver savings. For example, implementing best practice tariffs/regular attender tariffs, moving inpatient to day case and day case to outpatient and review of service restriction policy and procedures of limited clinical effectiveness.	Emily Hughes	Dr Sunil Gupta	Planned Care	
Urology - CAUTI & TWOC	Community based services for Trial Without Catheter as alternative to acute outpatient or inpatient trials. Reduction in catheter acquired UTIs through robust pathways and case management.	Matt Gillam	Dr Merali	Unplanned Care	
MSK	Commissioning an integrated pathway hub for MSK across South East Essex, allowing more effective care pathways and more timely identification of unwarranted variation which has in the past impacted on the quality of service to patients.	Vicki Bradley	Dr Mike Saad	Planned Care	

Ophthalmology	Development of an Ophthalmology Triage service to manage outpatient referrals from GPs and Optometrists and development of intermediate care Ophthalmology to deliver a reduction in follow up activity in secondary care.	Vicki Bradley	Dr Steve Taylor	Planned Care	
Pump priming of Expert Patient programmes around LTCs	Provide short term funding to establish patient educational support groups for long term conditions	Kevin McKenny	Dr Kash Siddiqui	Unplanned Care	
Intermediate Care Beds (inc PAW) review and future model for commissioning step up beds	Develop model of care for CP&R around step up facilities to avoid acute hospital emergency admissions. Implement model through commissioning processes.	Liz Paddison	Dr Sunil Gupta	Unplanned Care	
Diabetes early intervention and audit	Using GP clinical lead to review early detection and management across CP&R CCG	Kevin McKenny/ Tricia D'Orsi	Dr Ris Khan	Unplanned Care	
Integrated pathways for diabetes	Linked to work led by Diabetes Network to deliver single fully integrated community based service in SEE community based service that combines acute expertise and community services close to home	Kevin McKenny/ Tricia D'Orsi	Dr Ris Khan	Unplanned Care	
Joint scheme with ECC re improved areas to crisis response team	Developed via reablement and joint commissioning. Services aligned to support rapid interventions from health and social care for people in crisis.	Matt Gillam	Dr Sunil Gupta	Unplanned Care	
Minor procedures in primary care	Reviewing and enhancing the provision of services	Hannah Wood	Dr Kuriakose	Planned Care	
Enhancement of minor injuries LES	Reviewing and enhancing the provision of services	Hannah Wood	Dr Kuriakose	Unplanned Care	
GP triage telephone consultations	Formalise GP telephone consultations to provide more access in primary care.	Hannah Wood	Dr Kuriakose	Planned Care	
Community Centre for ear syringing	Reduce reliance on (and patients travelling to) acute Trust for ear syringing. Used to be more common within community/primary care but has recently become centralised at local acute Trust.	Vicki Bradley	Dr Merali	Planned Care	
OP referrals from A&E discharged after 1st patient apt with no FUP - further analysis to understand and solution.	Scope potential to reduce A&E follow ups AND direct referrals to OP from A&E that have no follow up or further intervention.	Emily Hughes	Dr Roger Gardiner	Unplanned Care	
All of cancer patients @ A&E to be reviewed in relation to HIUS	Establish use of A&E by cancer patients and provide intensive support/additional case management of these patients to avoid hospital attendances/admissions.	Kevin McKenny	Dr Gill	Unplanned Care	
GP advice line with consultant where small fee rather than referral	Links to referral management QIPP	Liz Paddison	Dr Alan Kerry	Referral Management	

Care home scheme looking at: Locally enhanced service for care homes easy access to reduce admissions. Early intervention in care homes. Best practice for care homes. Culture change targeted for care homes. HTS working together for care homes with providers to improve care - support and training OH telephone line for care homes collaborating with LAs re licensing /CQC. Review of existing OOHs	To reduce unplanned admissions from care homes (nursing and residential) by implementing enhanced services from primary and community care to increase pro-active case management of patients and alternatives to 'dialling 999' when it may not be appropriate.	Liz Paddison	Dr Sunil Gupta	Unplanned Care	
ESTATES					
Estates QIPP scheme	The CCG are required to meet the 'gap' between rental income and costs for estate within the locality. This equates to approximately £1.3m for CP&R. This scheme will take forward recommendations within the estates legacy document to increase occupancy and streamline estate.	Steve Downing	DR Taylor	Estates	
MEDICINES MANAGEMENT					
Centralisation of Dressings	Have a centralised dressing stock managed by SEPT nurses; ensuring formulary compliance.	Simon Williams	Dr Taylor, Dr Lester and Dr Ghauri	Meds MGT	
Patient / Public Education	Educating patient/public campaigns e.g. stockpiling medicines	Simon Williams	Dr Taylor, Dr Lester and Dr Ghauri	Meds MGT	
Training of staff to issue meds/equipment reducing waste	Training front line surgery staff during time to learn and one to one sessions in line with local formulary and repeat prescribing guidelines.	Simon Williams	Dr Taylor, Dr Lester and Dr Ghauri	Meds MGT	
Pain Medication	Review of medication prescribed for pain management - linked to pain scheme above	Simon Williams	Dr Taylor, Dr Lester and Dr Ghauri	Meds MGT	
Home Enteral feeds contract review	Take the enteral feeds off FP10 (NHS prescriptions) and procure a contract across South Essex	Simon Williams	Dr Taylor, Dr Lester and Dr Ghauri	Meds MGT	
Traffic lights for expensive medicines	Review Hospital Traffic Light guidelines and make sure that their use in implemented in Primary Care.	Simon Williams	Dr Taylor, Dr Lester and Dr Ghauri	Meds MGT	

Colostomy, leg bag review of formulary. Stoma nurses input (NHS to empty stoma nurse)	Development and implementation of a local formulary through collaborative working with stoma and continence teams.	Simon Williams	Dr Taylor, Dr Lester and Dr Ghauri	Meds MGT	
Dietetics - concern re use of supplements	Develop local formulary and ensure implementation	Simon Williams	Dr Taylor, Dr Lester and Dr Ghauri	Meds MGT	
Recycling of instruments within practices (plastic spectrums)		Simon Williams	Dr Taylor, Dr Lester and Dr Ghauri	Meds MGT	
MENTAL HEALTH					
Mountnessing Court	Dedicated inpatient facility for management of Dementia	Irene Lewsey	Dr Genthe	MH	
Dementia Intensive Support Team (DIST)	Assess impact to SEE roll out	Irene Lewsey	Dr Genthe	MH	
Psychological Therapies and Long Term Conditions	Providing psychological therapies for long term conditions (COPD) and stroke services to reduce admissions reduce re-admissions and reduce community activity. Good evidence that providing cognitive behavioural therapy based interventions improves mental health. Pilot is one of the first in the country to see whether improved mental wellbeing for people with long term conditions translates to changes in health behaviours and resource utilisation. Initial training with long term conditions teams has been extremely well received.	Debbie Morris	Dr Genthe	MH	
Re-configure CHC Beds		Irene Lewsey	Dr Genthe	MH	
Respite Beds	The aim of this project is to standardise the admission process for respite and get a clear picture about the level of inpatient respite beds required in the future.	Irene Lewsey	Dr Genthe	MH	
Rapid Assessment and Intensive Diagnostic (RAID)	Rapid assessment and intensive diagnostic (RAID) service is the model of psychiatric liaison developed in Birmingham. They found that for every £1 invested they saved £4. Many of the savings were in social care.	Irene Lewsey	Dr Genthe	MH	
Out Of Area Activity	The current areas of significant out of area expenditure are: • ADHD assessments • Neuro-psychiatric assessments • Mother and baby unit • Eating disorder inpatient unit The aim of this project will be to assess the business case for delivering this care nearer to home. This may deliver savings or may manage	Irene Lewsey	Dr Genthe	MH	

	cost pressures from increasing demand.				
S117 Pathway	There are 10 patients in Southend due to be discharged from secure services within the next 12 months or so. Discussions held with SEPT about opportunities to develop specialist forensic community team. Linked to decision regarding Richmond Fellowship.	Debbie Morris	Dr Genthe	MH	
Voluntary Sector Support to MH	The aim of this project will be to raise awareness of the current services, extend current contracts for 12 months, and incorporate VSO providers within strategy working groups to align VSO provision to stepped care model. In effect, we are seeking to develop alternative provision where this is clinically safe to do so.	Mark Tebbs	Dr Genthe	MH	
Recharging for Out of Area Activity within the Block	We are seeking a contractual agreement which clarifies SEPT process, provides activity reports, and a financial agreement which covers the administrative burden and encourages SEPT to recover these costs on behalf of the CCG's.	Mark Tebbs	DR Genthe	MH	
Assessment Unit	The pathway into the assessment unit is currently via Accident and Emergency. This is to undertake a physical screening to rule out the risk of ingestion of substances, assess for self-harm and to rule out any physical causes to the presenting symptoms.	Mark Tebbs	Dr Genthe	MH	
Dementia – Telephone Home Support Line	Pilot project to see whether admissions from care homes could be avoided if they had telephone support from dementia experts.	Irene Lewsey	DR Genthe	MH	
CHILDRENS					
Child Death Review – Rapid Response	A proposal has been sent to both providers of the service (which is a statutory requirement) recommending a change to the service in terms of rapid response to child death and in the case of South West a change to the medical structure. This approach will ensure a consistent model of delivery across Greater Essex	Stewart McArthur	Dr Siddiqui	C&YP	
Paediatric Assessment Unit / High Impact Pathways / Phlebotomy	An effect paediatric assessment model with appropriate differential tariff and implementation of the five high impact pathways and other key pathways (Diabetes and Epilepsy). Effective utilisation of the pathway for common childhood illness and conditions where all elements of the NHS take appropriate responsibility.	Stewart McArthur	DR Siddiqui	C&YP	
CAMHS – Eating Disorder	Reduce escalation of eating disorder children and young people to Tier 4	Maureen Fitzgerald	Dr Siddiqui	C&YP	

	residential provision and tier 3 CAMHS by providing local dietetic support to local Tier 2 provision and in some cases tier 3.				
Children's Equipment	Single referral and ordering gateway for children's equipment across Essex. Clear inventories for equipment retrieved and recycled within the Essex and Southend Equipment Stores.	Claire Mitchell	Dr Siddiqui	C&YP	
Children's – Continuing Health Care	CY&P Continuing Health Care Any Qualified Provider (AQP) standardised pricing framework. A consistent single model of procurement for CHC for Essex.	Claire Mitchell	Dr Siddiqui	C&YP	
CAMHS – High Costs Cases	To maintain a local prior approval scheme for all CAMHS Tier 4 cases. Reflect current scrutiny on expenditure to maintain the quality and safety of placement.	Maureen Fitzgerald	DR Siddiqui	C&YP	
Autistic Spectrum Disorder	Develop a process to ensure that patients in South Essex are able to access diagnostic testing for ASD from a local service with the development of the existing STAARS Service and repatriation of current tertiary activity for South East Essex.	Claire Mitchell	Dr Sidiqui	C&YP	
NURSING & QUALITY					
Pressure Ulcer - Care Homes	CQUIN with SEPT to introduce pressure ulcer equipment for at risk patients within care homes.	Tricia D'orsi	Dr Kamdar	Nursing & Quality	

Appendix 6

ECC approach to Assistive Technology

AT CCG plans.docx