MASTER COPY

NHS Basildon & Brentwood Clinical Commissioning Group

Integrated Plan 2013-15

Basildon and Brentwood Clinical Commissioning Group

CONTENTS

Section One

BASILDON AND BRENTWOOD CLINICAL COMMISSIONING GROUP INTRODUCTION

- Key facts about Basildon and Brentwood CCG
- How we operate
- The Health of Our population

OVERVIEW OF BASILDON AND BRENTWOOD

Introduction

Basildon and Brentwood CCG was set up in shadow from 1 April 2012. Its aim is to be authorised for formal establishment from 1 April 2013, as the statutory commissioner of healthcare for Basildon, Billericay, Brentwood and Wickford.

Commissioning in this case means planning and buying healthcare for the local population. This requires detailed assessments and analysis of health needs and work with partners including local authorities and service providers to commission the best ways to meet those needs. The CCG receives the budget available for its population and manages expenditure on healthcare through annually agreed contracts with service providers.

Basildon and Brentwood CCG is responsible for the area of Basildon, Billericay, Brentwood and Wickford, which has a total population of 264,630. As a CCG we work with four locality groups for Basildon, Billericay, Brentwood and Wickford. This enables us, as a CCG; to work more closely with the populations we serve and allows us to have insight into the diversity of our population.

The CCG buys healthcare from hospitals, community and mental health services and some specialist services (service contracts with GPs, dentists, pharmacists and opticians are managed by the NHS Commissioning Board). Basildon and Brentwood CCG has the lead responsibility for medium to long-term health plans for its local population, working with all organisations and representatives in the health and social care system, including service users and the public.

The Joint Strategic Needs Assessments (JSNAs) are the tools that commissioners for health and local authorities use to help them to plan services for their future populations. They are there to enable us to understand our local population health and social care requirements and we use these tools to commission services. JSNAs have been compiled separately for Basildon and Brentwood (available at: Essex Partnership Portal website).

WHAT IS THE CCG? OUR LEGACY

Overview of a CCG

- Formally established from April 2013
- GPs working in a membership model
- Designing local health services
- Work with:
  - patients and the public
  - Local authority
  - Other healthcare professionals
  - Third sector organisations
- **Commissioning services including:**
  - Elective hospital care
  - Rehabilitation care
  - Urgent and emergency care
  - Most community health services
  - Mental health & learning disabilities
- **Not:**
  - Primary care
  - Specialist services
  - Public health

Key Facts About Basildon and Brentwood CCG

Population

- 264,630 total patient population (GP practice population)
- The CCG has some of the most affluent and deprived Middle Super Output Areas in England

Members

- 45 member practices
- Arranged in 4 Localities
- Collaborative integrated working with Essex County Council and other public sector and voluntary organisations
- 2 large community hospitals, Brentwood Community Hospital and Mayflower Community Hospital (Billericay)

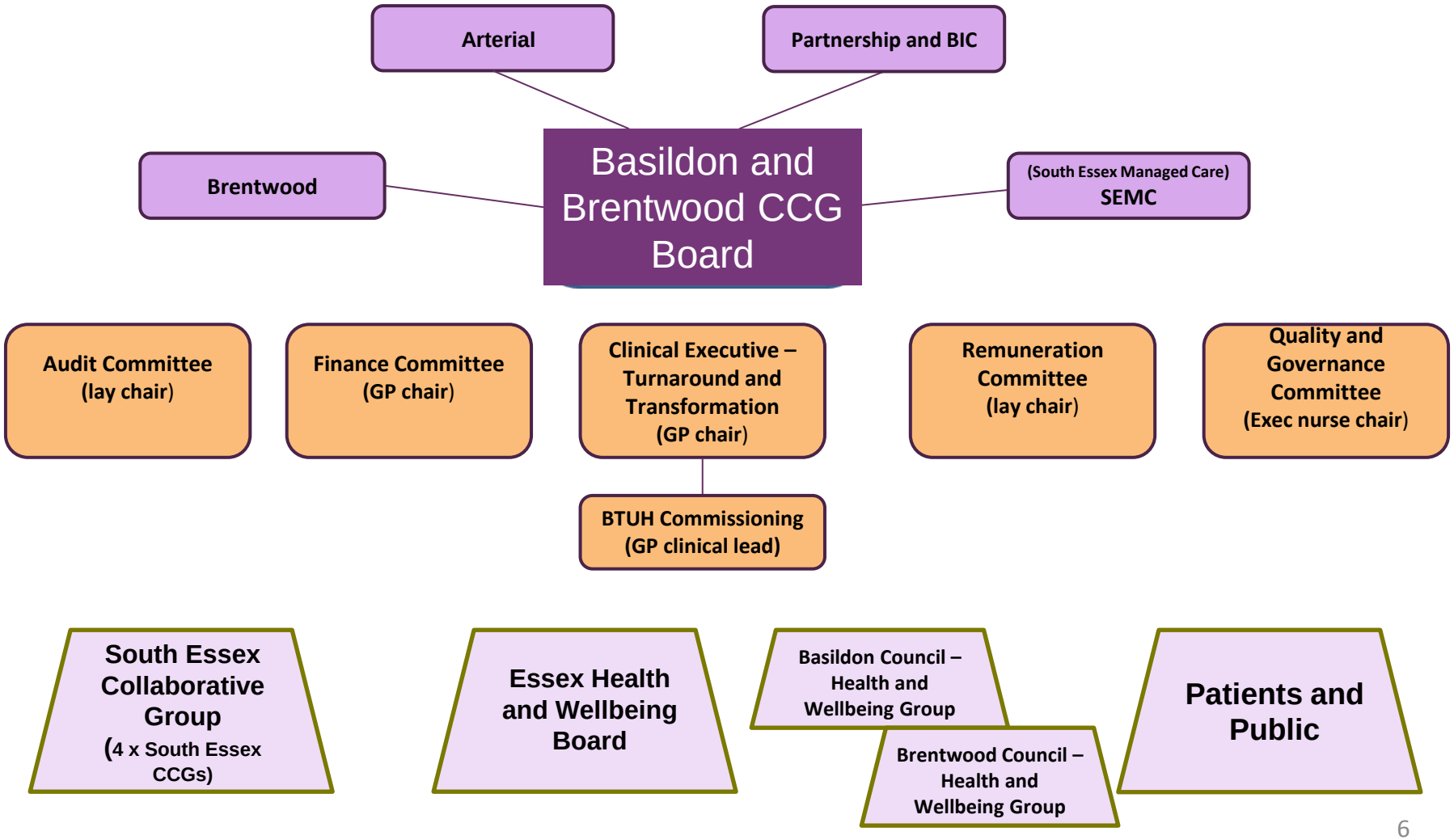
Main providers:

- Basildon and Thurrock Hospital (BTUH)
- Barking Havering and Redbridge Hospitals (BHRT)
- North East London Foundation Trust (NELFT)
- South Essex Partnership Trust Community and Mental Health services (SEPT)
- East of England Ambulance Service

Finance

- Anticipated delegated budget c£300 million

BASILDON AND BRENTWOOD CCG
CORPORATE GOVERNANCE STRUCTURE

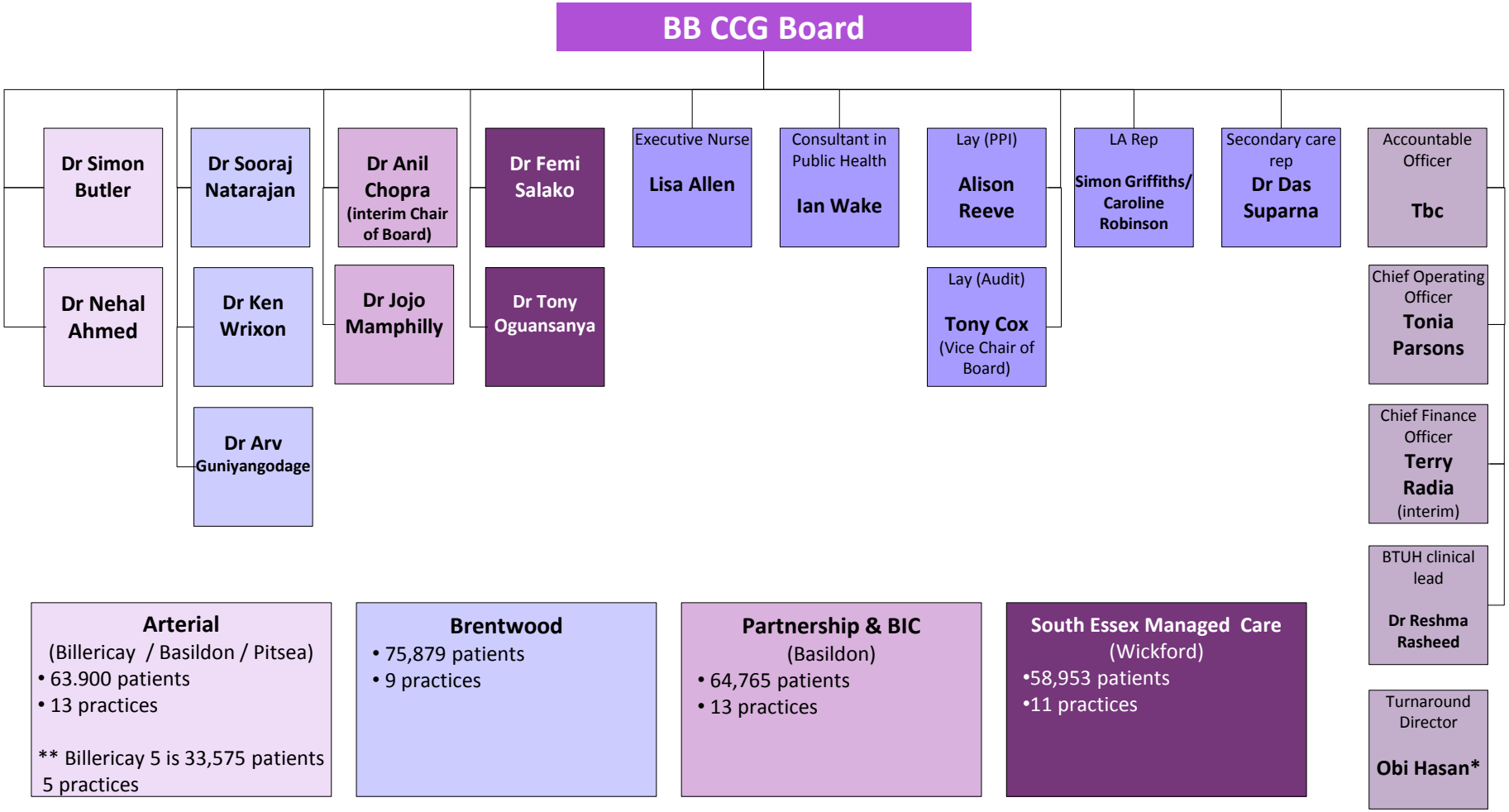


As well as being members of the Essex Health and Wellbeing Board, Basildon and Brentwood CCG is also a partner organisation in the following:

- Basildon Renaissance Partnership
- Basildon Health and Wellbeing Group
- Brentwood Health and Wellbeing Group
- Basildon Armed Forces Community Covenant
- South Essex CCG Collaborative

BASILDON AND BRENTWOOD CCG GOVERNING BODY

The structure and membership of the CCG Board together with the composition of each of the Localities, represented at the Board by a GP member per 25,000 patients.



* = in attendance

BASILDON AND BRENTWOOD CCG
QUALITY AND GOVERNANCE

The CCG's ambition is to place quality and safety at the heart of everything it does and commissions. We will work with our population and partner organisations to define those standards and the extent of services we will procure and manage. This Integrated Plan alongside the BB CCG Quality Strategy represents an important opportunity for all stakeholders to work together for mutual benefit to improve and maintain the best for our population.

The CCG recognises that the key to ensuring that patient experience influences commissioning decisions and improvements in services is to ensure that the information available is correlated and analysed effectively in the commissioning and performance management of providers. We will deploy a variety of ways through which we can make sure our patients can easily influence the way we commission and manage those services.

We must also live within our means and we recognise that we must achieve best value in our use of our patients' resources. We will use evidence to make sure that the way services are being delivered are the most cost effective. We will reduce unnecessary duplication and work with our patients and public health colleagues to help ensure that patients can make the best decisions to help maintain their own optimum health. It is essential that the impact of productivity savings on the quality of care delivered is monitored closely and the CCG has developed a Quality Impact Assessment tool for our clinicians to review all QIPP plans.

BASILDON AND BRENTWOOD CCG
QUALITY AND GOVERNANCE

In recognition of our ambition to put quality and safety at centre of all that we do as an organisation we have integrated the organisational functions of clinical, corporate and financial governance. These elements are monitored and reported through a single sub-committee of Governing Body chaired by the Executive Nurse and made up of clinical and non-clinical members of the organisation.

Recognising that there are multiple challenges in our healthcare system we know that working closely with our partner organisations is key to ensuring that patient safety and quality are key drivers in the commissioning and contracting process. To do this we are developing strong partnerships with our patients, healthcare providers, social care and other peer commissioning organisations. We already have both social care and public health representatives on our governing body.

There are also multiple national policy drivers that influence the quality agenda across the NHS:

- National guidance and priorities which the CCG will use to inform decision making
- Safety and quality measures that have been identified as key indicators of provider performance
- Local priorities for patent experience and quality of care – listening to patients and working with them to address their needs and concerns.

BASILDON AND BRENTWOOD CCG
SAFEGUARDING GOVERNANCE STRUCTURE

The CCG Accountable Officer and Executive Nurse hold the Board responsibility for ensuring that the CCG has safe systems in place for discharging its responsibilities.

The CCG Board receives a monthly report on quality and performance which will include safeguarding issues for children and vulnerable adults as part of the overall quality report

The CCG Executive Nurse is a member of the Children's Health Executive Forum for Essex and the Adult Safeguarding Board for Essex. The designated professionals for Children Safeguarding will be in a hosted arrangement across the CCGs in Essex and there will be dedicated professionals to each CCG.

The designated professionals for Adult Safeguarding will be in the Quality Support Team (hosted by Southend CCG), which has a Local Authority based structure to support the CCG nurses in working in collaboration with Local Authority partners

The safeguarding structures showing the inter dependencies across health and social care for the management of safeguarding children and vulnerable adults are shown in the Appendix.

Section Two

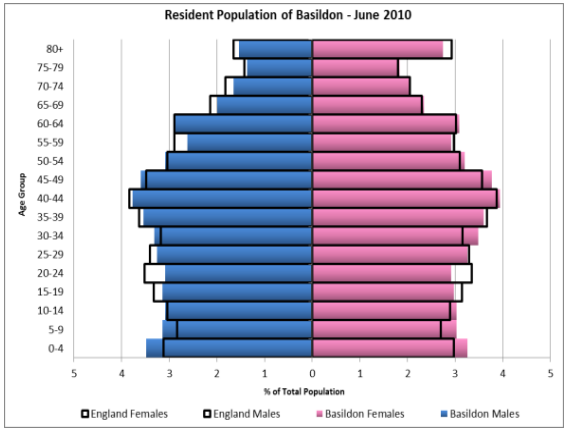
THE HEALTH OF OUR POPULATION

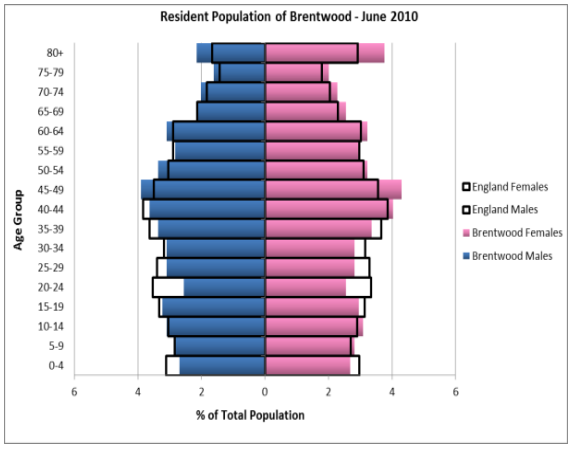
- Demography and Health Needs
- Deprivation and Inequalities
- The Burden of Disease 2013-15

DEMOGRAPHY, DEPRIVATION AND INEQUALITIES

We have worked closely with Essex County Council and Public Health to develop individual clinical JSNA products for Basildon and Brentwood. The document summarises some of the key issues facing the CCG. They have provided an opportunity for the CCG to initiate a series of 'Deep Dives' around the areas of greatest challenge to promote debate and consider opportunities for implementation of evidence base practice to improve the health of the population.

- Total population 264,630
- Basildon District has a younger population structure than England's
- Brentwood has a considerably older population structure than England
- The CCG has some of the most affluent and deprived Middle Super Output Areas (MSOAs) in England as defined by the Index of Multiple Deprivation (IMD) 2010 scores
- The greatest levels of deprivation are found in Basildon Town and the greatest levels of affluence in Brentwood





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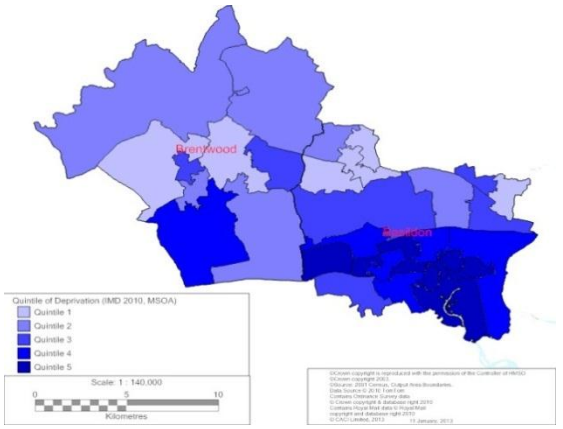
Different levels of deprivation drive health inequalities and result in mortality and morbidity rates in different geographical areas

Health damaging behaviour and poor lifestyles impacts on a significant proportion of BBCCG population, particularly those living in the deprived MSOAs in Basildon Town

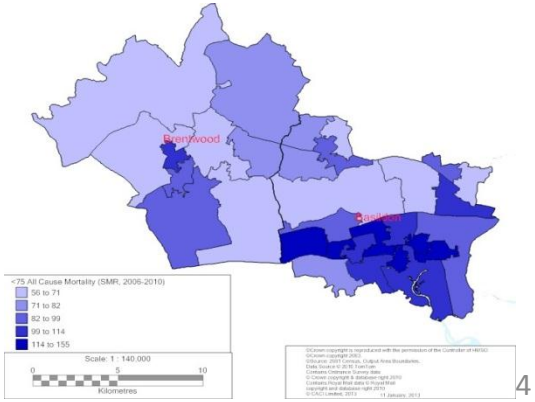
There is a 9.6 and 5.5 year life expectancy age gap at birth for males and females respectively born in the most affluent compared to the most deprived MSOA in BBCCG.

Certain specific populations also face significant health inequalities. For example our Gypsy and Traveler population at the 'Dale Farm' site have poor health outcomes and are less likely to access health services than our general population.

IMD Score (2010) by MSOA



<75 Standardised Mortality Ratio by MSOA



HEALTH NEEDS AND INEQUALITIES

Rates of alcohol attributable hospital admissions are increasing throughout the CCG and within the Basildon population they are increasing at a faster rate than nationally and our greater than the East of England rate.

19% of adults (16+) across BBCCG smoke but smoking prevalence within the most deprived quintile of the population is 35%. This in itself is a significant driver of health inequalities.

Adult obesity prevalence in Brentwood (21.6%) is significantly lower than England's but in Basildon, adult obesity prevalence (26.7%) is significantly greater than regional and national rates.

Basildon has the highest under 18 conception rate in Essex whilst Brentwood's rate is one of the lowest in England.

At 69.1%, breast feeding initiation rates across the CCG are significantly lower than England's.

Circulatory disease remains the biggest cause of mortality amongst our population, with significantly different rates between affluent and deprived communities

DEMOGRAPHIC PROFILE: THE IMPACT FOR BASILDON AND BRENTWOOD

- The Operational plan and commissioning strategy for 2012-13 outline how we met the challenges of our demographic profile
- A rising elderly population with an increasing number of patients with 2 or more long term conditions has increased the need for community health and social care services
- The CCG has focused over the past year on schemes that provide swift access to services, increase community capacity and reduce reliance on secondary care. This has resulted in a reduction in
  - Hospital admissions
  - Length of stay
  - Delayed transfers of care
- Schemes that have enabled people to be cared for in their own home rather than going to hospital , increasing independence for our elderly population.
- The following slides articulate how as a CCG we will build on the work of the past year to meet the needs of our population.

Section Three

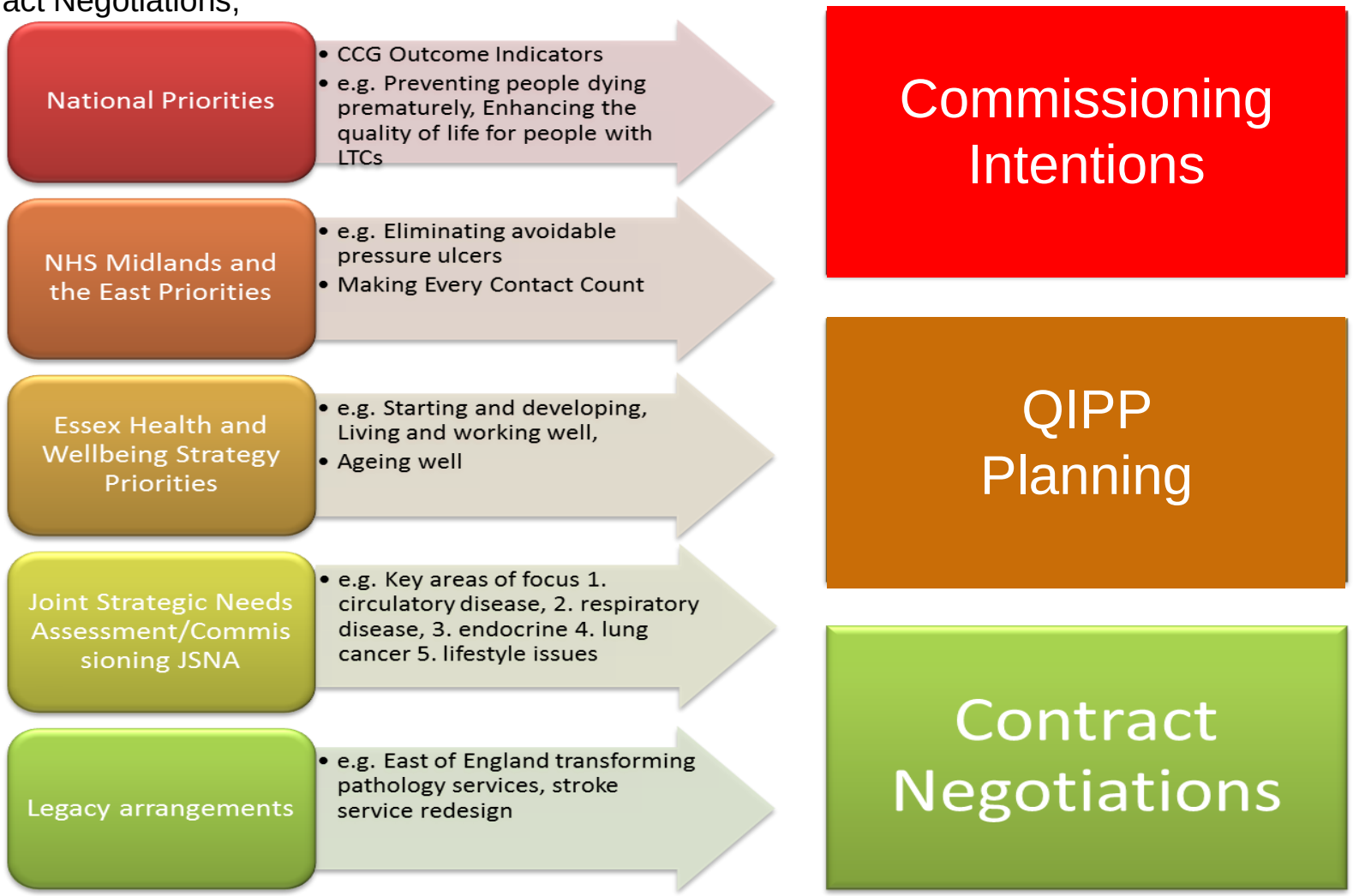
OUR STRATEGY

- Our Vision
- A patient story
- Strategic Priorities 2013–15
- System Challenges
- Prioritising Our Strategy
- Alignment to Health and Wellbeing Strategy

PRIORITIES, OBJECTIVES AND PLANNING

In its planning processes for 2013/14, the CCG has drawn in a combination of national, regional and local priorities (some of which are legacy arrangements transferred from NHS South Essex.

The diagram below indicates how these priorities inform QIPP Planning, Commissioning Intentions and Contract Negotiations;



OUR VISION 2012-15

- **How the local Health System will be transformed & improved for 2015**
- **How the local system will achieve this end state**

AIMS AND VALUES

The NHS belongs to the people (NHS Constitution, March 2010)
Basildon and Brentwood CCG supports the founding principles and values of the NHS. It will conduct its core commissioning activity under the ethos of the NHS for patients, for clinicians, for citizens.

The CCG aims to deliver, in partnership with its patients, a local health service that continually improves to meet today's demand and tomorrow's need.

MISSION

The practices of the CCG will work closely together to improve patient care, where the needs of patients should be at the very heart of clinical decision making. Members will work together with stakeholders to ensure that commissioned services are of the highest quality, making most effective use of resources and bringing care closer to home.

OUR VISION: What Does it look like when we get it Right for our Patients with Dementia …

South Essex Dementia Unit - Step up Step Down Beds

Inclusion Criteria **Patients with a diagnosis or suspected dementia and are eligible for adult services.**

- ***Requires 2 or more of the following:***
- ***Medical Care –*** *i.e Medically stable or requiring of only minor medical intervention e.g. intravenous fluid rehydration*
  Nursing Care
  Therapy Care *(OT/PT)*
  Social Care
- ***Be sufficiently alert*** *or have recent history of ability to follow directions and engage in therapeutic programmes*
- ***Be able to perform*** *activities of daily living with supervision and assistance of staff, which may include dressing, eating, etc*
- ***Have on-going*** *acute behavioural disturbance in context of their treated physical illness*
- ***Step-up*** *rehabilitation from community* - not acutely unwell (not requiring rapid diagnosis or intensive hospital type support)
- ***Step-down*** *– medically stable*

Exclusion Criteria

- ***Respite Care***
- ***Acutely unwell -*** requiring intensive medical care
- ***Who*** *do not have dementia or suspected dementia*
- ***Who*** *are not able to be re-abled*
- ***Who*** *do not have a physical condition*
- ***Urgent*** Social Care services need unless the primary need is for health care

Aim of the Service

Step Up - Admission avoidance via community based assessment and treatment as an alternative to secondary care for those experiencing an exacerbation of an existing condition, or decline in health and function, in patients who might otherwise be admitted to an acute hospital setting. Focussed multidisciplinary rehabilitation

Step-down - for patients who are assessed as likely to benefit from intense rehabilitation.

Accessing step up beds

Referral Route: Direct, DIST, SPOR, RRAS

Mountnessing Court 7 days a week (9am – 5pm)

Telephone: 01277 634711
Fax: 01277 634684

Community Hospital Step up Beds

OUR VISION: What Does it look like when we get it Right for our Patients with Dementia …

Dementia Intensive Support Team (DIST)

Dementia Intensive Support Team (DIST)

Mental Health and Physical Health Team

- Based in BTUH AE
- Provide support for up to 6 weeks
- Direct referrals from Ambulance Service and GPs
- Gatekeep Dementia Step Up – Step Down Unit

Admission Avoidance-

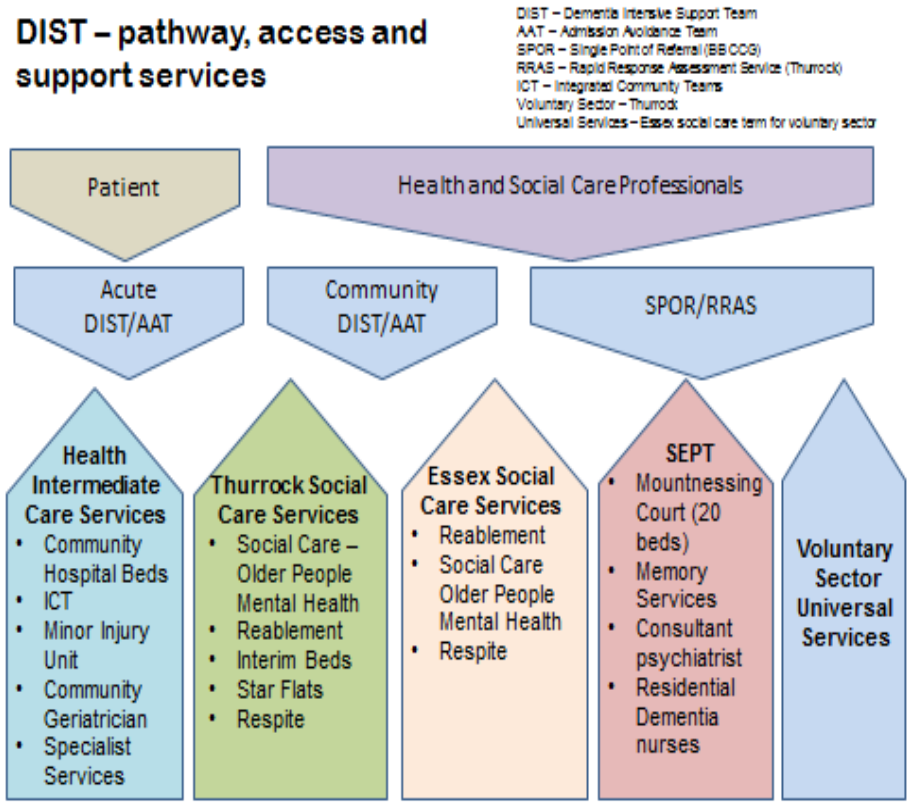
- Preventing inappropriate admissions, reducing the length of stay in hospital if admitted,
- Promoting and facilitating the use of Intermediate Care for people with Dementia,
- Increasing the percentage of people with Dementia who return to their own homes instead of residential care.

Inclusion criteria

- People with Dementia (or suspected Dementia) who are about to be admitted to BTUH with conditions that may not have required admission if there were not factors related to the Dementia.
- People with Dementia (or suspected Dementia) within BTUH where factors other than their Acute Condition are delaying discharge.

Joint working

- This service was commissioned with support from Social Services (under a health lead).
- The service shares KPIs across health and social care
- The service shares information
- The impact of the service is jointly monitored for effectiveness



Accessing Dementia Intensive Support Team

Direct referrals to the Team or via SPOR RRAS

Tel: 01268 524900 or 08451553111 Ext. 2873.
Fax: 01268 592865

OUR VISION: What Does it look like when we get it Right for Individual Patients …

Patient Experience and Feedback: *DIST Team - Excerpt from letter received from a family …*

"You played such a key role in Dads care while he was in hospital, he has returned to Scotland now and an appointment to see Psychiatrist has been arranged. Thank god he is doing well!! We want to say a huge thank you for the sensitive, caring way you supported dad and us during a very difficult time. You gave us hope when we had none and you helped get Dad home as soon as possible. You helped us trust again and restored our faith in the caring profession. Heartfelt thanks and Dad still remembers you and smiles at the mention of your name. "

OUR VISION: The future

We believe that our vision is best demonstrated by the aim to develop integrated commissioning and locality teams in partnership with the local authority and community health care . In summary we are:

- Integrating operationally existing health and social care teams under the leadership of GPs
- Increasing responsibility for case management
- Building the infrastructure in primary care and the community to manage our population
- Developing , more specialist services in the community that will avoid the need for a hospital referral
- Developing one route of referral to simplify access (one of our 3 local priorities)
- Targeting resource at those patients who need it most
- Reviewing data and risk stratifying in partnership we are increasing responsibility for case management

WHAT WE HAVE ACHIEVED

Working with Community

- Telephone support for people with long term conditions
- Practice level Multi-disciplinary meetings (Team around the Patient)

Working with Social Care

- Referral Gateway reviewing all secondary care out patient referrals,
- Development of MDT meetings within practices (including community, mental health and social services)
- Monthly peer review of outpatient referrals supported by secondary care consultant
- Single Point of Referral to an integrated Health & social care assessment & response

Working with Providers

- Pilot of GP in A+E (both walk in patients and majors)
- Integrated Pathway Hub for MSK
- Integrated Pathway for Diabetes
- Locality working : health & social care practitioners aligned to geographic areas

LOCAL PRIORITIES: WE HAVE IDENTIFIED 3 KEY PRIORITY AREAS
1. HYPERTENSION AND CORONARY HEART DISEASE

Priority: Preventing strokes and ischaemic heart disease through improving case finding of hypertension and by improving the clinical management of circulatory disease at practice level. BBCCG

Rationale: Clinical JSNA Profile identified Circulatory Disease as one of the key priority areas where spend was high but clinical areas were only average. At £180 per head of weighted population, Circulatory Disease is the programme that has the highest total spend within the CCG, and spend is also significantly greater than our Office for National Statistics (ONS) cluster comparator PCTs, making it a key QIPP priority.
In addition to its positive impact on population health, if successful this project would have a significant positive impact (in the long term) in social care by reducing the numbers needing social care

Proposal: The Hypertension Deep Dive concluded that GP practice Hypertension registers across the CCG were incomplete; around 38% of patients with Hypertension are not on a disease register and therefore may not be getting appropriate clinical care to manage their disease putting them at high risk of more serious circulatory disease events such as stroke, heart failure and myocardial infarction. As part of a Stroke Deep Dive, the CCG's Consultant in Public Health and Epidemiologist undertook multivariable linear regression analyses of a number of known risk factors for stroke.

Aim: To reduce the number of emergency admission due to stroke by improving case finding of hypertension and clinical management of hypertension, CHD and stroke

Objectives:
- To increase hypertension case finding across the CCG practices by implementing 11029 Health Checks and 612 Senior Health Checks per annum as a mechanism to identify undiagnosed hypertensives

- To pilot 8 blood pressure monitoring machines in GP reception areas as a further mechanism to identify undiagnosed hypertensive patients opportunistically

- To improve GP practice performance against QOF indicators related to circulatory disease across the CCG such that they match or exceed the poorest performing GP practice in the top quintile of performance nationally:

Potential QIPP benefits:

	NHS Cost of Case Finding (additional SHC)	Increased Hypertension Prescribing cost	Increased anti-coag and anti-platelet prescribing in CHD patients	Current Average Number of Admissions Annually	admissions avoided	NHS Saving (avoided non-elective admissions, a&e and ambulance)	Social Care Saving	Individual Saving (Self Funded SC proportion)	NET Saving	system saving (minus prescribing)	NHS savings (minus prescribing and SHC)
2013/14	£5,268.40	£52,006.24	£14.74	215	66	£238,769	£87,573	£107,033	£376,086	£269,053	£181,480
2014/15	£5,268.40	£99,239.18	£1,660.42	215	70	£253,601	£241,886	£295,639	£684,958	£389,319	£147,433
2015/16	£5,268.40	£143,358.11	£2,941.33	215	74	£270,275	£383,792	£469,079	£971,578	£502,499	£118,707
Total over 3 years	**£15,805.20**	**£294,603.53**	**£4,616.50**	**645**	**209**	**£762,645**	**£713,251**	**£871,751**	**£2,032,622**	**£1,160,871**	**£447,620**

LOCAL PRIORITIES: 2. FAMILIES WITH COMPLEX NEEDS

Rationale: The complexity of the Essex health and social care systems has led to difficulties in defining clear pathways across the various health and social care support services. This makes it difficult for families with multiple needs to navigate their way to appropriate support, leading to high use of reactive and specialist services, increased costs and duplication across agencies.

Proposal: The proposition is to establish a new approach across Essex to working holistically with disadvantaged families with multiple difficulties to enable them to make significant changes and improvements to their lives and thus reduce their dependence on high cost public services. This new approach required significant cultural change by and within all agencies and professional staff, to engage in multi-agency co-operation and the way in which we engage with families.

The project forms part of the system wide Community Budget programme, submitted to Whitehall in October 2012 and BBCCG has chosen this as a priority area to both address the needs of its population and expand system wide collaboration underpinning the spirit of the wider programme.

Aim: To build relationships with families, enabling them to identify what changes they want to make to make to improve their lives and reduce their dependency upon reactive solutions to long term problems. The benefits to the system will be in reducing expenditure in these reactive and specialist services, enabling funds to be deployed in a sustainable and more effective may in the long term. Wider expected community benefits include increased employment, improved health, reduction in crime, and improved learning and attainment.

Objectives:

- To establish 8 multi-disciplinary family teams across Essex from October 2013, with each team working intensively with some 135 families for up to one year. 4 further teams to be established in 2014, with potential for further expansion in the following years. In BBCCG this will mean that 68 families are on the programme by the end of March 2014.
- The teams will be multi-agency/multi-disciplinary, with staff and resources from children's services, district council services, health and others. It is expected that health visitors will play a particularly important role in the teams, linking this role with their wider remit for children and the requirement for them to manage a specific caseload for families with complex needs. Maternity, adult mental health and other services will work closely with the teams.
- Specific health service benefits expected include a reduction of the use of A&E and emergency health services .
- The project will help facilitate the establishment of a single data sharing and recording system to be used by all agencies.

Potential QIPP benefits:

The programme's financial objective is to provide a sustainable model, ensuring that unnecessary expenditure is avoided and available resources are used most efficiently for the long term benefit of the community. It is acknowledged the direct financial benefits of the programme are mainly longer term, but contributing to the financial savings set out in the respective medium term financial strategies of partnering agencies. Resources contributing to the programme are already deployed across the system, such as staff and premises. A full business case is available, an extract below setting out the following anticipated benefits:

LOCAL PRIORITIES: 3. INCREASING THE UTILISATION OF SINGLE POINT OF REFERRAL

Rationale: The provision of timely joint health and social response to patients in a crisis/exacerbation state is critical to maintain the patient in an out of hospital setting and improve their long term outcome. This has been demonstrated in various reviews of intermediate care service. The increased level of demand on acute services during 2013/14 for patients presenting with medical symptoms demonstrates that more needs to be done to provide appropriate care for this cohort of patients before they present to A&E.

Proposal: It is proposed that we increase the utilisation and impact of the Single Point of Response service. The assumption being that by providing a rapid health and social intervention, we will be able to maintain patients in their normal residence (home/care home) and improve their overall. There are two key target groups for improving the utilisation of SPOR namely;

a) General Practice – whilst the service has received some calls from general practice, the overall call volumes are low (especially in relation to the volume of cases seen that are appropriate for SPOR intervention).
b) Ambulance Services – as part of our wider strategy to reduce the conveyance rate to acute trusts, we are aiming to increase the proportion of calls to SPOR from on scene East of England Ambulance staff. We feel that through accessing SPOR, a quick response can provided to patients that will enable EEAST to safely manage patients in their normal residence.

Objectives:

- Increase the call volume to SPOR from General Practice
- Increase the call volume to SPOR from East of England Ambulance practitioners
- Extend the hours of the service to operate seven days a week
- Ensure a clear route of entry from the SPOR into more generic community services (with identified response times for those services)

Potential QIPP benefits:

The improved utilisation of SPOR will support the CCG's targets to reduce acute unplanned care activity (particularly in the frail elderly population). We expect the outcomes for the patients that utilise SPOR to improve as they will be managed in there normal place of residence with an appropriate care package. This could lead to reduced long terms care packages from both a health and social perspective offering a system wide QIPP opportunity.

OUR STRATEGIC PRIORITIES: LINKS WITH HEALTH AND WELLBEING STRATEGY AND JSNA PRIORITIES

		Health and Wellbeing Strategy				JSNA Priorities				
Domain	Initiative	Improve the quality of health and social care	Strengthen mental health/emotional wellbeing	Improve our response to frail elderly/dementia	Improve the physical health and wellbeing	Circulatory Disease	Respiratory Disease	Endocrine	Lung Cancer	Lifestyle Issues
Planned Care	Practice Level Referral Management	■			■					
Planned Care	Service Restriction Policy									
Planned Care	Diabetes Renal	■		■				■		
Planned Care	Podiatry	■		■						
Planned Care	Ophthalmology	■								
Planned Care	Dermatology	■								
Planned Care	Musculoskeletal Services	■								
Planned Care	Consultant to Consultants	■								
Planned Care	Direct Access	■								
Planned Care	Nuffield MRI/CT Contract	■								
Unplanned Care	Cellulitis	■		■						
Unplanned Care	Community Geriatrician (existing scheme)	■	■	■	■	■	■	■		
Unplanned Care	SPOR	■	■	■	■	■	■	■		
Unplanned Care	Step Up Beds	■	■	■	■	■	■	■		
Unplanned Care	PCAT	■	■	■	■	■	■	■		
Unplanned Care	Primary Care MDT (existing scheme)	■	■	■	■	■	■	■		
Unplanned Care	Decommissioning of Admission Avoidance Car			■						
Unplanned Care	GP Front End A+E	■		■		■	■	■		
Unplanned Care	Admission Avoidance Service	■		■		■	■	■		
Medicines Management	Paediatric ONS	■			■					
Medicines Management	ONS	■			■					
Medicines Management	ScriptSwitch	■			■	■	■	■	■	
Medicines Management	Respiratory 1	■			■					
Medicines Management	Respiratory 2	■			■					
Medicines Management	Insulins	■			■			■		

OUR STRATEGIC PRIORITIES: LINKS WITH HEALTH AND WELLBEING STRATEGY AND JSNA PRIORITIES

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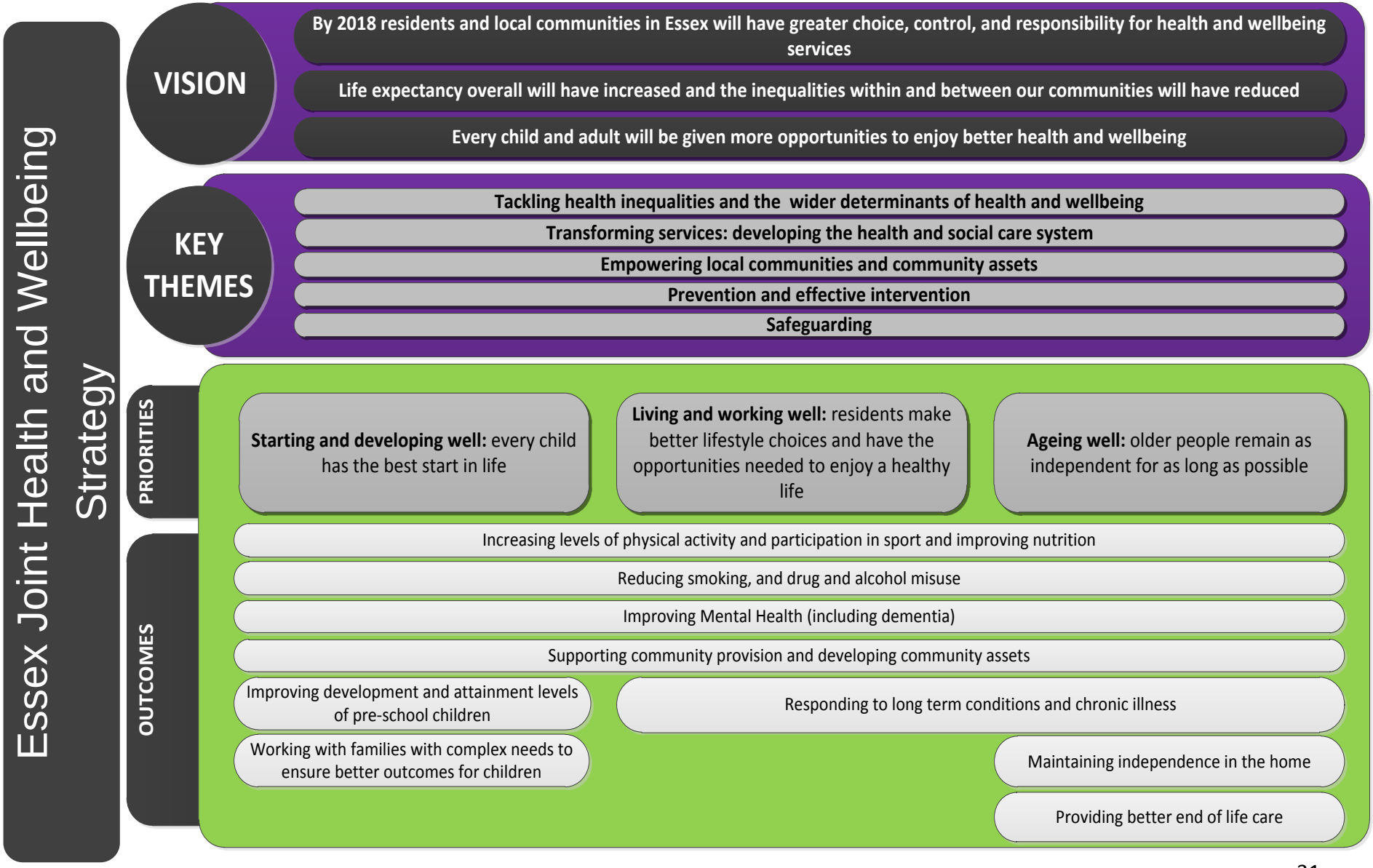
Domain	Initiative	Improve the quality of health and social care	Strengthen mental health/emotional wellbeing	Improve our response to frail elderly/dementia	Improve the physical health and wellbeing	Circulatory Disease	Respiratory Disease	Endocrine	Lung Cancer	Lifestyle Issues
Medicines Management	BGTS	■			■					
Medicines Management	Specials	■			■					
Medicines Management	Care homes	■			■	■	■			
Medicines Management	Mental Health	■			■					
Medicines Management	Stoma	■			■					
Medicines Management	Miscellaneous drugs	■			■					
Medicines Management	Woundcare	■			■					
Paediatric Services	Paediatric Assessment Unit	■			■					
Mental Health Services	Mountnessing Court	■	■	■						
Mental Health Services	DIST/CDN	■	■	■						
Mental Health Services	CHC/Respite reconfigurations	■	■	■						
Mental Health Services	COPD/Stroke	■	■	■			■			
Mental Health Services	MCCH/VSO	■	■	■						
Mental Health Services	RAID/assessment pathway	■	■	■						
Mental Health Services	Out of area activity/Recharging	■								
Mental Health Services	Dementia care line		■	■						
Contract Reductions	Patient Transport Services									
Contract Reductions	Total Void Space Rental									

OUR STRATEGIC PRIORITIES: LINKS WITH HEALTH AND WELLBEING STRATEGY AND JSNA PRIORITIES

		Health and Wellbeing Strategy				JSNA Priorities				
Domain	Initiative	Improve the quality of health and social care	Strengthen mental health/emotional wellbeing	Improve our response to frail elderly/dementia	Improve the physical health and wellbeing	Circulatory Disease	Respiratory Disease	Endocrine	Lung Cancer	Lifestyle Issues
Priority 1	Hypertension Registers	■	■		■	■				■
Priority 2	Families with Complex Needs	■	■		■					■
Priority 3	Use of SPOR	■	■	■	■	■	■	■		
Planned Care	18 Weeks	■			■	■	■	■	■	
Planned Care	Cancer Services	■			■				■	
Unplanned Care	End of Life	■	■	■		■	■	■	■	
Unplanned Care	Nursing Homes	■	■	■	■	■	■	■		
Unplanned Care	Falls	■	■	■	■	■	■	■		
Unplanned Care	Reducing conveyance rates	■	■	■	■					

ESSEX JOINT HEATH AND WELLBEING STRATEGY



PREVENTING ILL HEALTH AND ADDRESSING HEALTH INEQUALITIES

As part of the CCG Board's Strategic Commissioning Priority to improve the lifestyles of our population and reduce health inequalities, our Public Health aligned staff have undertaken a comprehensive 'deep dive' on Health Inequalities, Lifestyles and Prevention. The deep dive contains detailed analysis and commissioning recommendations for the CCG on:

- Reducing Health Inequalities
- Reducing the prevalence of smoking
- Tackling Obesity including improving diet and increasing physical activity with our population
- Delivering vascular health checks
- Reducing alcohol misuse
- Improving childhood and adult immunisation coverage
- Breastfeeding
- Improving participation of our population in cancer screening programmes.
- Improving the health of older people

BBCCG is committed to working collaboratively with Essex County Council Public Health staff to support delivery of their commissioned health improvement programmes by:

- Delivering 'Making Every Contact Count' at practice level and commissioning our providers to do the same
- Developing a 'Lifestyles Balanced Score Card' for each GP practice with detailed recommendations for improving the health the practice's population and reducing health inequalities.
- Delivering consistent high performance on health improvement programmes commissioned by ECC Public Health and Public Health England at practice level including smoking cessation, health checks, alcohol brief screening and intervention, immunisation and screening and sexual health

We will also:

- Commissioning falls prevention programmes in collaboration with ECC
- Implement the recommendations of the deep dives into Hypertension, Heart Failure, Stroke, and CHD at practice level to improve case finding and quality of clinical management of patients with circulatory disease

ALIGNMENT OF OUR STRATEGY WITH ESSEX JOINT HEATH AND WELLBEING STRATEGY (HWBS)

QIPP Programme and Integrated Plan – Workstreams and Pathways Structure

This table shows how the QIPP Workstreams fit into the development of the Integrated Plan

QIPP and Integrated Plan Schemes		CCG Workstreams				
		Unplanned Care	Planned Care	Children & Families	Mental Health	Prescribing
Essex CC Pathways	Families with Complex Needs	x	x	x		
	Elderly Care	x	x			x
	Children	x	x	x	x	x
	Mental Health				x	x
	Learning Disabilities		x	x		
	Public Health	x	x	x	x	x

ESSEX HEALT AND WELLBEING BOARD RESPONSE TO OUR INTEGRATED PLAN

The HWBB response

Section Four

CHALLENGES IN OUR LOCAL SYSTEM

- Financial Challenge (QIPP Challenge)
- System Challenges
- Performance Challenges
- Provider and Market

OUR FINANCIAL CHALLENGE – QIPP TARGET OF £15.1M

Quality, Innovation, Prevention, Productivity & Benchmarking

BASILDON AND BRENTWOOD CCG - FY13/14 CCG QIPP Development Summary

	In Year			In Year (Risk-Adjusted)		FYE
QIPP Workstream FY13/14 £'000	In Year FY13/14 Target	In Year Identified QIPPs	In Year Contract Reductions/ Void rental	RAG rating	Identified QIPPs and Contract Reductions (Risk Adjusted)	Identified QIPPs
Planned Care	2,574	3,491			1,745	3,631
Unplanned Care (Note 1)	3,013	2,535			1,267	2,714
Medicines Management	2,500	896			627	896
Paediatrics	750	973			681	920
Mental Health	1,475	275			69	275
Contract Reductions (Framework)	767		767		767	767
Contract Reductions (Other)	921		3,063		766	3,063
Void Space (PFI)	3,100		3,100		775	3,100
Total	**15,100**	**8,170**	**6,930**		**6,698**	**15,366**

Red = 25%	TD risk assessment criteria
Red-Amber = 50%	
Amber = 70%	
Green = 100%	

WHOLE SYSTEM CHALLENGES

The local system faces a number of challenges requiring a collaborative working health economy solution:

- The CCG turnaround strategy addresses the challenges by developing a system-wide approach.

- It targets improvements within its control and is working with other providers in the health economy to address 'structural' gaps requiring a system-wide response:

CCG challenges

- Internal Controls – Sound governance and strong financial controls

- Operational Efficiencies – Delivering QIPP efficiency savings

System-wide challenges

- Strategic Health Economy Solution – collaboration and integrated working with providers (BTUH, NELFT, SEPT) and other stakeholders

OTHER CHALLENGES IN OUR LOCAL SYSTEM

There are a number of challenges in the local system:

Significant QIPP challenge over the next 3 years
Patients are often admitted driven by pressures of the 4 hour A&E target
Complex patient flows across the system, using providers with whom we do not have direct influence, eg Queens and Broomfield hospitals
BBCCG financial challenge no greater than neighbouring CCGs but historic spending is high
Delivery of QIPP through locality groups allows local engagement but adds layer of complexity
Developing integrated services and single data recording systems takes time to develop, but financial pressures are in the here and now
Recurrent performance and quality issues at local Trust demand significant input

OTHER CHALLENGES IN OUR LOCAL SYSTEM - ORGANISATIONAL

There are a number of organisational challenges in the local system:

- New organisation, little history/experience of delivery and working across the system, conditional authorisation
- Growing demand in unplanned care
- Financial constraints - £15.1m QIPP required in 2013/14
- Transformation not widely accepted by all (e.g. local opposition to changes in pathology)
- Demanding performance management required

OTHER CHALLENGES IN OUR LOCAL SYSTEM - JSNA

There are a number of challenges in the local system identified from our JSNA products:

Health Inequalities

Life Expectancy Gap at Birth: ♂ 9.6years and ♀ 5.5 years between most affluent and most deprived MSOA

Poor lifestyles (particularly in Basildon)

Smoking Prevalence – 35% in most deprived quintile
Obesity
Alcohol

Circulatory Disease

High prevalence of undiagnosed hypertension (40%)
Third highest spend per head in England with only average outcomes

COPD

Significantly greater prevalence than England
Some practices have rates double England Average
Death rate in Basildon significantly worse than England

Diabetes

Spend per head of population in the top quintile nationally
Diabetes prevalence in Basildon significantly greater than England's

Lung Cancer

Spend per head of population is the highest in England and three times our ONS cluster

CURRENT PROVIDER AND MARKET PROFILE

We have multiple providers; the main 3 (in terms of contract size and strategic impact) are:

ACUTE CARE

Basildon and Thurrock University Hospital NHS Foundation Trust (BTUH)

- Basildon and Brentwood CCG spend circa £109 million on contracted activity (2012/13)
- Financial challenges: internal + commissioner commissioning/QIPP requirements
- Tension between commissioner strategy of care closer to home vs. maximizing value from BTUH services
- Challenges: - high cost base , big reliance on agency staff, - expensive estate in need of development

CARE HOMES

- Basildon and Brentwood have approximately 61 nursing and residential homes (41 homes across Basildon, Billericay and Wickford, and 20 in Brentwood) with the numbers growing
- Internal nursing and residential internal policies requiring an ambulance to be called when patients deteriorate.

EAST OF ENGLAND AMBULANCE

- Contract Value £8.5 million
- Ambition to support admission avoidance schemes
- Not consistently meeting CAT A performance

CURRENT PROVIDER AND MARKET PROFILE

PRIMARY CARE

GP PRACTICES.

- Key provider of NHS services
- 45 individual practices, no federated approach
- GP practices with the ambition to develop community facing extended services

COMMUNITY

North ‘East London Foundation Trust (NELFT)

- CCG contribute funds of £31.1 million of the providers contract value
- Provides community services for Thurrock and neighboring Basildon and Brentwood CCGs
- Financial challenges: internal + commissioner commissioning/QIPP requirements
- Challenges include; High overhead costs, some services too specialist in nature, issues with transparency of data.

MENTAL HEALTH CARE

South Essex Partnership Trust (FT)

- Basildon and Brentwood CCG contribute funds of circa £26.6 million of the providers contract value
- Provides mental health services for Thurrock and neighboring Basildon and Brentwood CCGs.
- Financial challenges: internal + commissioner commissioning/QIPP requirements
- Challenges include; High overhead costs, high historic caseloads, some services too specialist in nature, issues with transparency of data.

VISION FOR FUTURE PROVIDER MARKET

ACUTE CARE	**Basildon and Thurrock University Hospital NHS Foundation Trust (BTUH)** • Work in partnership with CCGs on a range of integrated QIPP schemes in areas such as MSK, Diabetes, community geriatrics & ophthalmology • Working in partnership with the wider health and social care system to ensure only those patients who require specialist hospital services are admitted. • Enable the transition of hospital teams providing specialist services in community settings
CARE HOMES	• Working in Partnership with community services to support residents to remain in their home when they become unwell.
THIRD SECTOR AND AQP	• Increase choice for patients by commissioning more services from the 3rd sector and through the process of AQP.

VISION FOR FUTURE PROVIDER MARKET

Our ambition is to develop the market in a way that increase the quality of care from our main providers, ensure value for money and increase choice for patients through working in partnership with the 3rd sector.

PRIMARY CARE

GP PRACTICES

- All practices offering Integrated health and social care teams wrapped around the GP patient and family
- Increased choice for patients able to access to more specialist services at practice level.
- Increased opening times
- Access to integrated information systems which enables them to risk stratify at practice level,
- All GP's taking part in practice level MDT with community nurse and social worker access.

COMMUNITY

North 'East London Foundation Trust (NELFT)

- Take the lead in developing innovative approaches to integrated flexible and responsive pathways that supports the patient to remain in their home and or their community setting
- Services contested for quality of care and VFM .
- Comprehensive service provision that provides the right care first time
- Reduction in hand offs between professions.
- Services where staff are skilled, flexible and able to manage a patient who reaches crisis

MENTAL HEALTH CARE

SOUTH ESSEX PARTNERSHIP FOUNDATION TRUST : Mental Health Services

- Work in partnership with the wider health and social care system to ensure only those patients who require specialist hospital services are admitted.
- Services where staff are skilled, flexible and able to manage a patient who reaches crisis
- Community dementia nurses integrated with the work of general practice
- Clinical input to appropriate bedded & non bedded capacity for mental health.
- Integrated CAMHS pathway across health & social care T1 –T4 with a single entry point

Section Five

OUR WORK PROGRAMME
TO DELIVER THE STRATEGY

- Priority Commissioning Work Programmes
- Patient, Enabling Programmes

OUR 3 LOCAL SERVICE PRIORITIES

- **Improved use of Single Point of Referral, esp for improved care of the elderly** – inc unplanned care, dementia, etc
- **Families with complex needs** – likely to focus on some children's services
- **Hypertension and CHD** – identified in JSNA

KEY COMMISSIONING PRIORITIES

- Improving quality of services
- Unplanned care – more care in community settings, joined up
- Planned care – reduce interventions of limited effectiveness, release people from repeated hospital visits and promote community services
- Listen to patients, work with them to shape service delivery and outcomes

WORKING WITH OTHERS: ENABLING PROGRAMMES

There are 5 priority areas for enabling work programmes; the CCG has identified clinical CCG Executive leads for each area:

GOVERNANCE

- Put in place sound governance recognised and respected by all member practices
- Develop a membership model which ensures 2 way accountability between the Board and member practices
- Developing the constitution that is recognised & owned by all member practices .
- Use quarterly membership meetings to review the delivery of our constitution and allow scrutiny from our member practice
- Develop a corporate understanding of governance through regular training and update

CLINICAL LEAD:
Dr Anil Chopra

PERFORMANCE

- Through increased use of our integrated information system increase focus on clinical outcome and pathway performance
- Use business intelligence tools to develop roll out practice level scorecards
- Using caretrak ensure presentation of an integrated at Health and Well Being Board
- Allocate GP leads for each of the challenged performance areas – 18 weeks , 62 day and A&E target
- Develop revised performance review template for each commissioning scheme
- Local schemes and business cases scrutinised by Clinical Execs
- Development and use of prioritisation framework

CLINICAL LEAD:
Dr tbc

ORGANISATIONAL DEVELOPMENT

- Produce a clearly articulated and compelling case for authorisation
- Profile individual/ team support to those taking on critical leadership roles within the CCG
- Establish accountability by delivering the CCG strategy for Patient & Public Engagement
- Develop a clear organisational operating model
- Have a clear Commissioning Plan which is communicated and owned throughout the organisation
- Each Board member to have a personal development plan
- Model CCG 5 year financial plan

BOARD LEAD:
Dr Anil Chopra

INFORMATION

- Launch CCG Website
- Launch Monthly Newletter
- Ensure regular updates are provided at the quarterly members meeting
- Establish and maintain an online forum (for primary care through the intranet page of the website
- Ensure every practice has access to medi analytics and care trak
- Continue CCG and practice agreement including information sharing
- Build on existing work to share information across health and local authorities.
- Develop with use of business intelligence to support our commissioning decisions
- Collaborative working with other CCGs and Public Health

CCG LEAD:
Tonia Parsons

QUALITY & SAFEGUARDING

- Identify safeguarding leads in each practice
- Safeguarding training and policy in each practice
- LSCB Accreditation and audit
- Chair contract Clinical review meetings with providers for outcomes
- CQUIN review with providers
- Host quality team on behalf of South Essex CCG
- Work with Essex Safeguarding hub via collaborative arrangements for quality & safeguarding

CLINICAL LEADS
Dr Sooraj Natarajan
Lisa Allen

WORKING WITH OTHERS: ENABLING PROGRAMMES

There will be a number of key enabling work programmes underpinning and supporting delivery of all of our commissioning work programmes: these will be delivered through a combination of internal and external resources identified in our Organisational Development Plan .

PRIMARY CARE PROVIDER DEVELOPMENT

- Establish a primary-care led programme of provider development
- Ensure programme is GP and/or Practice Manager led
- Ensure programme is resourced to deliver
- Ensure community and acute providers are engaged

CONTRACTING

- Ensure we have signed outcomes based contracts with all providers
- Develop contracts which encourage partnership working in terms of QIPP delivery
- Revise pricing currency for patients with long term conditions (year of Care)
- Revise assessment tariffs for identified high spend areas and where national tariffs do not apply
- Agree a 3 year transitional arrangement to manage the acute contract
- Ensure CQUIN is used to drive quality across all pathways

CLINICAL LEAD
Dr Reshma Rasheed

INTEGRATED COMMISSIONING

- Build on Integrated Commissioning Forum with Essex County Council for Mental health
- Develop integrated commissioning for reablement and frail elderly services
- Review opportunities to develop pooled budgets.
- Agree suitable integrated arrangements for children's commissioning
- Operationally roll out practice level MDTs with community and social care input
- Develop risk stratified pathway approach across health and social care for patients with long term conditions
- -Continue to develop an integrated information system across health and social care (caretrak)

CLINICAL LEAD
Dr tbc

HEALTH INFORMATICS

- Ensure continued roll out of system 1 across identified clinical pathways in primary, secondary and community care
- Support all practices in the use of medi – analytics
- Develop a local electronic integrated directory of services
- Continue close collaboration with ECC Public Health Resource to develop further JSNA 'deep dive' products that inform commissioning and QIPP.

CLINICAL LEAD
Dr tbc

COMMUNICATIONS AND ENGAGEMENT

- Delivery of Patient and Public Engagement Strategy
- Complete stakeholder analysis
- Establish stakeholder relationship management programme
- Maintain multiple communications methods (newsletters, website, intranet, social media
- Provide social marketing support
- Engage with emerging national commissioning
- Deliver regular campaigns / Media handling – pro-active and reactive
- Support CCG development of Patient Participation Groups
- Ensure through the development of the patient participation group the patient voice underpins all that we do and informs the development of our commissioning plans

CLINICAL LEAD
Dr tbc

ENGAGE WITH EMERGING NATIONAL COMMISSIONING BOARD

- Primary care commissioning & contracting
- Capital planning and Estates
- Emergency Preparedness
- Clinical Networks

CLINICAL LEAD
Dr tbc

Section Six

OUR FINANCE AND ACIVITY STRATEGY

BASILDON AND BRENTWOOD CCG FINANCE STRATEGY

- Medium Term Financial Plan (MTFP) from 2013 to 2016
- Allocations for 2013/14 confirmed
- Stretch target of £15.1m set for QIPP
- Details of 2013/14 QIPP schemes to deliver financial target in sections 4 and 7
- Outgoing PCT – no legacy debt expected
- Local Health System – financially challenged
- Encouraging integrated working across all partner organisations
- Cooperation agreement with local CCGs
- Main local provider is a Foundation Trust
- Providers focused on minimising cost base and increasing income
- Increased investment in community services and Reablement
- Local providers and partners expected to assist through collaboration in delivery of QIPP schemes through cooperation and contract levers

Key assumptions in MTFP

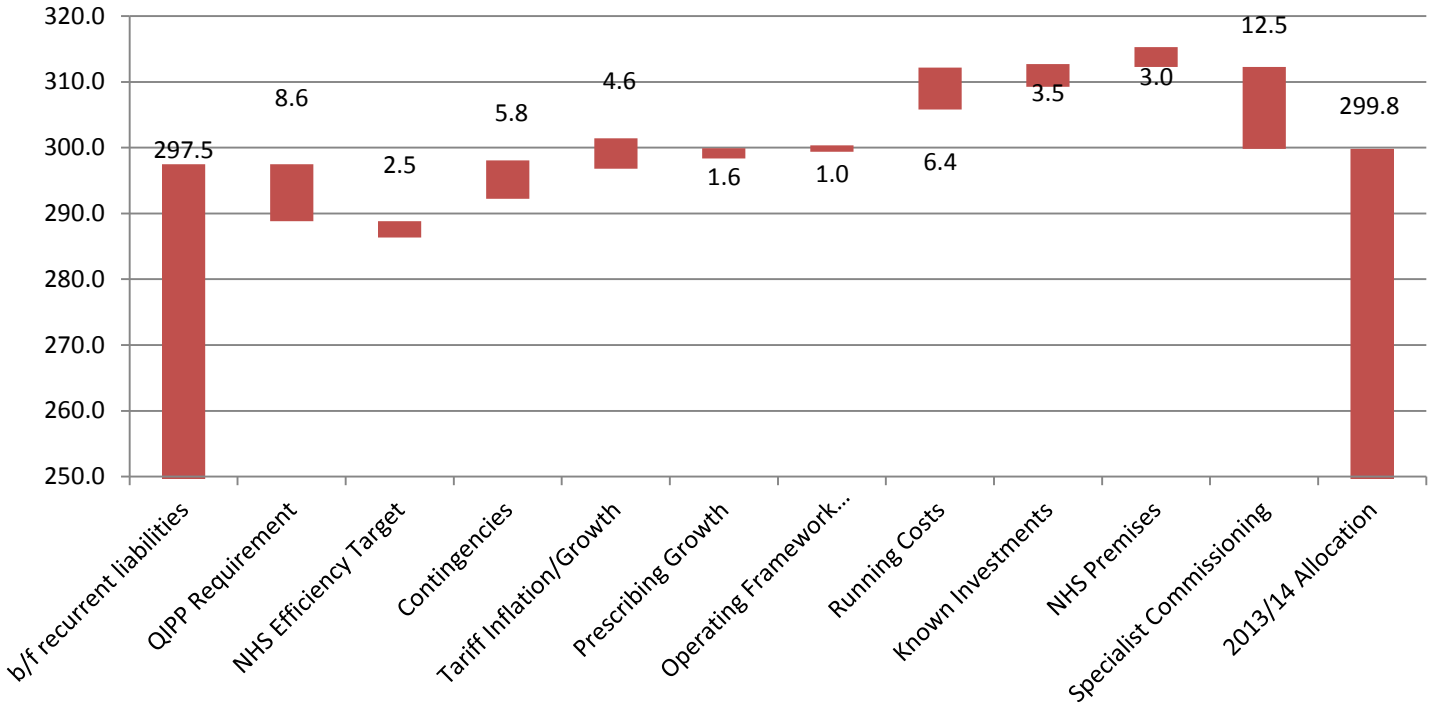
- Set aside 0.5% as per national requirement plus a further 0.5% local contingency
- Provided 1% for non-recurrent expenditure (contingency) in 2013/14 and 2% in future years (including 1% surplus)
- Providers expected to deliver national 4% efficiency less 2.7% inflation, a net reduction of 1.3% via PbR tariff or block contracts
- Provided for demographic growth and other local factors
- £8.6m QIPP assumed in likely scenario (£8.2m identified so far) for 2013/14
- Provision made for known commitments
- Allowed '£25 per head' for running costs
- CQUIN at 2.5% but expect increased rigour for providers to earn it
- Reablement monies included at same level as 2012/13
- Additional allocation is received for GP IT systems

Summary Financial Model

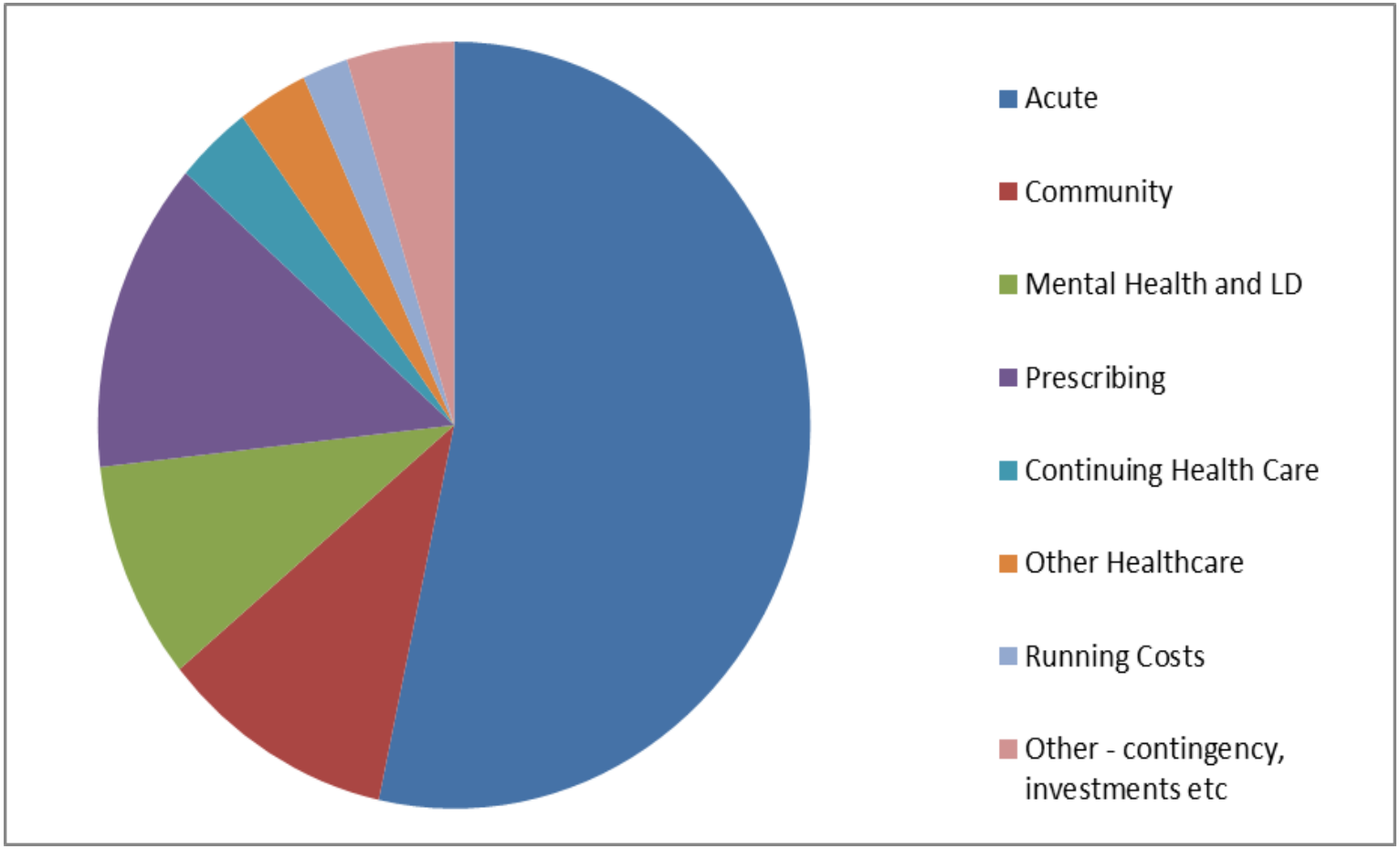
	2013/14			2014/15			2015/16			2012/13
	D/Side	Likely	Upside	D/Side	Likely	Upside	D/Side	Likely	Upside	Forecast Outturn
Recurrent allocation	**299.8**	**299.8**	**299.8**	**301.0**	**304.6**	**305.5**	**302.5**	**309.2**	**311.6**	**287.2**
Expected spend	**310.7**	**308.5**	**306.2**	**317.2**	**313.5**	**309.5**	**323.4**	**317.9**	**312.0**	**297.5**
QIPP Requirement - Identified	-9.6	-8.6	-6.4							
QIPP Requirement - Unidentified	-1.3			-16.1	-8.8	-4.0	-20.8	-8.7	-0.4	-10.3
Spend net of QIPP	**299.8**	**299.9**	**299.8**	**301.1**	**304.7**	**305.5**	**302.6**	**309.2**	**311.6**	**287.2**
Net Position	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
QIPP as % of Recurrent Allocation	**-3.6%**	**-2.9%**	**-2.1%**	**-5.3%**	**-2.9%**	**-1.3%**	**-6.9%**	**-2.8%**	**-0.1%**	

Summary Financial Model

The bridge chart below graphically represents the reconciliation between forecast brought forward liabilities, on the left hand side of the 'bridge' and the allocation expected to be received on the right. In between are the key changes from 2012/13 to 2013/14



2013/14 spend £308.5m before QIPP



Running Costs

£6.4m allocated based on £25 per head of population

- £1.6m on direct staff pay costs and 26.75 WTE
- £2.8m for payment of services bought from CSU and other
- £1.1m for locality structure, clinical, GP and lay members
- £0.7m for non pay costs such as office costs, audit etc.
- £0.2m for contingency

Quality, Innovation, Prevention, Productivity (QIPP)

- 2013/14 QIPP identified of £8.6m
- Details of all QIPP schemes outlined in section 4
- QIPP areas of focus include:
  - Non Elective admissions, Frail Elderly; Long Term Conditions & Paediatrics
  - Elective and Outpatients stretch to 'upper quartile', including targeting MSK
  - GP referrals to explore reasons for variation
  - Mental Health spend
  - Community Services – Integrated services
  - Continuing Care – Integration with Local Authority
  - Medicines management to continue excellent record on achieving efficiencies
  - Assess the Five High Impact Innovations at a local level
  - Procedures of limited effectiveness
  - Increase efficiency within provider contracts

QIPP DELIVERY - PMO REPORTING FUNCTION

- The CCG has a number of management processes in place to manage its resources and ensure that information is used properly to inform delivery of the desired service outcomes.
- The CCG commissions a Programme Management Office (PMO) through the Commissioning Support Unit (CSU) to aid implementation and monitor delivery of its QIPP projects.
- Each operational scheme lead to have completed a PMO template and associated milestones for each area of work
- Each scheme to have an individual performance report based on
    - Delivery of key milestones
    - Delivery of financial savings
    - Delivery of required activity changes
    - Management of risks
    - Quality impact assessment
- These areas will be monitored on a fortnightly basis by the Senior Commissioning Manager and Finance Officer
- Should performance concerns arise this will be escalated to the COO and CFO who will have to report to the CCG Board on key mitigating actions being undertaken

Key Risks and Mitigation

Risk	Mitigating Action
Underlying negative run rate of expenditure	Robust QIPP plans and monitoring
Late changes to Specialist Commissioning rules	Work through the changes and reconcile impact and ensure is matched to top sliced reduction
Continuing healthcare retrospective claims	Small provision included in the financial plans and preceding PCT may have made a provision
Slippage in QIPP delivery (risk adjusted saving is £6.7m v £8.6m assumed)	Programme Management Office (PMO) monitoring and formal escalation process
Contractual changes in main acute provider contract	Robust negotiations to minimise risk
Lack of transparency in block contracts	Obtain service line costings and improved KPI monitoring

Section Seven

ANNUAL OPERATING PLAN 2013/14

NB: The detail underpinning each of the workstreams is outlined in the workbook / plan for each scheme

BALANCED TURNAROUND STRATEGY

Striking the right balance between clinical and non-clinical savings

- Balanced turnaround strategy must focus on QIPP plans that strike the right balance between efficiency savings targeted at clinical services and those aimed at non-clinical areas such as ‘void’ establishment costs or ‘structural’ issues in the health economy

- Avoidable void rental costs of £3.1m is included in the £15.1m target resulting in an increased QIPP requirement

- Recognising this distinction, recovery of the financial deficit has been separated into two areas:

    1. QIPP efficiency savings of £12m from better commissioning of patient related services
    2. Void rental gap (PFI) £3.1m – non-clinical issue requiring an estates solution

FULL YEAR 2013/14 QIPP SUMMARY

FY 13/14 QIPP Target - Summary (Based on the original indicative budget)

Area	Budget (£m)	Planned Care (£m)	Unplanned Care (£m)	Other QIPP (£m)	Contract Reductions (£m)	Total QIPP & Contract Reductions (£m)	% Of Budget
BTUH	97.0	1.5	1.78		0.65	4.0	4.1%
BHRT	18.0	0.3	0.33		0.12	0.7	4.1%
MEHT	11.0	0.2	0.20		0.07	0.4	4.1%
SUHT	13.0	0.2	0.24		0.09	0.5	4.1%
Other Acute	25.0	0.4	0.46		0.00	0.9	3.4%
Acute	**164.0**	**2.6**	**3.0**	**0.0**	**0.9**	**6.51**	**4.0%**
Mental Health	**28.0**			**1.48**		**1.48**	**5.0%**
NELFT	31.0				0.7	0.7	2.4%
Other Community	13.0					0.0	0.0%
Community Services	**44.0**		**0.00**	**0.00**	**0.7**	**0.7**	**1.7%**
Prescribing	**42.0**			**2.50**		**2.50**	**6.0%**
Childrens, CHC and Others	**17.6**			**0.75**		**0.75**	**4.3%**
Void Space Rental	**2.4**			**3.10**		**3.10**	**129.2%**
Total	**298.0**	**2.6**	**3.0**	**7.8**	**1.7**	**15.1**	**5.1%**

QIPP PLANS FY13-14

Headline efficiencies including saving and budget area:

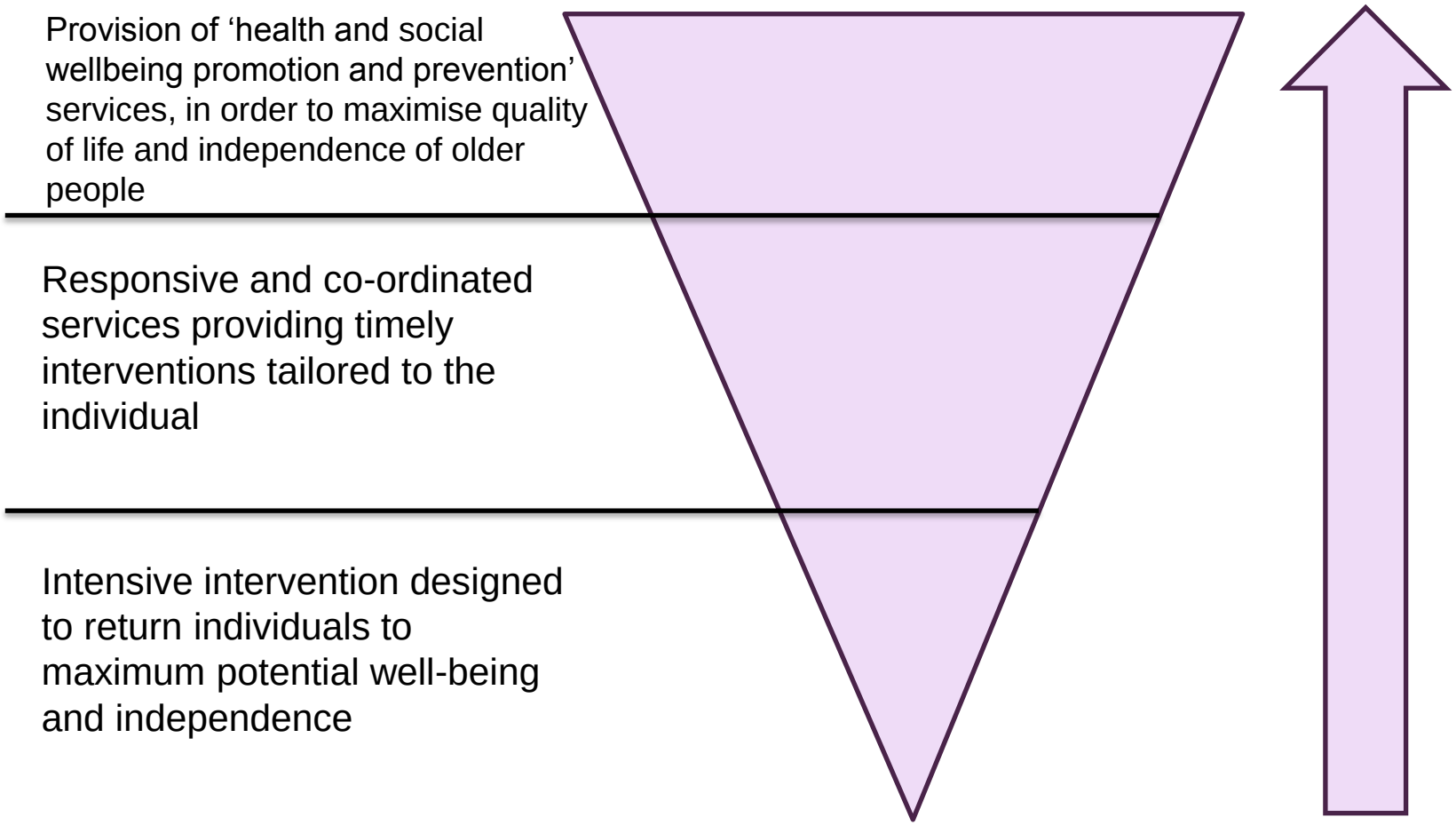
Area:	**Amount:**
Planned Care	£3.5m
Unplanned Care	£2.5m
Mental health	£0.3m
Prescribing	£0.9m
Children and Young People	£0.3m
Contract Reductions	£4.5m
Void Rental Costs	£3.1m
Total	**£15.1m**

Work stream

INTEGRATED UNPLANNED CARE

WORKSTREAMS: UNPLANNED CARE - VISION

Shared priority: to support older people to 'age well', remaining independent for as long as possible



WORKSTREAMS: UNPLANNED CARE - PRIORITIES

In addition to the QIPP plans outlined in the following section, the CCG has identified a number of quality improvement priorities. These align with the priorities of our partners (Essex County Council, Basildon and Thurrock Hospital and North East London Foundation Trust);

End of Life Services – the CCG will lead providers to ensure that there are integrated end of life pathways across the health and social system. We expect this to support the improvement of BTUH's SHMI

Nursing Homes Services – a disproportionate level of admissions into acute come from local nursing homes. We will review these trends and if appropriate, commission a new model of care to reduce the level of admissions

Falls Services – There has been significant growth in the level of falls related presentations (e.g. fractured neck of femur) into our local acute trusts. The CCG will review best practice evidence and seek to work with partners to improve outcomes for patient that fall and reduce the level of recurrences.

Ambulance Conveyance Rates – In 2012/13, working with partners the CCG has developed a number of alternatives to acute admissions. Now that these are embedded, we will work with East of England Ambulance Service to reduce the level of conveyances to acute for patients that can be appropriately managed in an alternative setting.

111 – The CCG will work closely with the new 111 provider to ensure that the directory of services supports our unplanned care strategy.

WORKSTREAMS: UNPLANNED CARE

Integrated Unplanned Care Services – FY13/14 Target £3.0m, Identified to-date £2.5m

Scheme	2012/13 Achievement	2013/14 Actions and Delivery Status	2013/14 Identified QIPP Savings	End Goal
GP Front End A&E ('Streaming' and 'Minors)	New scheme for FY 13/14.	• A thorough evaluation of the two schemes – GP triage (majors), GP streaming (minors) started in February 2013. Re-design of the emergency care pathway at clinically led working group meetings. • Initial evidence shows the scheme is making net savings with weekly activity to-date averaging 74, above break-even volume of 46. • Monitoring continuing. • Operational dashboard completed - weekly information available to each practice • Discussions are underway with EoA around the ECPs to carry out an appropriate assessment and engage with community health and social care providers via the SPOR. GP Practice Engagement and Escalation to support delivery: • Practice engagement, best practice support and escalation process agreed for implementation. • QP plus scheme being finalised to recognise QIPP delivery.	£0.4m	• Admission avoidance by ensuring 'appropriate' triage. Implementation of new front end A+E model involving GP majors and minors Triage and attendance avoidance. • Scheme implemented starting with pilot on1 Feb. • Results to-date show scheme is proving to be very effective • Net savings delivery of £15k p.w. (£0.75m p.a.) • On-going review. • GP Practice Engagement and Escalation to support delivery
GP Majors Triage and AAT	New scheme for FY 13/14.		£0.8m (FYE £0.9m) (allocated savings estimate)	

WORKSTREAMS: UNPLANNED CARE

Integrated Unplanned Care Services

Scheme	2012/13 Achievement	2013/14 Actions and Delivery Status	2013/14 Identified QIPP Savings	End Goal
PCAT*	Between April 12-Nov 12 PCAT reported 672 contacts, of the people they saw only 56 were admitted within 30 days. Effective admission avoidance service. .	• PCAT service delivers community based assessment and is aimed at patients requiring a more intensive treatment, but do not require emergency admission to hospital. • PCAT extended hours under review to improve access and utilisation by more GP practices. • UPC working groups working on detail of re-launch and re-market along with other alternatives. • There has been a significant increase in PCAT activity since the extension of hours, the purpose of which was to ensure GPs could continue to access the service during their afternoon/early evening surgeries. • The data also shows that the PCAT has sustained a rate of admission avoidance of 80% on average, this is based on the number of emergency admissions to hospital within 30 days of those people seen by the PCAT	£0.4m (FYE £0.5m) (allocated savings estimate)	• Admission avoidance to acute hospital. • Extending ease of access from all localities and increasing patient inflow. • Use of Primary Care and Treatment service in community. • GP Practice Engagement and Escalation to support delivery
Primary Care MDT (existing scheme)	Started at a number of practices but not taken up by majority. Operational dashboard information now being provided to show 'frequent flyers' and high cost patients to inform MDT meetings.	• Standard format for MDTs across BB, including attendees, selection criteria of patients for review and number of patients that can be reviewed effectively. • Use of Operational dashboard information to identify 'frequent flyers' and high cost patients. • Identification of patients by GP practices, community health team or social care professional, who are a) deemed to be at risk of deterioration in their condition, and b) would benefit from an integrated response from primary health/community health/social care providers.	£0.4m (allocated savings estimate)	• Risk management of patients to avoid inappropriate admission to acute hospital. Refining and increasing integration of existing schemes • GP Practice Engagement and Escalation to support delivery

WORKSTREAMS: UNPLANNED CARE

Integrated Unplanned Care Services

Scheme	2012/13 Achievement	2013/14 Actions and Delivery Status	2013/14 Identified QIPP Savings	End Goal
SPOR*	Since its launch in September 2012 and January 31st 2013 the SPOR has had made 102 contacts. Of these only 15% of patients had a subsequent emergency admission to hospital within 30 days and only 7% attended A&E.	Whilst contacts are low this indicates that the service is effective at avoiding admissions. Therefore, in order to maximise its capacity to avoid admissions, referrals into the service need to be increased as follows: • Re-design of service to improve effectiveness and GP practice usage. • Detailed specification using GP (users) input to make 'fit-for-purpose' service. Specification agreed with Essex CC who commissioned project manager to review service and work with CCG clinical workgroup. • Re-launch and re-market SPOR to increase uptake.	Enabling gateway to achieve admission avoidance schemes	• Admission avoidance. • Single telephone contact leading to rapid health and social care assessment of patients at risk of admission, and 'sign posting to appropriate services. • GP Practice Engagement and Escalation to support delivery
Community Geriatrician* (existing scheme)	Model commenced 17th Sept 2012. Between Sep 12-Nov 12 community Geriatrician had 32 contacts, from which there were 10 hospital admissions within 30 days indicating potential 22 avoided admissions.	• Evaluation to improve effectiveness of service commenced from 25 Jan-13 and changes being actioned to ensure the most effective use of the geriatrician provided by NELFT, e.g. setting of care, frequency etc. • Continued engagement with practices and providers to embed schemes and changes. • Current round of practice visits to be completed by 31 Mar-13. • Operational dashboard completed - weekly information available to each practice.	£0.3m (FYE £0.4m) (allocated saving estimate)	• Admission aviodance. Reduction in demand for secondary care capacity. • Consultant specialist input to management of frail elderly patients with complex co-morbidities, and development of a case management approach, based upon a Comprehensive Geriatric Assessment (CGA)

WORKSTREAMS: UNPLANNED CARE

Integrated Unplanned Care Services				
Scheme	**2012/13 Achievement**	**2013/14 Actions and Delivery Status**	**2013/14 Identified QIPP Savings**	**End Goal**
Step Up Beds	Use of step-up beds (29) to avoid admissions into hospital. Currently being utilised for step-down purposes to support BTUH capacity issues	• Resolve current blockage of step up beds due to over use for step down purposes as part of system wide support being provided to manage BTUH efficiency and capacity problems. • Operational dashboard completed - weekly information available to each practice	In progress	• Admission avoidance to acute hospital. • For patients requiring a high level of supervision and care for up to 7 days in order to stabilise their condition and allow for the appropriate packages of home care to be put in place. • GP Practice Engagement and Escalation to support delivery
Decommissioning of Admission Avoidance Car	This service has under-performed and can be provided using more effective alternatives.	• Serve notice on contract. • Training and information needs of wider groups of ambulance staff on alternatives to hospital admission.	£0.2m	• Decommission car and embed the principles across the entire blue light fleet

*Note: Due to scheme interdependencies it is not possible to determine the savings at scheme level. However, compared to previous year, spend on unplanned care admissions increased therefore schemes were unable to achieve a net financial benefit.

Alignment of QIPP Plans with Essex CC Plans

Integrated Unplanned Care Services Essex CC Subject Matter Expert – Caroline Robinson, Lesley Fewell, Barbara Herts		
CCG Scheme	**ECC Plans**	**Comments**
GP Front End A&E ('Streaming' and 'Minors)	• Urgent Care Pathways • Dementia • Support for carers • Continence management • GP practice MDTs • End of life care	• Essex CC Subject Matter Expert involved in reviewing the plans – Caroline Robinson, Lesley Fewell, Barbara Herts • Re-ablement funding and transformation monies for investment
GP Majors Triage and AAT		
PCAT*		
Primary Care MDT		
SPOR*		
Community Geriatrician*		
Step Up Beds		
Decommissioning of Admission Avoidance Car		
Cellulitis		

WORKSTREAMS: UNPLANNED CARE – JOINT WORKING

Why:

- Health and social services face similar challenges associated with an aging population.
- There is high correlation between patients with significant health needs/significant social needs
- Service users want to receive holistic services rather than those provided by health and those provided by social services

Objectives:

- To strengthen provision of 'promotion and prevention' services to older people in order to support individuals to maintain optimal personal independence and well being.
- To identify all older people who are experiencing a significant deterioration in their health status and/or social condition, in order to implement a rapid combined needs assessment, and commence the appropriate package of health &/or social care interventions required to restore, and maintain, maximal possible independence/wellbeing.

How:

- Map type and effectiveness of existing preventative services currently utilised within the local health & social care economy, and review preventative services that are proving effective elsewhere, in order to develop an integrated health & social care promotion and preventative strategy by end-March 2014, with a view to implementation in 2014/15.
- Maintain, and strengthen, engagement in GP practice-level MDTs by adult community team, community mental health team, social care and GPs – to provide a forum to identify, produce integrated care plans for, and monitor impact on, older people who would benefit from targeted community health or social care input to avoid further deterioration and optimise independence/well-being.
- Continue to develop, and potentially expand the scope of, the Single Point of Referral (SPOR) /RRAS service, which allows GPs, community health and social care professionals, to request a rapid health and social care assessment (i.e. with 2 hours) of an older person for whom a deterioration in their health and/or social situation has placed them at risk of admission to secondary care.
- Accelerate the adoption of assistive technologies across the patch
- Develop more condition specific joint pathways to ensure full co-ordination of pathways (e.g. Integrated continence pathway).

WORKSTREAMS: UNPLANNED CARE – JOINT WORKING

Section 256/Social Cares Monies:

Informed by a review of utilisation of 2013/14 Section 256 (reablement) funding, the CCG and Essex County Council are planning the optimum use of the allocation to be made by the CCG for 2014/15.

Following CCG Board approval it is anticipated that half of the allocation will be used to fund the existing contractual arrangement with Essex Cares for the provision of reablement. It is also anticipated that a proportion of the reablement funding will be used to fund the Single Point Of Referral, possibly in an expanded form (in terms of staff capacity and hours of operation) in order to more effectively support the provision of integrated community health and social care services in line with agreed QIPP objectives.

Other potential areas for funding will include the provision of an Integrated Crises Response service, the provision of dementia support beds at Mountnessing Court, social worker engagement in discharge planning from community in-patient beds, and social worker involvement in the GP practice-level MDTs

WORKSTREAMS: UNPLANNED CARE – JOINT WORKING

Section 256/Social Cares Monies:

Details of Reablement Project	Estimates of Potential Impact	£000s £1,436,000	Outcome measures.
		2013/14	
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	£703,000	10% reduction in Acute Admissions following Reablement.
Single Point of Referral	1. Reduction in placement delays from hospital. 2. Improved discharge planned. 3. Reduction in admissions and re-admissions to hospital.	£200k	10% reduction in acute admissions through more responsive community service. Integrated working between ECC and CCG leading to better outcomes for patients.
2 Social Work posts for discharge from Brentwood Community Hospital and Mayflower	Improved discharge planning.	£100k	Reduction in admissions to Hospital through use of step-up beds. Avoid approximately 50% of delays.
Dementia bed project		£50k	
Integrated Crisis Response Service.	1. Reduction in Frequent flyers from Community Health Teams. 2. Reduction in on-going care packages. 3. Reduction in GP call out's and re-visits	£213k	Expectation that project will give support to 50% of Community Health Teams cases.
Consultant to take forward South Essex integrated intermediate care strategy, crisis response and SPOR SPT worker for Basildon Hospital GP MDT worker	To facilitate timely discharge to community services.	£70k £30k £70k	To continue the established relationships with GP's to provide responsive support and sign post where appropriate.

WORKSTREAMS: UNPLANNED CARE – JOINT WORKING

Working Together:

The CCG will work in a collaborative way with all stakeholders including;

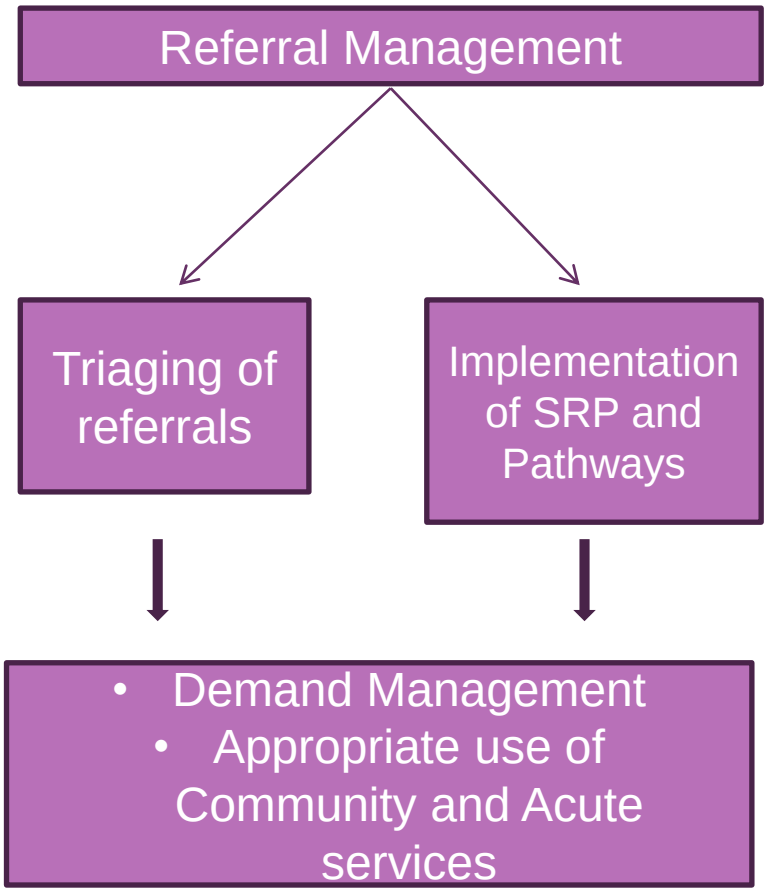
- Basildon and Thurrock Hospital
- Thurrock CCG
- North East London Foundation Trusts
- Essex County Council
- Out of Hours Providers
- East of England Ambulance Services

Unplanned Care will be overseen through the Unplanned Care Board (with representatives from the above organisation). This forum will provide direction across the sub economy's approach to improved management of unplanned care. This will be underpinned by a transparent approach to performance monitoring of schemes and services.

Work stream

Improved Planned Care Services

VISION: IMPROVED PLANNED CARE SERVICES



- Enhancing referral management services to improve triage
- Update the existing SRP to ensure procedures with low clinical value are excluded using intelligence from our JSNA products
- Setting up clinical networks to provide clinical guidelines to primary care clinicians for effective management of patients in primary care
- Setting up alternate community settings in collaboration with secondary and community providers to ensure care is provided closer to service users

WORKSTREAMS: PLANNED CARE - PRIORITIES

In addition to the QIPP plans outlined in the following section, the CCG has identified a number of quality improvement priorities across planned care services;

Maintenance of 18 week performance – We are currently under performing against key 18 week standards. We will work with providers to ensure that we consistently achieve these standards for our patients.

Cancer Services – The CCG will undertake a number of initiatives to try and improve cancer outcomes. This will include a review of the two week referral system as well as other key standards in cancer care.

Stroke Services – The CCG is working collaboratively with all Essex CCGs to support the implementation of the new stroke service specification that has disseminated from the Midlands and East review and to improve services by implementing recommendations of the local JSNA Stroke ‘Deep Dive’

WORKSTREAMS: PLANNED CARE

Integrated Planned Care Services – FY13/14 Target £2.6m, Identified to-date £3.5m				
Scheme	**2012/13 Achievement**	**2013/14 Actions and Delivery Status**	**2013/14 Identified QIPP Savings**	**End Goal**
Consultant to Consultant (C2C) Referrals	New scheme for FY 13/14.	• New contract terms issued as of 01 Feb 2013, requiring all C2Cs to be referred back to GP practices. • 20% of all first appointments made result from a Consultant to Consultant referral. • 44% increase in C2C referrals since last year increasing costs by £0.5m. • Evidence suggests this practice often results in an inappropriate referral • Introduction of contractual levers to restrict C2C referrals, reducing costs by eliminating unnecessary first outpatient appointments. • Contract variation communicated and agreed with acute trusts prior to FY 2013/14, i.e. all non-urgent C2Cs to be directed back to the registered GP. • Robust monitoring of contract to be implemented.	£0.7m	• GP review of consultant to consultant referrals to reduce the level of inappropriate activity • Scheme implemented at BTUH from 1 Feb 2013
First to Follow-up Cap	New scheme for FY 13/14.	• Contract negotiations with BTUH to agree the revised first to follow up targets and cap activity. If the targets are therefore not met, the CCG will not be financially liable to pay for the activity.	£1.1m	• Reduction in activity to top 10% productivity based on national benchmarks

WORKSTREAMS: PLANNED CARE

Integrated Planned Care Services				
Scheme	**2012/13 Achievement**	**2013/14 Actions and Delivery Status**	**2013/14 Identified QIPP Savings**	**End Goal**
Service Restriction Policy	Updated for FY 13/14. Not measured at this time.	• SRP under revision. Audit being completed by end Feb-13. • Compared to application of service restriction policy by peer commissioners there is recognised scope to extend the current Service restriction policy and add further services/treatments deemed as 'low clinical priority' that provide poor value for money and effectiveness. • SRP currently contains a number of procedures however only 3 are currently audited and 19% of these reimbursed by the provider as inappropriate. • In order to drive down or reclaim reimbursement for inappropriate activity an audit has been undertaken. Eight high spend areas have been reviewed and the potential outcome is increased threshold and savings. • These have been agreed by clinical leads across the CCGs, the SHA/NCB and public health and will now be taken forward into contract negotiations with providers including BTUH, SUHFT, BHRT.	£0.7m	• Extend the scope and the effectiveness of the Service Restriction Policy to exclude treatments deemed as 'low clinical priority' that provide poor value for money and effectiveness.
Practice Level Referral Management	Triage of all referrals to reduce GP referrals into secondary care and peer review of GP referrals. YTD actual overspend £385,863.	RMC review underway by planned care working group , next steps agreed. Options are to increase take-up of current systems or look at alternatives. Peer challenge on referrals (may include risk management of C2C referrals).	£0.5m	• Peer review to minimise inappropriate referrals. • GP Practice localities have been set targets

WORKSTREAMS: PLANNED CARE

Integrated Planned Care Services				
Scheme	**2012/13 Achievement**	**2013/14 Actions and Delivery Status**	**2013/14 Identified QIPP Savings**	**End Goal**
Fortis RMC Decommissioning	New scheme for FY 13/14.	• Decommission service • BBCCG RMC Model already in place.	£0.25m	• Single more effective RMC Model
Community Rheumatology and Acupuncture		• Re-design rheumatology services and repatriate patients out of an acute setting into community services which have a consultant led, MDT approach. • Decommissioning of Rheumatology Outpatient Clinics with identified exclusions/red flags which would continue to be seen in secondary care.	£0.1m	• Re-designed pathway for more effective service.
Dermatology	Scheme to develop community specialist diagnosis and management of patients. YTD actual savings £13,593.	• BB and Thurrock CCGS's are currently going through the evaluation process following AQP advert. 4 providers have come forward.	£0.05m (FYE £0.06m)	• Any Qualified Provider procurement - intermediate dermatology service shifting care out of an acute setting • The service is being advertised at 80% of tariff

WORKSTREAMS: PLANNED CARE

Integrated Planned Care Services				
Scheme	**2012/13 Achievement**	**2013/14 Actions and Delivery Status**	**2013/14 Identified QIPP Savings**	**End Goal**
Diabetes Renal	New scheme for FY 13/14.	• Using diabetic retinal patient data to identify likely demand for service. Cost-benefit analysis to take place, and next steps agreed. Diabetes Renal working group met and shared activity to cost the service accurately. Timescale of 6 months agreed to implementation.	£0.05m (FYE £0.1m)	• Re-design renal service for diabetic patients and repatriate into the community as an MDT approach which is consultant led and more economical
Nuffield MRI/CT Contract	Identified that the current cost per scan is in excess of PBR tariff.	• Data used to investigate the scope for savings in transferring MRI/CT activity from Nuffield to Basildon at PBR tariff. Updated to reflect YTD activity and cost, reviewed on 25/02/2013. Agreement in principle has been made with BTUH that this activity could be managed by them at the PBR cost.	£0.06m	• Reduced tariff or new provider at PBR tariff • The contract has not been renewed beyond 31st March therefore it is likely that any savings will be realised from 1st April.
Direct Access	New scheme for FY 13/14.	• Review of testing activity by practice in relation to CCG averages and disease prevalence. • Education of practitioners on costs of individual test to discourage 'ticking' of all available boxes rather than required boxes.	£0.05m	• Reduction in volume of Biochemistry and other test volumes - increase of appropriateness
Podiatry	New scheme for FY 13/14.	• NELFT (ONEL) confirmed they will support this scheme, therefore there would be no challenge. Procurement advised. • Next step is to serve notice.	£0.03m (FYE £0.04m)	• Transfer of Brentwood service from NELFT to SEPT • New diabetic foot pathway in place

Alignment of QIPP Plans with Essex CC Plans

Integrated Planned Care Services
Essex CC Subject Matter Expert – Lesley Fewell, Barbara Herts, Steve Allen

CCG Scheme	ECC Plans	Comments
Consultant to Consultant (C2C) Referrals	• Planned Care Pathways • Dementia • Support for carers • Diabetes • End of life care	• Essex CC Subject Matter Expert involved in reviewing the plans – Lesley Fewell, Barbara Herts and Steve Allen
First to Follow-up Cap		
Service Restriction Policy		
Practice Level Referral Management		
Fortis RMC Decommissioning		
Community Rheumatology and Acupuncture		
Direct Access		
Dermatology		
Diabetes Renal		
Nuffield MRI/CT Contract		
Podiatry		

JOINT WORKING: PLANNED CARE

The CCG will work collaboratively both with fellow South Essex CCGs and providers to establish specialty specific networks. The networks will identify opportunities for improved efficiency/effectiveness in addition to improved outcomes. The specialties prioritised are Dermatology, MSK/T+O and Ophthalmology.

The Planned Care programme is underpinned by practice level targets for reducing referrals. This will be supported by the enhancement of the Referral Management Centre and the review of non urgent consultant to consultant referrals. Practice level performance will be overseen by the localities. This process is outlined further on in this plan.

Workstream

PRESCRIBING AND MEDICINES MANAGEMENT

WORKSTREAMS: MEDICINES MANAGEMENT

Integrated Medicines Management Services – FY13/14 Target £2.5m, Identified to-date £0.9m				
Scheme	**2012/13 Achievement**	**2013/14 Actions and Delivery Status**	**2013/14 Identified QIPP Savings**	**End Goal**
Respiratory 1 and 2	Single respiratory scheme achieved YTD actual savings £80k.	• Raise Nurse and GP awareness of major issues • Deployment of Sessional Pharmacists to support practices in reviewing patients regularly and altering the dose or type of medication if necessary • Inclusion of asthma review in Prescribing Incentive Scheme • Change in Formulary Guidance for LAMA's • Pharmaceutical support to deliver project	£0.26m	• Maximise the cost-effectiveness of respiratory prescribing • Reduce cost of ICS using Fostair/Flutiform and Step down • Reduce use of Spiriva using newer LAMAs
ScriptSwitch	YTD actual savings £205k.	• Recruitment/ support of new ScriptSwitch Practices • Optimisation of ScriptSwitch savings for low performers • Identify further ScriptSwitch savings	£0.25m	• Using the ScriptSwitch prescribing decision support software to include atypicals, OAB, Lipid lowering, 5ASA, PDE5s
ONS and Paediatric ONS	YTD actual savings £55k and further new scheme for FY 13/14.	Workbooks/project plans are currently being worked on	£0.14m	• Promote cost effective formulations

WORKSTREAMS: MEDICINES MANAGEMENT

Integrated Medicines Management Services				
Scheme	**2012/13 Achievement**	**2013/14 Actions and Delivery Status**	**2013/14 Identified QIPP Savings**	**End Goal**
Insulins and BGTS	YTD actual savings £35k and new scheme for FY 13/14.	• Support for BGTS for practices not performing well against this target • Liaise with MMC/ Specialists/ DSNs regarding recommendations • Formulary recommendation	£0.09m	• Optimise prescribing by discouraging use of analogue insulins, review of the effectiveness of newer antidiabetics and review of quantities and types of Blood Glucose Testing Strips (BGTS) prescribed in primary care • Analogues to NPH • Maintain or reduce volume
Specials and Miscellaneous drugs	YTD actual savings £18k.	• Monthly analysis of Epact specials data and FP10 • Highlight specials prescribing at Prescribing meetings • Liaison with Pharmacies, manufacturers and suppliers where necessary. Liaise also with MMC and specialists.	£0.08m	Specials review including alternative route of supply for Derm specials Practice support initiative (Pharmacist/Technician)

WORKSTREAMS: MEDICINES MANAGEMENT

Integrated Medicines Management Services				
Scheme	**2012/13 Achievement**	**2013/14 Actions and Delivery Status**	**2013/14 Identified QIPP Savings**	**End Goal**
Care homes Mental Health and Stoma	YTD actual savings £78k and new scheme for FY 13/14.	• Regular reviews of Care Home patients • Support of MDT medication reviews • Education and training where necessary	£0.08m	• Collaborative work with MDTs/ Pathway redesign/care homes
Woundcare	YTD actual savings £18k.	• Regular meetings with providers of service • Regular assessment of Orders to ensure stock control is appropriate	£0.02m	• One central point in community to order wound care products. • Non-FP10 pathway (Care home extension)
Dietetics	New scheme for FY 13/14.	• Deployment of Dietician to support practices review ONS • Inclusion of Dietetics review in Prescribing Incentive Scheme • Dietetics Guidelines	TBA	• Optimised prescribing of oral nutritional supplements

Workstream

IMPROVING OUTCOMES FOR CHILDREN AND FAMILIES: PAEDIATRICS

WORKSTREAMS: PAEDIATRICS

Paediatrics Services – FY13/14 Target £0.75m, Identified to-date £1.0m				
Scheme	**2012/13 Achievement**	**2013/14 Actions and Delivery Status**	**2013/14 Identified QIPP Savings**	**End Goal**
PAU and Acute Activity reductions (12 Beds)	New scheme for FY 13/14.	• 12 beds reduced due to activity reduction in acute and patients managed more appropriately in community. Delivered.	£0.8m	• Patients managed more appropriately in community • PAU model with appropriate differential tariff and implementation of the five high impact pathways.
Special Paeds (0.6 WTE reduction)	New scheme for FY 13/14.	• Decommissioning of CDR post	£0.08m	• More effective pathway re-design.
Paediatric Diabetes Best Practice Tariff	New scheme for FY 13/14.	• Delivered. Best Practice tariff agreed.	£0.04m	• Reduced Best Practice tariff
Specialist Developmental Playgroups	New scheme for FY 13/14.	• Decommission service	£0.03m (FYE £0.05m)	• Decommission service

Alignment of QIPP Plans with Essex CC Plans

Paediatrics Services - Essex CC Subject Matter Expert – Barbara Herts		
CCG Scheme	**ECC Plans**	**Comments**
PAU and Acute Activity reductions (12 Beds)	• Families with complex needs • CAMHS • Maternity • CHC	• Essex CC Subject Matter Expert involved in reviewing the plans – Barbara Herts
Special Paeds (0.6 WTE reduction)		
Paediatric Diabetes Best Practice Tariff		
Specialist Developmental Playgroups		

Workstream

MENTAL HEALTH

WORKSTREAMS: MENTAL HEALTH

Mental Health Services – FY13/14 Target £1.5m, Identified to-date £0.3m				
Scheme	**2012/13 Achievement**	**2013/14 Actions and Delivery Status**	**2013/14 Identified QIPP Savings**	**End Goal**
MCCH	New scheme for FY 13/14.	• Negotiation weekly bed rate with provider from contract end date. • Confirm in writing the end of the contract with MOAT. • Draft cost per case contracts for health funded patients from contract end date. • Agree further reductions in year as a result of de-registration. • Write to local authorities setting out implications for joint funded patients. • Rehabilitation team review patient's recovery plans. • Review strategic direction for service • Explore options for s256 agreements with local authorities for this provision	£0.15m	• Move health funded patients onto cost per case contracts, review recovery plans and review strategic objectives of the service
RAID	New scheme for FY 13/14.	• Meet with SEPT Clinical Leads and Ambulance Service BTUH & SUHFT • Agree pathway protocols - SEPT to take to CMT • CCG's informed of the new pathway and criteria • Agree data collection • Monthly monitoring via QIPP	£0.05m	• Rapid assessment and intensive diagnostic - psychiatric liaison in an acute setting
Repatriation of out of area activity	New scheme for FY 13/14.	• OATS budget reduction	£0.05m	• Repatriation of complex care and intermediate care out of areas

WORKSTREAMS: MENTAL HEALTH

Mental Health Services				
Scheme	**2012/13 Achievement**	**2013/14 Actions and Delivery Status**	**2013/14 Identified QIPP Savings**	**End Goal**
Dementia Care Line	New scheme for FY 13/14.	• SEPT negotiations	£0.03	• Avoiding admissions from care and residential homes
COPD / Stroke	New scheme for FY 13/14.	• Confirm funding with SHA • Complete Needs Assessment • Agree model, pathway and protocol • Engage with Respiratory MDT • Engage with Expert Patient Group • Agree KPI's and develop baselines • Monitor impact of service • Complete and submit Evaluation report	In progress	• Clinical psychology input to the existing LTC service and to make cognitive behavioural therapy (CBT) interventions available for people with LTC.
Psychological therapies for people with LTCs	New scheme for FY 13/14.	• SEPT negotiations	In progress	• Improve access to therapies for patients with LTCs
Reconfigure CHC beds	New scheme for FY 13/14.	• SEPT negotiations	In progress	• Make more efficient use of CHC beds
Respite Beds	New scheme for FY 13/14.	• SEPT negotiations	In progress	• Make more efficient use of respite beds

Alignment of QIPP Plans with Essex CC Plans

Mental Health – Essex CC Subject Matter Expert – Caroline Robinson		
CCG Scheme	**ECC Plans**	**Comments**
Mountnessing Court Dementia Intensive Support Team MCCH RAID Repatriation of out of area activity COPD / Stroke Psychological therapies for people with LTCs Reconfigure CHC beds Respite Beds	• Improve the capability of GP's and practice staff to recognise, assess, support and refer people with mental health problems. • Improve the gateway into services so people are directed to the right support at the right time. • Improve primary care and preventative mental health services so more people are supported without the need to be in secondary care. • Focus secondary care on providing intensive, specialist support which improves recovery, personalisation and choice, so fewer people need residential care. • Focus secondary care on providing intensive, specialist support which improves recovery, personalisation and choice, so fewer people need residential care. • Improve crisis responses so that fewer people need inpatient care. • Focus on developing the usage of alternative providers and self-management where it is safe and appropriate to do so. • Focus on meeting the needs of higher risk groups who may have specialist needs.	• Essex CC Subject Matter Expert involved in reviewing the plans – Caroline Robinson • Re-ablement funding and transformation monies for investment

JOINT WORKING: MENTAL HEALTH

Mental Health services for Working Age 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.

JOINT WORKING: MENTAL HEALTH

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

- Improve the confidence and capability of GP's and practice staff to recognise, assess, support and refer people with mental health problems.
- Improve the gateway into services so people are directed to the right support at the right time.
- Improve primary care and preventative mental health services so more people are supported without the need to be in secondary care.
- Focus secondary care on providing intensive, specialist support which improves recovery, personalisation and choice, so fewer people need residential care.
- Focus secondary care on providing intensive, specialist support which improves recovery, personalisation and choice, so fewer people need residential care.
- Improve crisis responses so that fewer people need inpatient care.
- Focus on developing the usage of alternative providers and self-management where it is safe and appropriate to do so.
- Focus on meeting the needs of higher risk groups who may have specialist needs.

JOINT WORKING: MENTAL HEALTH

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.

The strategy shows how we will commission the delivery of the strategy through co-ordinated health and social care commissioning arrangements.

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

Essex County Council and Basildon and Brentwood 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).

Work stream

IMPROVING MENTAL HEALTH OUTCOMES FOR CHILDREN AND YOUNG PEOPLE

WORKSTREAMS: CHILDREN AND YOUNG PEOPLE

Paediatrics Services – FY13/14 Target £0.75m, Identified to-date £0.25m			
Scheme	**2012/13 Achievement**	**2013/14 Actions**	**End Goal**
CAMHS High Cost 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
Children's Equipment		PID going to Procurement Group on 12 March 2013 for sense check.	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
Children's Continuing Healthcare	Planned start date Oct 12.	AQP procurement completed and mobilisation near to being finalised. AQP has yielded 12 accredited providers for children and young people's continuing care. Financial monitoring in progress. Next steps: formalise care pathways and transitions.	CY&P Continuing Health Care Any Qualified Provider (AQP) standardised pricing framework. A consistent single model of procurement for CHC for Essex
CAMHS Eating Disorder			Reduce escalation of eating disorder children and young people to Tier 4 residential provision and tier 3 CAMHS by providing local dietetic support to local Tier 2 provision and in some cases tier 3

WORKSTREAMS: CHILDREN AND YOUNG PEOPLE

Paediatrics Services			
Scheme	**2012/13 Achievement**	**2013/14 Actions**	**End Goal**
Paediatric Assessment Unit	Planned start date Oct 12.		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
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
Autistic Spectrum Disorder		PID going to Procurement Group on 12 Feb 2013 for sense check.	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

Work stream

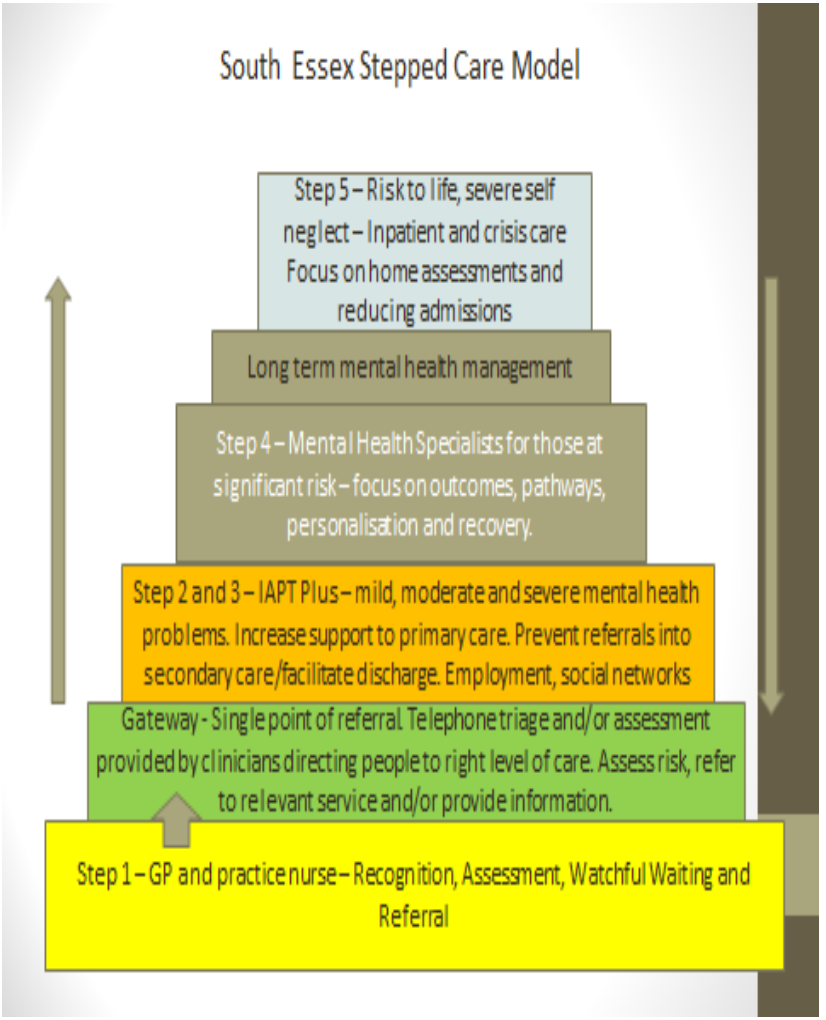
STRONGER PARTNERSHIPS ACROSS MENTAL HEALTH AND LEARNING DISABILITIES

WORKSTREAMS: MENTAL HEALTH SERVICE - PRIORITIES

Our shared vision is that the services we commission 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 aligns with our local Health and Wellbeing Board strategy.



JOINT WORKING: MENTAL HEALTH SERVICES

In order to deliver upon the Mental Health Strategy and our own local Mental Health QIPP Programmes, the CCG will be an active participant in the South Essex Mental Health Strategy Board. This is chaired by a local authority representative and includes representation from;

- Essex County Council
- Southend LA
- Thurrock LA
- Southend CCG
- Castlepoint, Rayleigh and Rochford CCG
- Thurrock CCG
- Basildon and Brentwood CCG

In addition to the main steering Board, the CCG will participate in a number of subgroups to support specific projects.

The CCG aims to be able to develop the foundations of joint working in 2013/14 that will lead to genuine joint commissioning in 2014/15. This will include sharing information systems, understanding existing finance flows and having a transparent approach to contracting.

Work stream

CONTRACT REDUCTIONS

WORKSTREAMS: CONTRACT REDUCTIONS AND VOID RENTAL

Contract Reductions – FY13/14 £3.9m			
Scheme	**2012/13 Achievement**	**2013/14 Actions**	**End Goal**
Acute		£1.9m	Affordable contract
NELFT and Other Community		£1.1m	Affordable contract
Mental Health		£0.8m	Affordable contract
Void Rental Costs		£3.1m	Affordable Estate
Total		**£6.9m**	

Section Eight

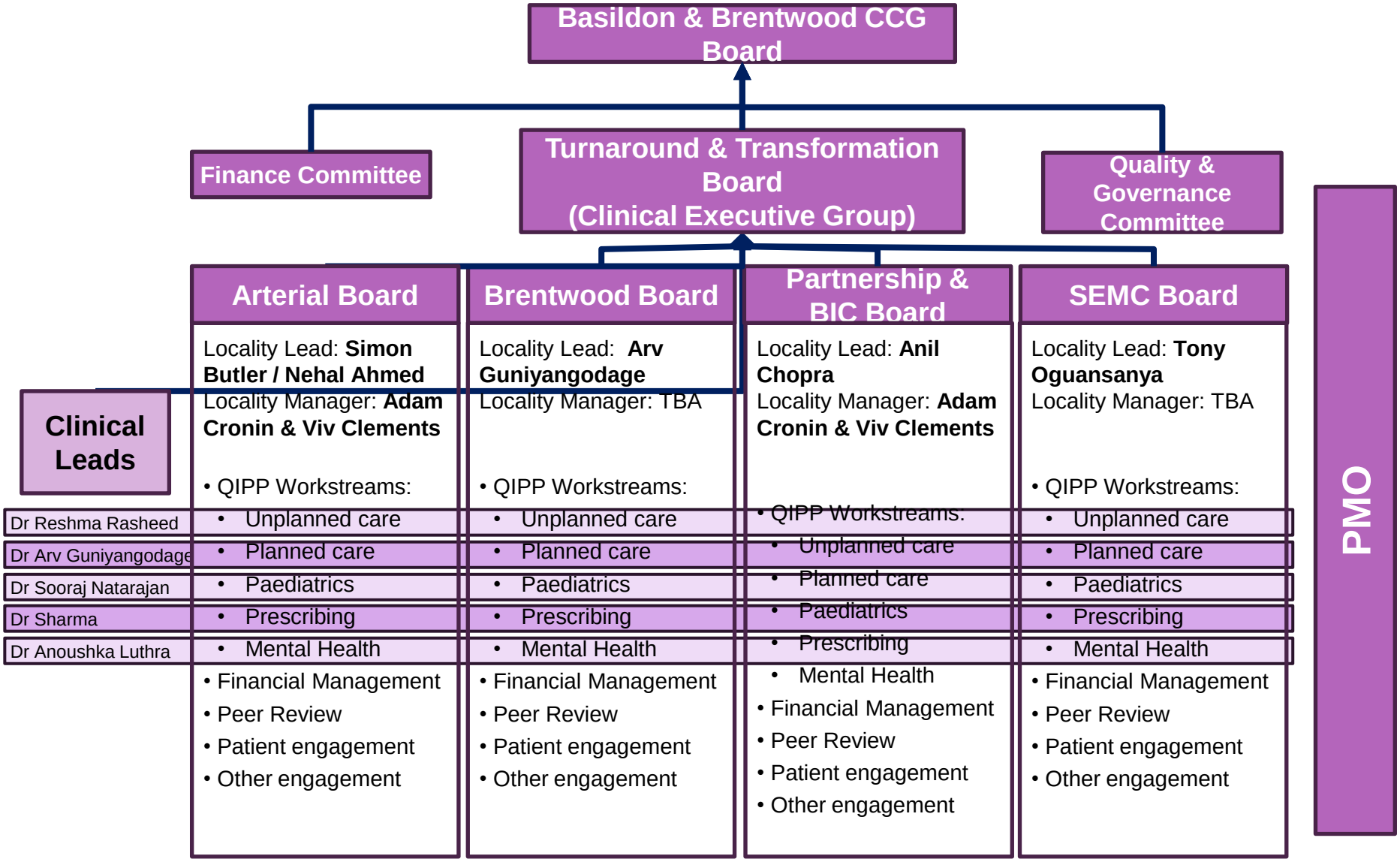
RISK MANAGEMENT, GOVERNANCE AND MONITORING OF INTEGRATED STRATEGY

- Risk Governance framework
- Board Assurance Framework

OUR ASSURANCE PROCESSES

- Risk Management Strategy in place
- Board Assurance framework in place
- A series of policies have been adopted by the Board
- The governance structure to support QIPP delivery has been formalised
- The management and reporting process for QIPP delivery is via the PMO reporting function outlined on slide 56 above.

GOVERNANCE STRUCTURE



GOVERNANCE STRUCTURE: DUTIES AND RESPONSIBILITIES

This table sets out the duties and responsibilities of the CCG Board, Locality Boards and Member Practices. Further detail is included in Schedule 5 of the Constitution.

Meeting	Duties	Responsibilities
Basildon & Brentwood CCG Board	The **statutory body** of the CCG **Allocation** of Locality Management Budget BBCCG retains the right to change the amount of **funding available** to the **locality**	Responsible for the overarching **commission strategy** and **budget**, based on the needs of the local population.
Locality Groups: • Arterial • Brentwood • Partnership & BIC • SEMC	Support **engagement** of the member practices and ensure engagement with patients and communities takes place at a local level. Funding will be made available to Localities through a dedicated cost centre budget, the **Locality Management Allowance Budget** administered by the CCG, providing the expenditure falls within the allocated budget and is used to deliver the agreed objectives.	• **QIPP delivery** against agreed actions • Analysis of **commissioning activity/spend** • **Peer Review** to address specific areas of relevant variation • Ensure **referral management systems** are in place and being used by all **practices** • **Patient engagement** including delivery of the engagement plan, including developing patient groups, PPGs, newsletters, etc • Using patient feedback to influence **service development** • **Engaging with all member practices** and with other local bodies • **Financial management** and a spending plan for the locality management budget
Member Practices	The member GP Practices are an integral part of the CCG, sharing responsibility for **delivering primary care services** to their local community as well as participating in the **delivery of locality functions**.	• **Sign up to the 'ethos'** of their locality group and CCG • Active involvement with and promoting **innovation and service developments** • **Share good practice** and promote the highest quality services • Following the **clinical pathways** and **referral protocols** of the CCG • Participating in and **delivering**, the clinical and cost effective strategies through the **QIPP plans** • Internal and intra-practice **peer review** • **Sharing** appropriate **data**

Section Nine

COMMISSIONING INTENTIONS 2013/14: COLLABOATIVE ARRANGEMENTS

- Local Service Priorities
- Key Commissioning Priorities
- JSNA Health Priorities
- Whole Essex Community Budget
- Integrated Planning and Commissioning
- Alignment with JHWBB Priorities / Cross Cutting Themes
- QIPP Plans / Budget Summary

ESSEX COUNTY COUNCIL'S (ECC's) CHILDREN AND FAMILIES COMMISSIONING PRIORITIES 2012-15

Vision

ECC adheres to the multi-agency Children, Young People and Families Partnership Vision which is as follows:

Our vision is that all children, young people and their families will be encouraged and supported to reach their full potential. We have the highest aspirations for children, ensuring that they grow up safe and healthy, supported by a range of educational and social opportunities that maximise their skills, employment opportunities and general life chances.

Families are the foundation upon which strong and healthy communities are built, and we will continue to support the family as the main contributor to a child's safety, health and wellbeing, putting families and children at the centre of communities.

Where families experience difficulties, we will ensure they get the help they need at the earliest possible opportunity, working in partnership to commission and deliver this help locally. We will support families to gain access to the information and support they need to avoid minor difficulties escalating to become more major challenges and we will operate in a way that promotes family resilience.

Our belief is that the wellbeing of children and young people is best achieved by living with their own families. Where this is not possible we will strive to provide support in a strong alternative family setting. Where children or young people require care and protection we will ensure it is provided to a consistently high standard so that those who do come into public care will have their life chances enhanced by the experience.

We will develop and strengthen our safeguarding services striving to ensure that children and young people are protected from abuse and neglect, reducing and where possible eradicating risks to children. We believe that this will be achieved most effectively by working alongside families building on their strengths and enabling them to make the changes that are required. Where children are suffering significant harm and the required change cannot be made we will act decisively in order to protect them.

ESSEX COUNTY COUNCIL'S (ECC's) CHILDREN AND FAMILIES COMMISSIONING PRIORITIES 2012-15

Getting the best for families will mean doing the right things well, being outcome focused and family orientated and putting the needs and aspirations of children, young people and their families first. We will listen to the children, young people and families we work with, ensuring they are engaged and consulted in everything we do and, wherever it is possible, act on what they say. We will clearly demonstrate where the views of children, young people and their families have directly influenced the quality, development and delivery of what we do.

We will adopt a whole system approach to the way we do things, working in partnership to maximise efficiency and effectiveness, reduce barriers to services and exploit the value of integrated strategies, systems and services. We will strengthen our commitment to collaborate with each other to be local and national champions of families, children and young people.

Summary of Needs

The priority presenting needs based on both the Essex Joint Strategic Needs Analysis and the locality based needs analyses for each quadrant are:

- Families experiencing multiple problems or complex needs
- Children and young people on the edge of care
- Children and young people with drug or alcohol dependent parents
- Children and young people with emotional health and wellbeing problems
- Children and young people with parents experiencing mental health problems
- Children and young people exposed to domestic abuse
- Families with adolescents experiencing challenging and troubled behaviour
- Geographical inconsistencies in school attainment, e.g., Basildon, Braintree, Castle Point, Harlow, Maldon and Tendring performing below the county average
- Poor attainment in the early years at Early Years Foundation Stage
- Lower attainment of children and young people in care when compared to their peers
- Significantly lower life chances for children and young people in need, on a protection plan, in care and leaving care
- Higher rates of NEET in some areas, Tendring (16.2%), Basildon (13.2%) and Braintree (11.4%), compared to a county average of 6.3% and national average of 6.0%
- High re-offending rates amongst young offenders
- Increasing diversity of population especially in West Essex with the consequent requirement for services to be inclusive and proactive in meeting their needs

ESSEX COUNTY COUNCIL'S (ECC's) CHILDREN AND FAMILIES COMMISSIONING PRIORITIES 2012-15

Priorities

Both ECC and the Children, Young People and Family Partnership are determined to focus effort on the areas of most need and where we know we can have the most impact on the life chances and wellbeing of children, young people and their families. We are working to the priorities identified through the Whole Essex Community Budget programmes. Our priorities are:

- Providing 'Early Help' (targeted help) to families
- Strengthening the services and processes that keep children and young people safe from neglect and abuse
- Improving children's emotional health and wellbeing
- Supporting parents to improve their capacity to manage their children's behaviour, particularly the behaviour of their teenage children
- Supporting parents in improving the life chances of children and young people in need or subject to a protection plan,
- Improving the experience and life chances for care leavers and children and young people in care and leaving care
- Improving support for troubled, troublesome and vulnerable adolescents, including young carers and teenage parents
- Improving the aspirations and attainment of children and young people most at risk of underachievement
- Reducing NEETs, increasing skills and supporting young people to succeed
- Improving attainment at Early Years Foundation Stage
- Raising standards at underachieving schools
- Improving Transitions, especially from childhood to adulthood
- Providing children, young people and families with opportunities to contribute meaningfully and be involved in the development and delivery of services in their local communities

ESSEX COUNTY COUNCIL'S (ECC's) CHILDREN AND FAMILIES COMMISSIONING PRIORITIES 2012-15

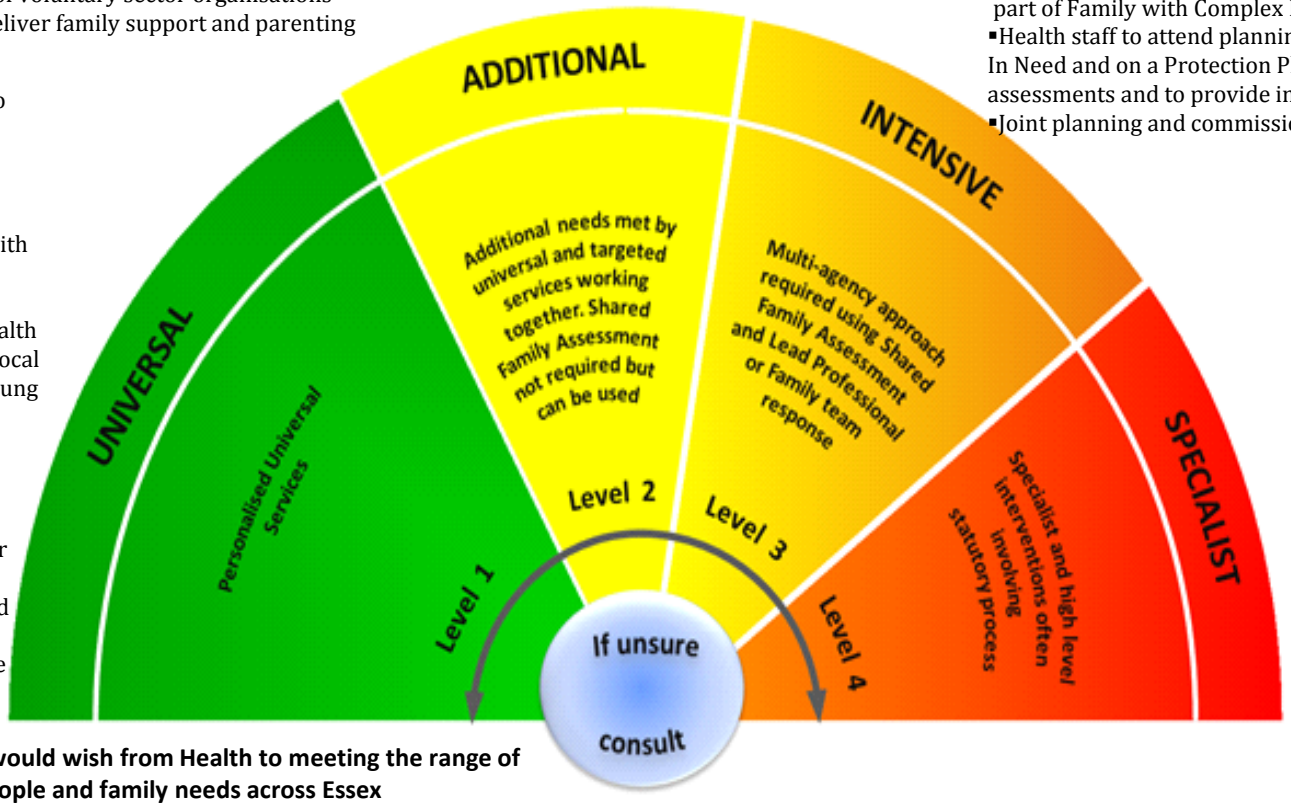
The Essex Effective Support Windscreen

Multi Agency Guidance: Working in partnership to help children and families improve their lives

- Joint commissioning of voluntary sector organisations
- Health staff to help deliver family support and parenting programmes

- Health to contribute to Healthy Schools
- Midwifery and Community Health services to work in effective partnership with children's centres and schools
- Provision of sexual health and advice services in local venues accessible to young people

In 2013-14 continue CAMHS gateway and subsequently jointly commission and deliver the Early Intervention Advice, Information and Referral Hub to direct referrals to appropriate tier and provision.



Contribution ECC would wish from Health to meeting the range of children, young people and family needs across Essex

- Health visitors and adult mental health workers to be part of Family with Complex Needs Teams
- Health staff to attend planning and review meetings of Children In Need and on a Protection Plan, to contribute information to assessments and to provide interventions
- Joint planning and commissioning for Children with a Disability

- Health staff to attend planning and review meetings of Children In and Leaving Care, to contribute information to assessments and to provide interventions including health promotion
- Joint planning and funding for Children with Continuing Care needs
- Medical advice to fostering and adoption panel
- Health staff to ensure effective health transition for young people leaving care Health staff to ensure effective transfer of health care packages for children in care moving placements or following discharge from in-patient units
- CAMHs Tier 3 services to ensure accessible and flexible services for children in and leaving care

All partners working with children, young people and their families will offer support as soon as we are aware of any additional needs. We will always seek to work together to provide support to children, young people and their families at the lowest level possible in accord with their needs

COMMISSIONING PRIORITIES AND INTENTIONS 2012-15

ECC commissioning priorities fall into two groups:

- Those where we wish to see joint commissioning commence from April 2013
- Those where we wish to commence discussions and detailed planning from April 2013 so that we can jointly commission from April 2014 onwards.

- **Joint Commissioning to Start in 2013-2014**

Area and ECC contact	**CCG contribution – to include in Integrated Plan**	**Current Health input**
Families with Complex Needs (Philippa Bull)	One Health Visitor, one adult mental health workers and one drug/alcohol post to be seconded/deployed to each of the initial 8 FCN teams from October 2013. Health staff to contribute to coordinated delivery of family support and parenting programmes. £400,000 resource from health across Essex also sought. Significant links with the MESCH/FNP programmes	
CAMHS (Barbara Herts/Sally Hughes)	Continue to resource the CAMHS quadrant gateways; contribute resource to the ECC CAMHS T2 service; Improve service to Children In and Leaving Care and children on a Protection Plan ECC to attend performance management meetings of the Mental Health Trusts.	
Maternity and early years (Carolyn Terry)	Improved links and information sharing and joint working by maternity, health visitor/MESCH/FNP services with children's centres and other early years services (Note: there are significant overlaps with the NHS CB and public health)	
Support for Children In Care, Leaving Care and Care Leavers Nicky O'Shaugh-nessey	Improve the quality, speed/priority and cross County consistency of health and dental assessments and treatment for Children In and Leaving Care and ensure good transition for Care Leavers over 18 - embed in main contracts without further charge to ECC. Health staff to contribute to assessments, attend planning and review meetings of Children In and Leaving Care and provide interventions to meet the needs of children and young people in and leaving care, Consistent provision of Medical Advice to Adoption and Fostering Panels without further charge to ECC by embedding the provision of this function within the main health contracts. Improved CAMHS T3 provision for Children In and Leaving Care.	
Safeguarding and Child Protection Mark Stancer	Health providers to contribute to Child Protection Assessment, Planning and Review activities as required and that this is embedded in the main contracts and jointly performance managed. Health providers to recognise and deliver their role as active members of Core Groups for children subject to child protection plans, including direct intervention to improve parenting skills improved CAMHS T3 provision for Children on a Protection Plan	
Continuing Care Packages Suzie Goodman/ Tony Crouch)	Continue to jointly plan and fund the care packages for children with complex and specialist care needs (via the JAP).	
Early Help Processes Philippa Bull	Providers to help develop and then use agreed referral and assessment tools and participate in joint training.	

COMMISSIONING PRIORITIES AND INTENTIONS 2012-15

Domestic Abuse Kevin Nunn/Janice Logie	CCGs to support the development of effective screening for DV survivors across key NHS service settings: Post/Ante natal, Gynaecology, pregnancy counselling, family planning, hospital dentistry, and mental health. Screening in health identified V victims 2 to 3 years earlier than they present to Police or other services. CCGs to across Essex to share costs of 7 new IDVA posts, £210,000, within the new domestic abuse multi-agency HUB to enable IDVA support to be extended to all high risk domestic abuse survivors using services in Essex. Agree to support fast tracked assessment of child and adult residents in women's refuge at risk of eviction as a result of conduct disorder problems.	

2. Plan in 2013-2014 for joint commissioning to start in 2014-15

CAMHS (Barbara Herts/ Sally Hughes	Joint commissioning of an integrated T2 and T3 service – ideally retendering	
Children with Disabilities and Special Educational Needs (incl Autism/ ADHD/ Developmental and Conduct/Behaviour Disorders) Barbara Herts	Provision of speech and language and any OT/physio to meet the needs of children with those requirements identified in their statement to be commissioned in main health contracts so provision is consistent across the County and does not incur additional costs to ECC. Review/develop and ensure implementation of clear integrated pathways including for transition to adulthood Review equipment provision and consider scope for improvement. Commissioning in line with the All Age Disability Strategic Framework (also Richard Powell, Annemarie Blackshaw, Elizabeth Cornish and Tony Crouch)	
Domestic Abuse Janice Logie/Kevin Nunn	To commit to joint development of a detailed business case for funding (or not) in 2014/15 of the priority actions identified in the WECB business case to tackle domestic abuse.	
Vulnerable Adolescents Sally Hughes	Integrated planning and provision to ensure increased targeted intervention is provided for adolescents at risk Note; Significant links with public health (sexual health, substance misuse) and school nursing	

Alignment with the Essex Health and Wellbeing Board: Joint Health and Wellbeing Strategy for Essex: 2013-1018

The Essex Health and Wellbeing Board brings together key partners to improve health and wellbeing through the development and implementation of a Health and Wellbeing Strategy for the communities of Essex. The Strategy is a principal high level plan for Essex and provides a strategic framework for the commissioning and delivery of health and social care services for the next five years for both children and adults. A Children, Young People and Families Plan is being developed to inform the aspects of the HWS which relate to children and young people and in turn the CYPF Plan will act as a key delivery mechanism for the HWS. The key needs and priorities identified in the HWS regarding children and young people can therefore be found within the CYPF Plan in addition to a range of other wider and locally defined issues.

JSNA HEALTH PRIORITIES

How our Integrated Plan responds to our challenges

- **Health Inequalities**
  - JSNA identified populations with poor lifestyles GP Practice Balanced Score Card for addressing Inequalities
- **Lifestyles**
  - Making Every Contact Count - Provider Contracts and GPs
  - Alcohol services, screening
- **Circulatory Disease and Diabetes**
  - Commissioning Hypertensive Case Finding Initiatives including expanding health checks and senior health checks
- **COPD, Lung Cancer**
  - Further planned deep dives will generate Integrated Commissioning Recommendations and QIPP plans

WHOLE ESSEX COMMUNITY BUDGET

Theme	Intention
Health & Wellbeing	• Commissioning Plans align to the Essex JHWBS • MECC across Primary Care and Providers • Alcohol IBA and Alcohol Nurse Liaison Service • Full delivery and expansion of Health Checks and Senior Health Checks • Hypertension Case Finding and treatment
Domestic Violence	• To undertake a joint ECC/CCGs review of the Community Budget business case during 2013/14 for potential to inform future commissioning plans.
Families with Complex Needs	• To review Community Budget business case and relative priority for joint commissioning as part of children's agenda

INTEGRATED PLANNING AND COMMISSIONING

Area	Extent of Integration to date
Older People	• Agreement to commission jointly with ECC at CCG level • Single point of access – Essex CC • Falls Prevention Services • Multi disciplinary teams – GP, community, social services • Intensive dementia support teams in place • Community geriatrician service – Basildon hospital, NELFT
Mental Health	• Agreement with ECC and partners to joint commissioning and single plan incorporating QIPP schemes • Improved Crisis Response • Recovery Oriented Services • Stepped care model • MH Accommodation strategy implementation

JSNA HEALTH PRIORITIES

Area	Extent of Integration to date
Children's Services*	• Agreement with ECC to commission some services jointly at CCG level (e.g. Families with Complex Needs, Maternity/Early Years • Collaborative commissioning of specialist services with the NHS CB • Collaborative working with Children's Services Commissioners in the CSU • Multi stakeholder paediatric exec group chaired by GP • Joint commissioning of CAMHS • To be developed further at South Essex Children's Services workshop
Learning Disability	• Agreement to commission at system level with partners • Self assessment of services • Implementing recommendations of Winterbourne review
Public Health	• Commissioning of lifestyle modification services e.g. smoking cessation at Essex level where this leads to optimal economies of scale • Partnership with Public Health England and LAT on Immunisation and Screening Programmes • Local JSNA Prevention and Lifestyle Review will ascertain local health improvement and health inequalities commissioning plans at practice level • Circulatory Disease Local Priority will deliver savings to CCG and ECC

ALIGNMENT WITH JHWBB PRIORITIES

Priority	Major Interventions you will be commissioning
Starting & Developing Well	• System wide children's commissioning group led by GP • Improved paediatric care pathways in acute care
Living & Working Well	• Better communications with patients, understanding preferences to address lifestyle issues (making every contact count) • Managing long term conditions through MDTs, PH local enhanced schemes, better community services • Making Every Contact Count – Primary Care and Providers
Ageing Well	• South Essex cluster wide pathways for dementia • National priorities to reduce potential years of life lost – mortality review group with BTUH • Stroke service review • Circulatory Disease - Local Priority Programme • Reablement services • Community Geriatrician Service • Falls Prevention

ALIGNMENT WITH JHWBB CROSS CUTTING THEMES

Self assessment of extent of integration of theme throughout Plan	1 poor	2	3	4	5 excellent
1. Tackling Health Inequalities and wider determinants of health			x		
2. Transforming services: developing the health and social care system			x		
3. Empowering local communities and community assets		x			
4. Prevention and effective intervention			x		
5. Safeguarding				x	

APPENDICES

- How we are delivering the NHS outcomes framework
- How we are delivering NHS National operating framework
- How we are delivering the NHS Constitution
- Safeguarding structures

HOW WE ARE DELIVERING THE NHS NATIONAL OUTCOMES FRAMEWORK

We have mapped our work programmes to the indicators in the National Outcomes Framework to ensure we are delivering against this requirement.

	Work Streams and Priorities															
	Integrated Unplanned Care	Improved Planned Care	Stronger Partnerships Across Mental Health and LD	Prescribing and Medicines Management	Improving outcomes for children and families	Staying Healthy	Clinical Effectiveness and Patient Safety	Priority 1 - Hypertension	Priority 2 - Families with complex needs	Priority 3 - SPOR	End of Life	Nursing Homes	Falls	111	18 Weeks	Cancer Services
1. Preventing people from dying prematurely																
Potential years of life lost (PYLL) from causes considered amendable to healthcare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Under 75 mortality rate from cardiovascular disease	X	X		X		X	X	X							X	
Under 75 mortality rate from respiratory disease	X	X		X		X	X	X		X				X		
Under 75 mortality rate from liver disease		X		X		X	X								X	X
Under 75 mortality rate from cancer		X		X		X	X								X	X
2. Enhancing quality of life for people with long term conditions																
Health-related quality of life for people with long-term conditions	X	X	X	X	X	X	X	X		X	X	X		X	X	
Proportion of people feeling supported to manage their condition	X	X	X	X		X	X	X	X	X						
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)	X	X	X	X				X			X	X	X	X		
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	X	X		X	X										X	
Estimated diagnosis rate for people with dementia	X	X	X	X			X					X				
3. Helping people to recover from episodes of ill health or following injury																
Emergency admissions for acute conditions that should not usually require hospital admission	X		X	X	X	X	X	X	X	X	X	X	X	X		
Emergency readmissions within 30 days of discharge from hospital	X		X	X	X	X	X	X	X	X	X	X	X	X		
Total health gain assessed by patients i) Hip replacement ii) Knee replacement iii) Groin hernia iv) Varicose veins		X					X								X	
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)	X				X		X		X							
4. Ensuring that people have a positive experience of care																
Patient experience of primary care i) GP Services ii) GP Out of Hours services	X	X	X		X		X				X	X			X	X
Patient experience of hospital care	X	X	X		X		X				X	X			X	X
Friends and family test	X	X	X		X		X				X	X			X	X
5. Treating and caring for people in a safe environment and protecting them from avoidable harm																
Incidence of healthcare associated infection (HCAI)							X									
i) MRSA ii) C. difficile							X									

HOW WE ARE DELIVERING THE NHS NATIONAL OUTCOMES FRAMEWORK

	Work Streams and Priorities															
	Integrated Unplanned Care	Improved Planned Care	Stronger Partnerships Across Mental Health and LD	Prescribing and Medicines Management	Improving outcomes for children and families	Staying Healthy	Clinical Effectiveness and Patient Safety	Priority 1 - Hypertension	Priority 2 - Families with complex needs	Priority 3 - SPOR	End of Life	Nursing Homes	Falls	111	18 Weeks	Cancer Services
TARGETS																
Referral To Treatment waiting times for non-urgent consultant-led treatment																
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%		X					X								X	
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%		X					X								X	
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%		X					X								X	
Diagnostic test waiting times																
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99%		X													X	X
A&E waits																
Patients should be admitted, transferred or discharged within 4hours of their arrival at an A&E department – 95%	X		X		X	X	X		X	X	X	X	X	X		
Cancer waits – 2 week wait																
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%		X				X	X									X
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%		X				X	X									X
Cancer waits – 31 days																
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96%		X				X	X									X
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%		X				X	X									X
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%		X				X	X									X
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%		X				X	X									X

HOW WE ARE DELIVERING THE NHS NATIONAL OUTCOMES FRAMEWORK

	Work Streams and Priorities															
	Integrated Unplanned Care	Improved Planned Care	Stronger Partnerships Across Mental Health and LD	Prescribing and Medicines Management	Improving outcomes for children and families	Staying Healthy	Clinical Effectiveness and Patient Safety	Priority 1 - Hypertension	Priority 2 - Families with complex needs	Priority 3 - SPOR	End of Life	Nursing Homes	Falls	111	18 Weeks	Cancer Services
TARGETS																
Cancer waits – 62 days																
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%		X				X	X									X
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%		X				X	X									X
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set		X				X	X									X
Category A ambulance calls																
Category A calls resulting in an emergency response arriving within 8minutes – 75% (standard to be met for both Red 1and Red 2calls separately)	X		X		X	X	X		X	X	X	X	X	X		
Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%	X		X		X	X	X		X	X	X	X	X	X		
Mixed Sex Accommodation Breaches																
Minimise breaches		X	X				X									
Cancelled Operations																
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.		X					X								X	X
Mental health																
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%			X				X									

APPENDIX: DELIVERING THE NHS CONSTITUTION

BASILDON AND BRENTWOOD CCG WILL UPHOLD THE RIGHT & PLEDGES MADE IN THE NHS CONSTITUTION

1 FOR PATIENTS:	
Access to health services	✔
Quality of care and the environment	✔
Nationally approved treatments, drugs and programmes	✔
Respect, consent and confidentiality	✔
Informed choice	✔
Involvement in your healthcare and the NHS	✔
Complaint and redress	✔
Patient and public responsibilities	✔
2 FOR STAFF	
Staff rights	✔
Staff Pledges	✔
Staff legal duties	✔
Expectations of staff	✔

For a detailed explanation of the actions we are taking to ensure the rights and pledges within the NHS Constitution are delivered for Basildon and Brentwood, please see following sections.

HOW WE ARE DELIVERING THE NHS CONSTITUTION

Expected rights and pledges from the NHS Constitution 2013/14	**Starting Risk**
Referral To Treatment waiting times for non-urgent consultant-led treatment	
Diagnostic test waiting times	
A&E waits	
Cancer waits – 2week wait	
Cancer waits – 2week wait	
Cancer waits – 62 days	
Category A ambulance calls	
Mixed Sex Accommodation Breaches	
Cancelled Operations	
Mental health	
Additional measures NHS Commissioning Board has specified for 2013/14	
Referral To Treatment waiting times for non-urgent consultant-led treatment	
A&E waits	
Cancelled Operations	
Ambulance Handovers	

APPENDIX: DELIVERING THE NHS CONSTITUTION

NHS CONSTITUTION COMMITMENT TO PATIENTS	BASILDON AND BRENTWOOD CCG COMMITMENT
1 ACCESS TO HEALTH SERVICES	
You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.	The CCG will commission all NHS services to meet this fundamental NHS right
You have the right to access NHS services. You will not be refused access on unreasonable grounds.	The CCG will commission all NHS services to meet this fundamental NHS right
You have the right to expect your local NHS to assess the health requirements of the local community and to commission and put in place the services to meet those needs as considered necessary.	The CCG will ensure needs assessment informs all that it does. It will support and make use of the Joint Strategic Needs Assessment to inform its strategy and highlight health inequalities. The CCG will utilise commissioning expertise and business informatics to ensure its commissioning programmes are evidence-based. The CCG will continue to maintain strong business relationships with Public Health capability within Portsmouth City Council.
You have the right, in certain circumstances, to go to other European Economic Area countries or Switzerland for treatment which would be available to you through your NHS commissioner.	The CCG will commission all NHS services to meet this fundamental NHS right
You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, religion or belief, sexual orientation, disability (including learning disability or mental illness) or age.	The CCG will commission all NHS services to meet this fundamental NHS right. The CCG will have a published Equity & Diversity framework which it will use to assess the impact of its commissioning plans.
You have the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible.	The CCG will commission all NHS services to meet the national pledges on waiting times (eg for cancer, for ambulance response, for elective and emergency care). Where services are not meeting waiting times standards the CCG will require a rectification plan from the provider and will use available contract levers to incentivise recovery or penalise non-compliance.
The NHS commits to make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered.	The CCG will conduct CCG Governing Body business in public. The CCG Governing body will include elected members from local GP practices and the Local Authority. The CCG will be an active member of the Portsmouth Health & Wellbeing Board. It will also deliver against its Communications & Engagement Strategy aiming to further involve patients and the public in shaping CCG plans. The CCG will adhere to all Freedom of Information requirements and endeavour to ensure all decisions are made in an accessible manner.
The NHS commits to make the transition as smooth as possible when you are referred between services, and to include you in relevant discussions.	The CCG' s strategic vision includes further integration of all aspects of care, stopping fragmentation and including the patient in decisions about their care.

APPENDIX: DELIVERING THE NHS CONSTITUTION

NHS CONSTITUTION COMMITMENT TO PATIENTS	BASILDON AND BRENTWOOD CCG COMMITMENT
2 QUALITY OF CARE & ENVIRONMENT	
You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality	The CCG will commission all NHS services to meet this fundamental NHS right
You have the right to expect NHS organisations to monitor, and make efforts to improve, the quality of healthcare they commission or provide	The CCG will continue to ensure a strong emphasis on quality & safety in all contracts for NHS provision and will routinely monitor and discuss quality & safety at CCG Governing Body meetings and in its Clinical Leads sub-committee.
The NHS commits to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice	The CCG will continue to ensure a strong emphasis on quality & safety in all contracts for NHS provision. This will include estates and environment issues. The CCG will routinely monitor and discuss quality & safety at CCG Governing Body meetings and in its Clinical Leads sub-committee.
The NHS commits to continuous improvement in the quality of services you receive, identifying and sharing best practice in quality of care and treatments.	The CCG will expect to see continuous improvement as a core function within all provision it commissions, with clear supporting processes for providers to improve the quality of their care. The CCG will routinely monitor and discuss quality & safety at CCG Governing Body meetings and in its Clinical Leads sub-committee.
3 NATIONALLY APPROVED TREATMENTS, DRUGS AND PROGRAMMES	
You have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you.	The CCG will adhere to NICE recommendations, utilising regional Priorities Committees to ensure good clinical input into any local decisions on treatments.
You have the right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you.	The CCG will continue to make use of regional Priorities Committees to ensure good clinical input into any local decisions on treatments. It will operate an Individual Funding Requests policy, shared on a regional basis, that will support individuals and their GPs to reflect individual cases and needs when making drug treatment decisions.
You have the right to receive the vaccinations that the Joint Committee on Vaccination and Immunisation recommends that you should receive under an NHS-provided national immunisation programme	The CCG will adhere to national vaccination recommendations and will continue to support local vaccination programmes.
The NHS commits to provide screening programmes as recommended by the UK National Screening Committee.	The CCG will adhere to national screening recommendations and will continue to support local screening programmes.

APPENDIX: DELIVERING THE NHS CONSTITUTION

NHS CONSTITUTION COMMITMENT TO PATIENTS	BASILDON AND BRENTWOOD CCG COMMITMENT
4 RESPECT, CONSENT AND CONFIDENTIALITY	
You have the right to be treated with dignity and respect, in accordance with your human rights.	The CCG will commission all NHS services to meet this fundamental NHS right. The CCG will adhere to this right in all of its engagement with patients and the public.
You have the right to accept or refuse treatment that is offered to you, and not to be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests.	The CCG will commission all NHS services to meet this fundamental NHS right
You have the right to be given information about your proposed treatment in advance, including any significant risks and any alternative treatments which may be available, and the risks involved in doing nothing.	The CCG will commission all NHS services to meet this fundamental NHS right
You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure.	The CCG will commission all NHS services to meet this fundamental NHS right
You have the right of access to your own health records. These will always be used to manage your treatment in your best interests.	The CCG will commission all NHS services to meet this fundamental NHS right
The NHS commits to share with you any letters sent between clinicians about your care.	The CCG will commission all NHS services to meet this fundamental NHS right
5 INFORMED CHOICE	
You have the right to choose your GP practice, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons	The CCG will work with the local office of the National Commissioning Board to ensure this right is upheld
You have the right to express a preference for using a particular doctor within your GP practice, and for the practice to try to comply.	The CCG will work with the local office of the National Commissioning Board to ensure this right is upheld
You have the right to make choices about your NHS care and to have information to support these choices. The options available to you will develop over time and depend on your individual needs.	The CCG will commission all NHS services to meet this fundamental NHS right
The NHS commits to inform you about the healthcare services available to you, locally and nationally.	The CCG will commission all NHS services to meet this fundamental NHS right. The CCG will have an annual campaign programme that delivers information about local services to local communities.
The NHS commits to offer you easily accessible, reliable and relevant information to enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the quality of clinical services where there is robust and accurate information available	The CCG will commission all NHS services to meet this fundamental NHS right

APPENDIX: DELIVERING THE NHS CONSTITUTION

NHS CONSTITUTION COMMITMENT TO PATIENTS	BASILDON AND BRENTWOOD CCG COMMITMENT
6 INVOLVEMENT IN YOUR HEALTHCARE AND THE NHS	
You have the right to be involved in discussions and decisions about your healthcare, and to be given information to enable you to do this	The CCG will commission all NHS services to meet this fundamental NHS right
You have the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.	The CCG will involve users, patients and local communities in the design of local services; in particular the CCG will adhere to its responsibilities regarding formal consultation where there is a significant change in services proposed. The CCG will establish a regular series of events and other engagement activities (including on-line) to seek routine input from local people into the planning of services.
The NHS commits to provide you with the information you need to influence and scrutinise the planning and delivery of NHS services	The CCG will actively publish and promote information about its strategy and intentions. It will engage fully with local Health Overview and Scrutiny arrangements.
The NHS commits to work in partnership with you, your family, carers and representatives	The CCG will adopt this as a principle in its business
7 COMPLAINT AND REDRESS	
You have the right to be involved in discussions and decisions about your healthcare, and to be given information to enable you to do this	The CCG will commission all NHS services to meet this fundamental NHS right
You have the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.	The CCG will involve users, patients and local communities in the design of local services; in particular the CCG will adhere to its responsibilities regarding formal consultation where there is a significant change in services proposed. The CCG will establish a regular series of events and other engagement activities (including on-line) to seek routine input from local people into the planning of services.
The NHS commits to provide you with the information you need to influence and scrutinise the planning and delivery of NHS services	The CCG will actively publish and promote information about its strategy and intentions. It will engage fully with local Health Overview and Scrutiny arrangements.
The NHS commits to work in partnership with you, your family, carers and representatives	The CCG will adopt this as a principle in its business

APPENDIX: DELIVERING THE NHS CONSTITUTION

NHS CONSTITUTION COMMITMENT TO PATIENTS	BASILDON AND BRENTWOOD CCG COMMITMENT
8 PATIENT AND PUBLIC RESPONSIBILITIES	
You should recognise that you can make a significant contribution to your own, and your family's, good health and well-being, and take some personal responsibility for it.	The CCG expects and welcomes this in all of its patients, local communities and stakeholders.
You should register with a GP practice – the main point of access to NHS care.	The CCG expects and welcomes this in all of its patients, local communities and stakeholders.
You should treat NHS staff and other patients with respect and recognise that causing a nuisance or disturbance on NHS premises could result in prosecution.	The CCG expects and welcomes this in all of its patients, local communities and stakeholders.
You should provide accurate information about your health, condition and status.	The CCG expects and welcomes this in all of its patients, local communities and stakeholders.
You should keep appointments, or cancel within reasonable time. Receiving treatment within the maximum waiting times may be compromised unless you do	The CCG expects and welcomes this in all of its patients, local communities and stakeholders.
You should follow the course of treatment which you have agreed, and talk to your clinician if you find this difficult.	The CCG expects and welcomes this in all of its patients, local communities and stakeholders.
You should participate in important public health programmes such as vaccination.	The CCG expects and welcomes this in all of its patients, local communities and stakeholders.
You should ensure that those closest to you are aware of your wishes about organ donation.	The CCG expects and welcomes this in all of its patients, local communities and stakeholders.
You should give feedback – both positive and negative – about the treatment and care you have received, including any adverse reactions you may have had.	The CCG expects and welcomes this in all of its patients, local communities and stakeholders.

APPENDIX: DELIVERING THE NHS CONSTITUTION

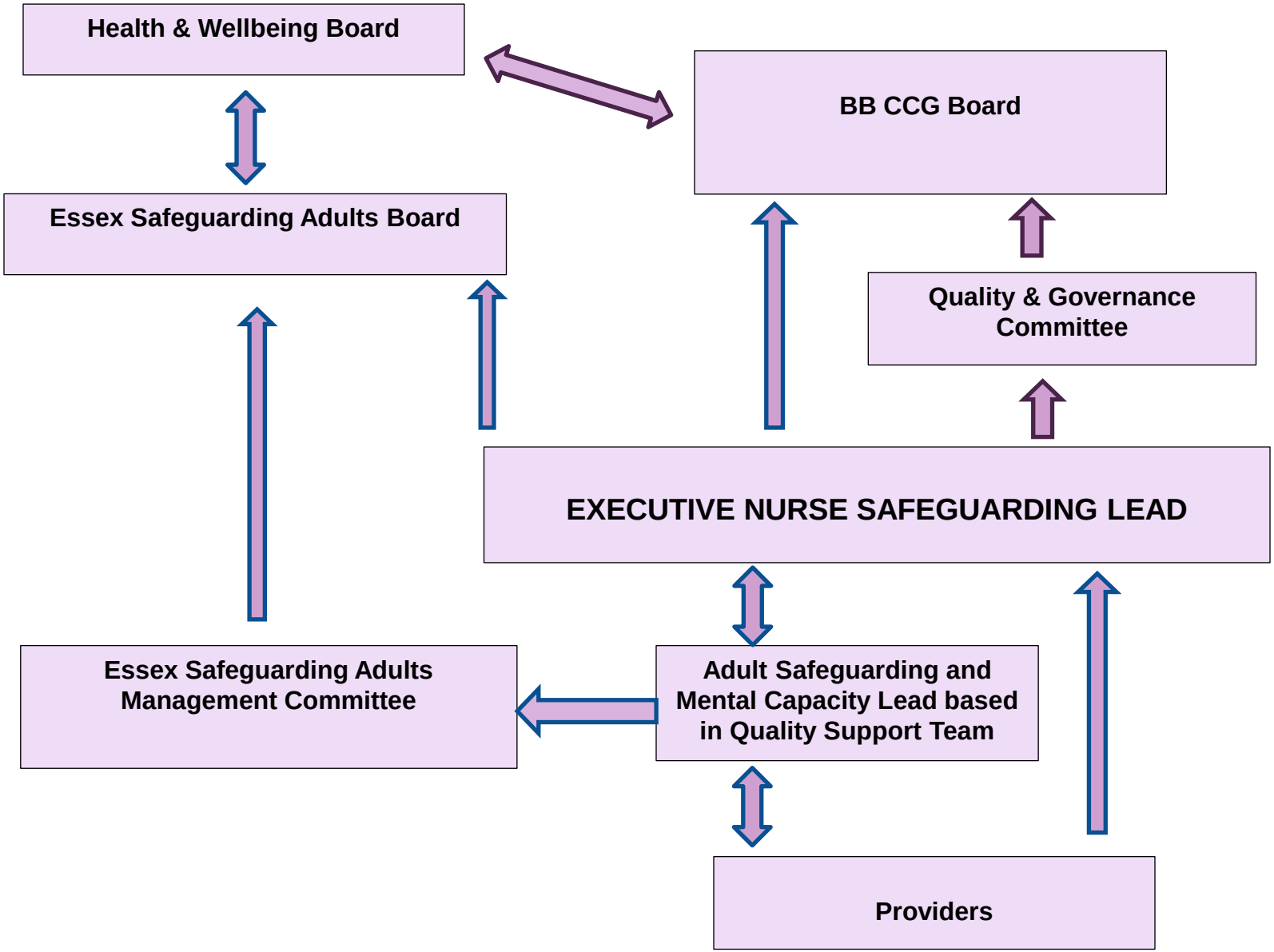
	NHS CONSTITUTION COMMITMENT TO STAFF	CCG COMMITMENT
1	**STAFF RIGHTS:**	
1.1	To fair treatment regarding leave, rights and flexible working and other statutory leave requests relating to work and family, including caring for adults that you live with.	The CCG will ensure this right through its HR framework and underpinning policies such as its flexible working and leave policy (including maternity, adoption and paternity leave)
1.2	To request other 'reasonable' time off for emergencies (paid and unpaid) and other statutory leave (subject to exceptions).	The CCG will ensure this right through its HR framework and underpinning policies such as its flexible working and leave policy (including maternity, adoption and paternity leave)
1.3	To expect reasonable steps are taken by the employer to ensure protection from less favourable treatment by fellow employees, patients and others (e.g. bullying or harassment).	The CCG will ensure this right through its HR framework and underpinning policies such as its disciplinary and grievance policy including bullying and harassment
1.4	To pay; consistent with the National Minimum Wage or alternative contractual agreement.	The CCG will ensure this right through its HR Framework, commitment to ongoing use of national terms and conditions and oversight of its Remuneration committee
1.5	To fair treatment regarding pay.	The CCG will ensure this right through its HR Framework, commitment to ongoing use of national terms and conditions and oversight of its Remuneration committee
1.6	To be accompanied by either a Trade Union official or a work colleague at disciplinary or grievance hearings in line with legislation, your employer's policies or your contractual rights.	The CCG will ensure this right through its HR framework and underpinning policies such as its disciplinary and grievance policy including bullying and harassment
1.7	To consultation and representation either through the Trade Union or other staff representatives (for example where there is no Trade Union in place) in line with legislation and any collective agreements that may be in force.	The CCG will ensure this right through its HR framework and underpinning policies such as its disciplinary and grievance policy including bullying and harassment
1.8	To work within a healthy and safe workplace and an environment in which the employer has taken all practical steps to ensure the workplace is free from verbal or physical violence from patients, the public or staff, to work your contractual hours, take annual leave and to take regular breaks from work.	The CCG will ensure this right through its HR framework and underpinning policies such as its Health and Safety policy, and its flexible working and leave policy
1.9	To a working environment (including practices on recruitment and promotion) free from unlawful discrimination on the basis of race, gender, sexual orientation, disability, age or religion or belief.	The CCG will ensure this right through its Equality and Diversity Strategy and HR Framework as well as through its values and code of conduct
1.10	To have disciplinary and grievance procedures conducted appropriately and within internal and legal requirements.	The CCG will ensure this right through its HR Framework and underpinning policies such as its Disciplinary policy and grievance policy
1.11	To appeal against wrongful dismissal.	The CCG will ensure this right through its HR Framework and underpinning policies such as its Disciplinary policy and grievance policy
1.12	If internal processes fail to overturn a dismissal, you have the right to pursue a claim in the employment tribunal, if you meet required criteria	The CCG will ensure this right through its HR Framework and underpinning policies such as its Disciplinary policy and grievance policy
1.13	To protection from detriment in employment and the right not to be unfairly dismissed for 'whistleblowing' or reporting wrongdoing in the workplace	The CCG will ensure this right through its HR Framework and underpinning policies such as its whistleblowing policy and grievance policy
1.14	You have a right to employment protection in terms of continuity of service for redundancy purposes if moving between NHS employers.	The CCG will ensure this right through its HR Framework and underpinning policies such as its organisational change policy and its transition arrangements put in place to support specific programmes of change
1.15	You have rights relating to the ability to join the NHS Pension Scheme.	The CCG will ensure this right through its HR Framework and its commitment to use national terms and conditions including the right to join the NHS Pension scheme
2	**STAFF PLEDGES**	
2.1	The NHS commits to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities	The CCG will ensure, in line with its HR Framework, that all staff have clear job descriptions and fair pay evaluation schemes, as well as annual appraisal and access to individual development activities.
2.2	The NHS commits to provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed.	The CCG will ensure, in line with its HR Framework, that all staff receive support to access identified development opportunities as identified through appraisal.
2.3	The NHS commits to provide support and opportunities for staff to maintain their health, well-being and safety.	The CCG will ensure, in line with its HR Framework, access to occupational health services, employee assistance programme and other initiatives to support health and well-being. The CCG will also have a Health & Safety policy.
2.4	The NHS commits to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families	The CCG will deliver this commitment through its HR Framework, policy on organisational change, as well as working with staff representatives and groups. The CCG will also have a range of staff involvement mechanisms including regular local briefings.
2.5	The NHS commits to support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice, or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Public Interest Disclosure Act 1998.	The CCG will deliver this commitment through its HR Framework and its grievance and whistle-blowing policies as well as developing a culture of openness and responsibility across the organisation.

APPENDIX: DELIVERING THE NHS CONSTITUTION

3	**STAFF LEGAL DUTIES**	
3.1	To accept professional accountability and maintain the standards of professional practice as set by the appropriate regulatory body applicable to your profession or role.	The CCG expects and welcomes this of all its staff and will ensure support is provided to individuals to assist them in discharging this duty
3.2	To take reasonable care of health and safety at work for you, your team and others, and to co-operate with employers to ensure compliance with health and safety requirements.	the CCG expects and welcomes this of all its staff and will ensure that its expectations as set out in its Health and Safety related policies are publicised.
3.3	To act in accordance with the express and implied terms of your contract of employment	The CCG expects and welcomes this of all its staff and will use its Remuneration Committee to oversee this.
3.4	Not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation."	The CCG expects and welcomes this of all staff and will ensure all staff have sufficient awareness of the CCG requirements
3.5	To protect the confidentiality of personal information that you hold unless to do so would put anyone at risk of significant harm	The CCG expects and welcomes this of all staff and will expect them to work within the requirements of national and local information governance policies and procedures.
3.6	To be honest and truthful in applying for a job and in carrying out that job	The CCG expects and welcomes this of all staff and will have systems and processes in place both at recruitment and ongoing to validate this.
4	**EXPECTATIONS: HOW STAFF SHOULD PLAY THEIR PART IN ENSURING THE SUCCESS OF THE NHS**	
4.1	You should aim to maintain the highest standards of care and service, taking responsibility not only for the care you personally provide, but also for your wider contribution to the aims of your team and the NHS as a whole.	The CCG expects and welcomes this of all staff as one of its important values.
4.2	You should aim to take up training and development opportunities provided over and above those legally required of your post.	The CCG expects and welcomes this of all staff and will, as set out in its HR Framework, ensure staff are committed to fulfil their development plans and apply their learning in practice.
4.3	You should aim to play your part in sustainably improving services by working in partnership with patients, the public and communities	The CCG expects and welcomes this of all staff as one of its important objectives.
4.4	You should aim to raise any genuine concern you may have about a risk, malpractice or wrongdoing at work, (such as a risk to patient safety, fraud or breaches of patient confidentiality), which may affect patients, the public, other staff, or the organisation itself at the earliest reasonable opportunity	The CCG expects and welcomes this of all staff and will expect staff to use the mechanisms in place such as its financial policies or performance management policies.
4.5	You should aim to be open with patients, their families, carers or representatives, including if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in a spirit of co-operation. You should contribute to a climate where the truth can be heard and the reporting of, and learning from, errors is encouraged.	The CCG expects and welcomes this of all staff and will expect staff to work within its policies for handling concerns and complaints
4.6	You should aim to view the services you provide from the standpoint of a patient, and involve patients, their families and carers in the services you provide, working with them, their communities and other organisations, and making it clear who is responsible for their care	The CCG expects and welcomes this of all staff and will ensure that the patient is kept at the centre of all of its business.

Appendix

BASILDON AND BRENTWOOD CCG SAFEGUARDING ADULT GOVERNANCE STRUCTURE



BASILDON AND BRENTWOOD CCG SAFEGUARDING CHILDREN GOVERNANCE STRUCTURE