NHS North East Essex
Clinical Commissioning Group
Embracing better health for all

NHS

North East Essex Integrated Plan

2013 - 2018

Version control of drafts

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NORTH EAST ESSEX INTEGRATED PLAN 2013 - 2018

SECTION 1

Executive Summary

Highlights that this start of integrated commissioning journey

The executive summary will be written once all sections have been included.

We would like the executive summary to enable the various audiences of this plan to get a broad and comprehensive understanding of what the plan is describing,

Our audiences will be:

Public, patients and their carers

CCG staff and board

Health and Well Being Board

The main providers of our healthcare in NEE – Colchester Hospital, ACE, NEPFT, Harmoni, GP practices, voluntary and third sector providers,

Our commissioning partners – ECC, North Essex CCGs, NHS Commissioning Board, member practices

Our partners – Colchester Borough Council, Tendring District Council, Health Forum Committee, Patient and Public groups, and other statutory and voluntary organisations.

Sections will include:

- An overview of the current North East Essex System
- The position of the system going into next year – recognising all the contributions from the many different sectors during the past year
- Identification of the key strategic challenges of the system
- Integrated working
- Commissioning for outcomes
- Clear acknowledgement of our commitment to our population
- Our vision, values and models of care going forward
- The frameworks that we will be working to
- Enablers
- Key measures of success
- Integrated working
- Commissioning for outcomes

Process for signing off integrated plan

- Wednesday 27th February NEE CCG will submit plans to be shared privately with Health and Well Being Board members
- Tuesday 19th March NEE CCG will present current version of their Integrated Plan to their Board
- Tuesday 19th March NEE CCG will submit further version with Health and Wellbeing Board for publication in their board papers on the 20th March
- Friday 5th April submit to the National Commissioning Board – Local Area Team

SECTION 2

INTRODUCTION TO NORTH EAST ESSEX

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

2.1 Changes in the NHS

The commissioning landscape in North East Essex has changed significantly. The Health and Social Care Act 2010 brought in new structures and has wide spread implications for commissioning and providing health services. These changes take effect from 1st April 2013.

The most significant change is the creation of **Clinical Commissioning Croups** (CCGs) in place of Primary Care Trusts (PCTs). Unlike PCTs, CCGs are clinically-led bodies, run by local clinicians who are best placed to know the needs of the local population.

The **NHS Commissioning Board** was formally established as an independent body, arm's length to the Government, on 1 October 2012. It is responsible for:-

- Partnerships and relationships
- Direct commissioning of certain services
- Quality improvement and clinical leadership
- Governing frameworks
- Patient safety

The Act also established **Health and Wellbeing Boards** (HWBs), whose purpose is to co-ordinate a joint approach to commissioning health and social care. HWBs match the boundaries of upper tier local authorities and membership is drawn from the local authority, CCGs and HealthWatch

HealthWatch replaces LINKs as the statutory bodies representing patients and public.

Strategic Health Authorities and Primary Care Trusts cease to exist on 31st March 2013

2.2 North East Essex Clinical Commissioning Group

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

The CCG was formally established on 1st April 2013 but has been operating in shadow form with responsibility for budgets since April 2012.

The CCG was an early adopter of joint working with Essex County Council (ECC). The ECC representative on the CCG Board has full voting rights and has been actively involved in the production of this plan, along with key members of the ECC team. The CCG Chair and Clinical Chief Officer are active members of the Essex Health and Wellbeing Board and Executive Team. The CCG Chair is working with Sir Thomas Hughes-Hallett as part of the Who Will Care? Commission into health and social care strategy The Commission was set up by Essex County Council but is independent of the council.

2.3 Our vision and values

Our vision is “Embracing better health and wellbeing for all.” Even though we will focus on priority groups within North East Essex, everybody should be able to expect an improved level of health and wellbeing from the services we commission.

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

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

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

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

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

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

2.4 Geography and Key demographics

Insert map of NE Essex

Add key points on demography

Joint Strategic Needs Assessment (JSNA) has been a statutory duty for Primary Care Trusts and upper tier local authorities since 2007. Aimed at commissioners and policy makers, the JSNA provides a comprehensive picture of the current and future health and wellbeing needs of the population and informs commissioning in order to achieve better outcomes and reduce inequalities.

The Health and Social Care Bill 2010 confirms an ambitious and central role for JSNA, including the expectation that JSNAs will inform the new statutory Joint Health and Wellbeing Strategy (JHWS). This has certainly been the case in Essex as the JSNA has been central to the development of the Essex Joint Health and Wellbeing Strategy.

Responsibility to jointly produce JSNA and JHWS, and to commission with regard to them, is placed on Clinical Commissioning Groups (CCGs) and the local authority. Other key bodies will also be obliged to have regard to JSNA. The process for producing the Essex JSNA can be found in App XX`

2.5 Key Strategic issues and main challenges

The health and social care system faces considerable financial challenges over the coming years. Working with our partners in Essex County Council and other Clinical Commissioning Groups in Essex we will need to improve quality and productivity whilst reducing costs and demand. We will do this by:-

- Commissioning integrated health and social care
- Combined, streamlined commissioning and procurement
- Reducing the complexity of care
- Promoting self-care and support for carers
- Promoting prevention and early intervention
- Delivering care in the home and community - with care in hospital only where it adds value

The Essex Health and Wellbeing Board is the overarching partnership board to facilitate and encourage integration of health and wellbeing services for the population of Essex.

NE Essex CCG and Essex County Council (ECC) affirm their commitment to the Essex Health and Wellbeing Strategy, with the 3 priorities of:

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

The CCG and ECC are committed to joint commissioning and have agreed draft principles and outcomes of integrated services for older people, children, mental health services and learning disability services.

2.6 Our commissioning partners

Essex County Council (ECC)

ECC is responsible for social care services for adults and children, schools and Public Health across Essex.

ECC understands and welcomes the opportunities offered by working with the CCGs and has made a strategic commitment to collaborate with NE Essex CCG in developing and delivering the Integrated Plan.

NE Essex CCG shares this commitment to collaborative working and this is already embedded with current arrangements with Essex County Council **Public Health** staff. The CCG benefits from having a joint post of Consultant in Public Health which is also represented on the CCG board and executive team.

The CCG supports the delivery of their commissioned health improvement programmes by:

- Supporting practices to deliver 'Making Every Contact Count' (where health professionals use all contacts with patients to deliver key health messages)

- Supporting practices to deliver health improvement programmes including smoking cessation, health checks, alcohol brief screening and intervention, immunisation and screening and sexual health.

The Public Health Plan on a Page can be found in Appendix XXX

Essex Health and Wellbeing Board

The Board is a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.

Board members collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future.

Mid Essex CCG and West Essex CCG

In certain service areas, it makes sense for a group of CCGs to work together in order to maximise benefits for patients through shared resources. NEE CCG has a collaborative working agreement with Mid Essex and West Essex CCGs which has within in it memorandums of understanding in areas such as safeguarding, infection control and emergency preparedness. The CCGs may add other areas to this portfolio in the future.

Essex Local Area Team of the NHS Commissioning Board (LAT)

The NHS Commissioning Board works through LATs which are responsible for overseeing the work of CCGs and for commissioning the following services:-

- primary care services (GPs, dentists, pharmacists and optometrists)
- specialist services eg neonatal
- health visiting services
- health services for people in the armed services
- health services for people in prison

The LAT is also responsible for monitoring the work of CCGs and ensuring that the NHS Outcomes Framework is delivered.

The LAT's plans for primary care services can be found in APPENDIX XXX

Essex Commissioning Support Unit (CSU)

CCGs are much smaller bodies than their predecessor PCTs with a prescribed running cost allowance which they are required to remain within. In order that this can happen commissioning support units have been developed to enable CCGs to benefit from 'at scale services'.

The Essex CSU provides a range of operational and "back room" services to Essex Clinical Commissioning Groups. For North East Essex CCG those services include:

- Clinical and operational services (Medicines Management, Continuing Healthcare and Individual Funding Requests)
- Business and Corporate support services (Financial Services, HR support, IT support, Corporate Governance support and advice, Performance monitoring)
- Transformational and strategic change services (Business Intelligence, Procurement, Contract and Provider Management, Project and Programme Management, plus commissioning of Mental Health and Learning Disability)

Engaging patients and the public in commissioning

The Clinical Commissioning Group in NE Essex is committed to working with and supporting groups who represent patients, carers and the public. When the CCG took over the role of Public, Patient and Carer Engagement from the PCT, they asked local groups and people for ideas on improving engagement. Local groups came up with the idea of the North East Essex Health Forum ADD LINK.

North East Essex Health Forum – is a public membership scheme and currently has over 200 members. It aims to give a greater voice to patients, carers and the public. Members have elected a Committee, which also includes representatives from the voluntary sector and HealthWatch (SEE BELOW)

A member from the Health Forum Committee sits on the CCG Board and other members serve on various CCG sub-committees. In addition, the Health Forum locality groups (based in Harwich, Clacton and Colchester) can raise issues with commissioners and invite them to come along to locality meetings to hear concerns and answer questions, whilst providing potential solutions and ideas.

The Health Forum has its own constitution INSERT LINK

To date, 85% of our member practices have **Patient Participation Groups (PPGs).** PPGs are groups of patients from a particular GP practice who meet to discuss local issues such as access, parking and online booking of appointments. PPGs have a good understanding of such issues and can suggest solutions and the Health Forum Committee has set up a working group to find out how the work of the PPGs can be used on a systematic basis to influence commissioning decisions, including their views and experience of being offered and exercising choice. The CCG will work with GP practices to develop these groups further and to ensure that they are well advertised.

HealthWatch Essex is a new organisation being set up with the vision of being 'an independent voice for the people of Essex, helping to shape and improve local health and social care services'.

Healthwatch Essex is part of a national network of similar organisations that is being established by Government to ensure that citizens are able to have a greater say in how the NHS – and other public services such as social care and public health – are run. HealthWatch replaces LINks (Local Involvement Networks).

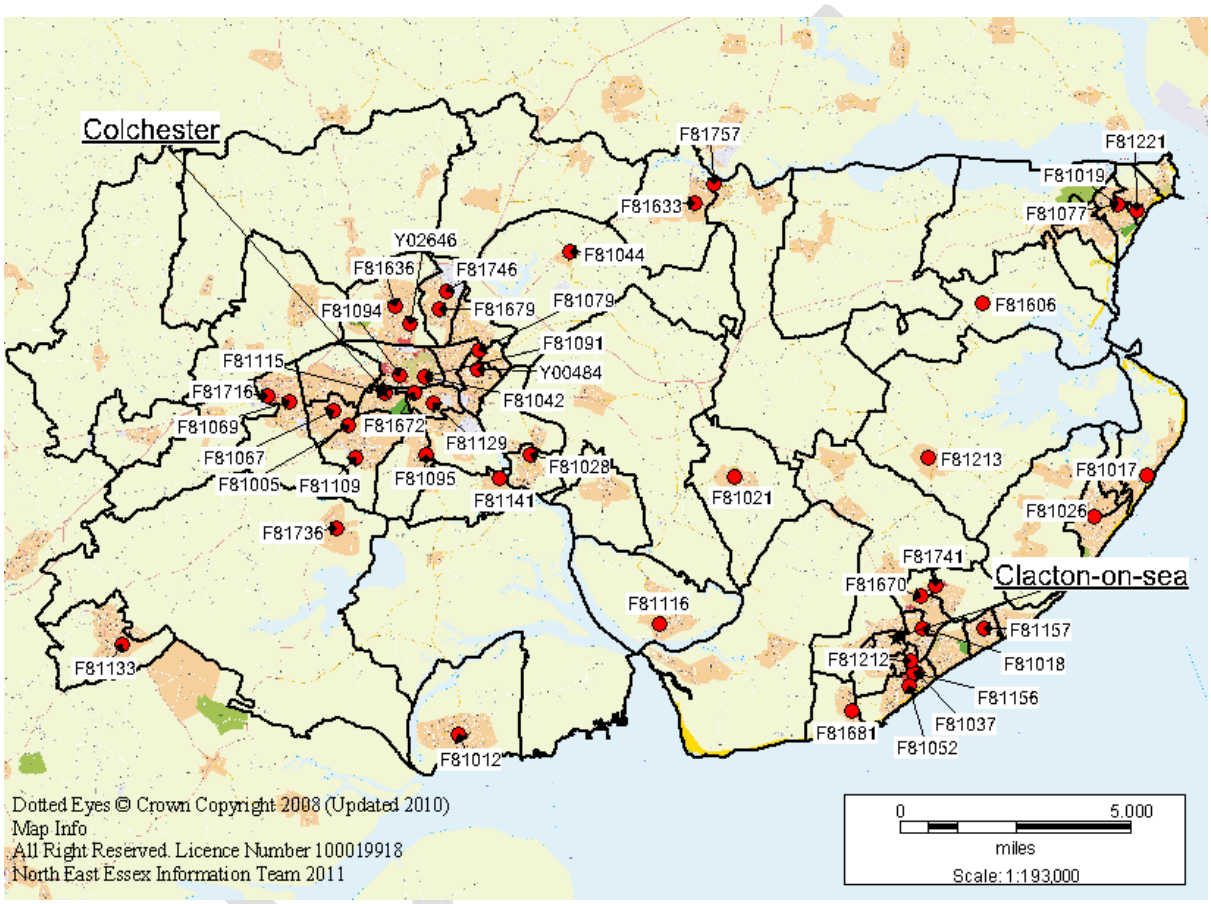
2.7 Our current providers

Since April 2009, all patients have had the right to choose which hospital provider they are referred to by their GP. This choice extends to any NHS hospital plus any independent hospitals which have a contract with the NHS. Patients are also free to choose their GP practice. Further information about choice here ADD LINK TO CHOICES WEBSITE

Information about the main providers in our area is set out below:-

Primary care

Primary care is provided by GPs, dentists, optometrists and pharmacists. They are independent contractors who are commissioned to provide NHS services. GP practices provide core services under a national contract but they can also choose to sign up to provide additional services under Directed Enhanced Services (DES) which are set nationally and under Local Enhanced Services (which CCGs can set up). Examples of DES contracts include extended hours and health checks for people with learning disabilities. Examples of LES contracts include minor surgery.



Within North East Essex PCT there are 43 main GP practices and some additional branch surgeries.

Acute services

The main local provider of acute services is Colchester Hospital University NHS Foundation Trust. The Trust is a medium to large sized district general hospital currently based on two main sites: Colchester General Hospital and Essex County Hospital. The Trust provides healthcare services to around 370,000 people from Colchester and the surrounding area of north east Essex. In addition, it provides radiotherapy and oncology services to a wider population of about 670,000 people across north and mid-Essex. A new £25m state-of-the-art radiotherapy centre is being built at Colchester General Hospital and should start treating its first patients in early 2014 and will replace the current

radiotherapy centre at Essex County Hospital. A new service for major arterial vascular surgery began in July 2012 for the 750,000 population of north east Essex, east Suffolk and the Colne Valley. The Trust is financially balanced with a forecast surplus in 13/14 of £2m and Cost Improvement Plans (CIPS) of around £7m.

Community services

Anglia Community Enterprise (Community Enterprise Company) provides community health services, primarily to the people of North East Essex including:-

- health and wellbeing services eg smoking cessation, alcohol and drug services
- adult therapies eg physiotherapy, podiatry
- children's services eg speech and language therapy, immunisation
- community nursing
- community hospitals at Harwich and Clacton Hospitals
- minor injury units

As a community enterprise, it reinvests surplus income back into the local community.

ACE was set up in 2011/12 out of the Provider Arm of NE Essex PCT.

ACE delivered their planned surplus of £0.36m in 11/12 and are on target to deliver a surplus in 2012/13. ACE have delivered £2m productivity savings in 2012/13 and have planned savings of around £1.6m for 2013/14.The main challenges going forward are the development of the community tariff and the wider range of commissioners following the closure of the PCT.

Out of hours services

Harmoni is commissioned to provide the GP out of hours service for North East Essex. This service is currently provided from three bases, Colchester, Clacton and Harwich.

Harmoni is also commissioned to provide the North Colchester Healthcare Centre which incorporates a Walk in Centre which is open 365 days a year. This provides an additional resource not only for residents of Colchester but also visitors and commuters into the area.

ACE runs minor injury units at both Harwich and Clacton Hospitals

Mental health services

North Essex Partnership Foundation Trust is the main provider of Mental Health services in North East Essex. The Trust delivers services to over 900,000 population of North Essex. The Trust's planned target surplus for 2013/14 is £1.6million (same as 2012/13) and Cost Improvement Plans of approximately £4million.

The range of services and individual care they provide for people and their families can be categorised into the following main groups:

- Child and Adolescent Services
- Early Intervention in Psychosis
- Services for Working Age Adults
- Older Adult Services
- Substance Misuse Services

- Rehabilitation Services for Working Age Adults
- Psychological Services

Facilities include day units and inpatient units, including a specialist mother and baby unit.

Learning disability services

Hertfordshire Partnership NHS Foundation Trust is the main provider of specialist services for people with learning disabilities in North East Essex.

Assessment & Treatment Services are provided for adults with learning disability at the Lexden Hospital Site. This is a specialist service for a wide range of service users including those with profound and complex needs. The Trust also train other professionals and staff, including doctors and nurses, in how to communicate with and support people who have learning disabilities.

Community Learning Disability teams are based across North, Mid and West Essex. There is an intensive inpatient assessment and treatment service in Colchester as well as a Home assessment and treatment Services across the three localities, supporting people with challenging behaviours or mental health needs to be assessed and treated at home where ever possible.

The learning disability services also work in partnership with North Essex Mental Health Partnership Trust to support people with learning disabilities to receive appropriate mental health care.

The Allied Health Professionals (AHPs) who work as part of the multi-disciplinary team, are managed by Anglia Community Enterprise.

Colchester Council for Voluntary Services (CCVS)

CCVS is an independent, charitable infrastructure organisation whose aim is to inspire groups to seize opportunities and become more enterprising and sustainable. Their core functions are:

- Development
- Support
- Liaison
- Representation
- Strategic Partnerships

Community Voluntary Services Tendring

Tendring CVS is run by the local community to promote and develop the effectiveness of voluntary and community action by:-

- Providing support to groups such as information, advice and training.

- Identifying needs and developing new initiatives to meet them.
- Promoting partnership between the statutory and voluntary sectors in the delivery of services
- Supporting innovation, accountability and good practice in local services.
- Encouraging organisations to put forward their views on local and national policies and decisions.
- Creating and promoting channels used by government and other bodies to consult the community.

add social care providers

SECTION 3

REVIEW OF 2012/13

3.1 SUMMARY OF PERFORMANCE

During 2012/13 the North East Essex system has seen some significant improvement in performance against the national indicators, which during a year of transition and significant change within the NHS is a testament to the dedication of the staff in the system.

Throughout the year performance of our main acute hospital, Colchester Hospital University Foundation Trust, against the target for 18 weeks referral to treatment of both admitted and non-admitted has been consistently achieved. During the last quarter the trust has also been able to demonstrate that these targets have been achieved down to speciality level.

Colchester Hospital has also consistently achieved month on month 95% of patients who have spent 4 hours or less in the accident and emergency department.

Unfortunately the ambulance trust has struggled throughout the whole year to consistently achieve both the category A (response within 8 minutes) and category A (response within 19 minutes) targets. This is an East of England wide contract.

Performance against the national cancer indicators was inconsistent at the beginning of the year, but following the production and implementation of a robust action plan, Colchester Hospital University NHS Trust have achieved all indicators since September 2012. This has taken a great deal of work as a number of the indicators involve a number of partners and trusts working together to ensure that pathways are efficient and effective.

There are two stroke indicators which North East Essex have consistently achieved since Quarter two; 80% of stroke patients who spend 90% of their treatment in a stroke unit and 60% of TIA patients who are treated within 24 hours.

The Standard Hospital Mortality Index for Colchester Hospital has been reported as being above the upper control limit during 2012/13. This has resulted in the system producing and implementing an action plan. In January it was announced that Colchester Hospital had been identified to receive an intensive investigation, led by Sir Bruce Keogh, supported by the regulators (CQC, and Monitor) to identify the possible causes for the higher than expected mortality in the North East Essex system.

Colchester Hospital remains on target to achieve the indicator to ensure that 90% of adult inpatients have had a Venous Thromboembolism (VTE) risk assessment undertaken.

North East Essex CCG remain confident that the target number of people who have quit smoking will be achieved during 2012/13, but due to the timing of reporting this indicator we will not have that information for a number of months.

Achievement of the two healthcare acquired infection indicators has been challenging during the year due to a number of factors both in the hospital and the community. Unfortunately this has resulted in the clostridium difficile in both the acute and system wide failing to achieve the target. For MRSA bacteraemia the acute trust achieved their target of 0 but system wide there was one reported incidence against a target of zero.

Our local hospital has continued to perform well against the indicator of a zero threshold for unjustified breaches of mixed sex accommodation. Unfortunately there have been a small number of breaches within one of the London Hospitals, Barts, which has affected the patients of North East Essex.

Performance against our plan for hospital activity, including 1st outpatient attendances, GP referrals and elective (planned) activity, has been consistently above the target during the year. There are a variety of reasons for this including some coding issues, planning inaccuracies, demand from patients and lack of effective demand management.

The IAPT (Improving access to psychological therapy) service has found the two indicators difficult to achieve during 2012/13, which will result in failing to achieve the two targets.

The number of eligible people who have been offered an NHS Health check has exceeded the target of 20% and we are confident that by the end of the year the numbers of eligible people who have received the check will also meet the target.

3.2 QUALITY needs further work

- Patient experience including Friends & Family, complaints and compliments
- Patient safety including Serious Incidents
- Clinical effectiveness
- Safeguarding
- HCAIs
- Pressure ulcers
- Mortality
- Clinical Quality Review Groups
- Walkabouts

3.3 Delivery of Quality Innovation Productivity and Prevention

The Transformation and Delivery Committee is responsible for delivery on behalf of the CCG Board. During 2012/13 it carried out its work via three Delivery Groups, whose terms of reference are summarised below:-

- To prepare business cases for approval by the Transformation and Delivery Committee (TDC)
- To ensure schemes abide by the values of the NHS Constitution, CCG Constitution, Equality Act 2010 and Public Services Social Value Act 2012
- To ensure that all identified stakeholders are fully involved and engaged in the work of the Delivery Group
- To project manage new schemes, ensuring objectives and outcomes are delivered within resources and time scale
- To implement agreed QIPP plans

There are three Delivery Groups :-

1. **Making the system work better (MSWB)**
2. **Healthy Mind and Healthy Body (HMHB)**
3. **Looking after Yourself (LAY)**

Their membership and what they achieved in 2012/13 are shown below.

Membership of the Delivery Groups	
Chairmanship:	
MSWB – Head of Transformation & Development	
HMHB - Head of Delivery	
LAY – Director of Nursing & Clinical Quality	
Members:	
CCG Member	Vice Chair
CCG Member (x2)	Clinical input
Programme Manager – PMO	Programme Overview
Clinical Quality/Patient Safety	Quality & Safety
Finance Accountant	Financial Overview
Business Delivery Managers	Commissioning

	Making the System Work Better	Healthy Mind and Health Body	Looking after yourself and our NHS
Scope	Monitoring the System Transformation of Primary Care Transformation of Community Services Transformation of Urgent Care Ensures join up of commissioning and contracting/performance management	Improve physical health of people with mental health care needs Develop services for people with a Learning Disability Deliver care closer to home Improve outcomes for patients with Long Term Conditions Promote Patient & Carer Engagement	Public Health Maximise use of Assisted Technologies End of Life Third Sector Providers Children & Maternity Community Nursing
Outcomes in 2012/13	Establishment of Urgent Care Strategy Group Progressing the development and continuation of more services delivered in an out of hospital setting, including cardiology and dermatology Redesigning the MSK pathway, making initial savings due to the reduction in diagnostics The roll out of the Productive General Practice Programme The review of community services and Local Enhanced Services Monitoring of 18 week compliance to improve patient care Monitoring of cancer targets which has led to more seamless pathways	Continued implementation of Virtual Ward project Redesigned renal pathway and improved the quality of services Designed Diabetes Integrated Pathway Hub, procurement underway Supported development and implementation of 'The Journeys Programme' to improve outcomes for patients with mental health care needs. Supported implementation of HOPE Project to improve recovery based services for adults with mental health care needs. Improved outcomes and access to services for people with learning disabilities Chronic Obstructive Pulmonary Disease pathway improved-patients can now access psychological therapies directly	Ensured public health & CCG priorities aligned. Worked with main community provider to embed use of assisted technologies for people with long term conditions. Set up working group to redesign End of Life pathways into single point of access model Set up joint venture with Social Services to reduce Care Home demand on urgent services. Set up review of community nursing Children and Maternity services – worked to drive forward the care closer to home agenda and to facilitate greater integration between primary & secondary care, the voluntary sector & the Local Authority. *Third Sector Providers – to be added* *Community Nursing – to be added*

3.4 FINANCE

NHS North East Essex Clinical Commissioning Group was established in shadow form on 1st April 2012 and had delegated authority to manage commissioning funds that were identified as being the future responsibility of CCGs. The CCG was authorised as a statutory body on 18th January 2013 and is accountable for funds allocated to it for the financial year 2013/14 and beyond.

The CCG is on target to achieve financial balance in 2012/13 for its delegated funds. In addition to this the CCG will start the financial year with an agreed brought forward surplus of £18.250m. Utilisation of this surplus will be in a planned way and will assist in pump priming service re-design, innovation and new technology where it is considered long term benefits can be realised.

The funding allocation process for 2013/14 has been based on historic spending patterns and therefore has not allowed for any movement in terms of distance from target under previous funding formulas. A move to a formula driven allocation beyond 2013/14 is anticipated. The funding formula process presents a significant risk to the CCG going forward. Historically the PCT that commissioned services prior to creation of the CCG was 5% distance from target which equates to a potential shortfall of £20m. It is unlikely that any future funding formulas will fully address this disparity

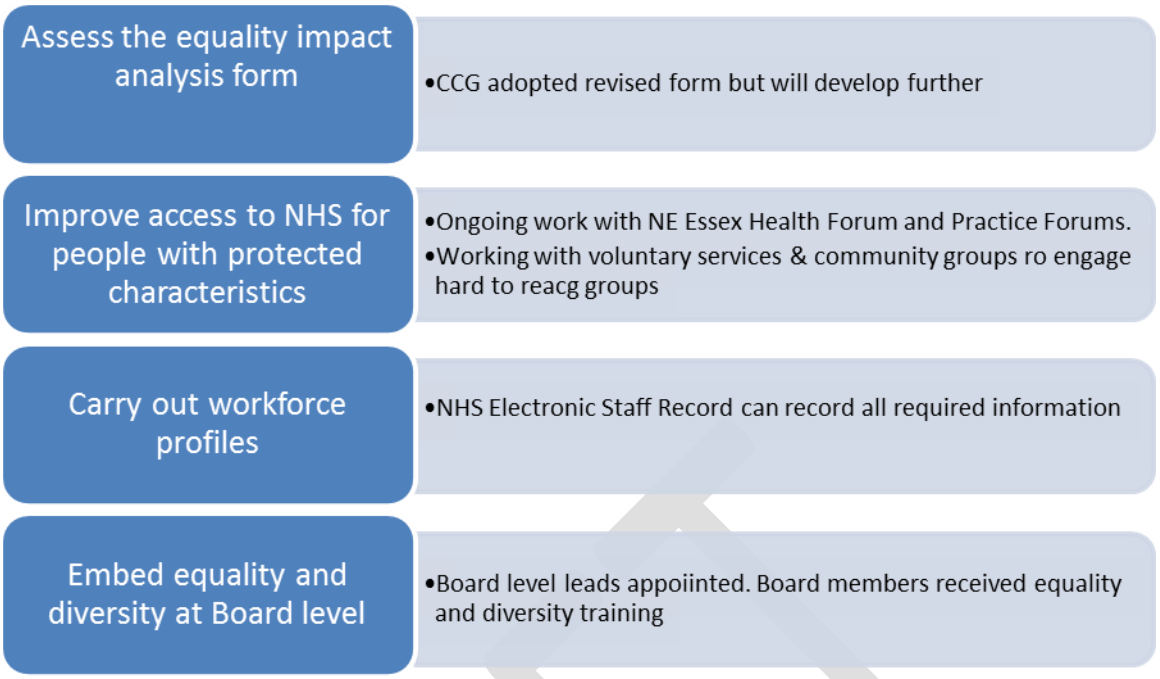
3.5 EQUALITY AND DIVERSITY

In line with the Equality Act, as a public sector body, Clinical Commissioning Groups are required to:-

- publish information to show their compliance with the Equality Duty, at least annually; and
- set and publish equality objectives, at least every four years.

During the transition year of 2012/13, equality and diversity work was led by the North Essex PCTs Cluster Board and NEE CCG had representation on the working group. The Cluster implemented the Equality Delivery System (Equality Delivery System), which is a tool for assessing how well an NHS organisation complies with the requirements of the Equality Act 2010. A key part of the tool is asking local community groups for their views.

The CCG adopted the outcomes of the EDS and subsequent action plan and also produced its own Equality and Diversity Strategy. The EDS action plan included the following four high level equality objectives (each of which is underpinned by a further series of actions). The objectives and the CCG's progress against them are summarised below:-



The CCG is in the process of planning a consultation with community groups, in particular those which represent people with protected characteristics, and asking them to measure CCG progress against the above objectives. The consultation will also include setting new or extended objectives for 2013/14

3.6 ENGAGEMENT

North East Essex CCG recognises the key role that our stakeholders play in helping us to design and commission health services which meet the needs of our local population. We have worked with members of the public, patients, carers and other partners to develop and articulate our vision, values and priorities and we are committed to ensuring that that we have on-going open and inclusive dialogue .

We will build on our existing engagement with voluntary and community groups to reach out to as many people as possible and to make sure that “no decision about me without me” becomes a reality.

In May 2012 the CCG held an engagement event which was attended by over one hundred people from the local community, including patients, voluntary groups and local authority partners. We presented our plans and priorities and took on board the issues and concerns raised. One of the messages was for the CCG to make full use of existing community and voluntary groups when engaging with the wider public and we have made this a key strand of our engagement strategy.

North East Essex Health Forum

We are delighted that the North East Essex Health Forum has been established. This was a result of the CCG working with a review group of patients, carers and community groups, including the voluntary sector, in order to find out how local people wanted to engage with the CCG. The Health Forum has its own constitution which can be found on the CCG website and a representative sits on the CCG Board and key sub committees.

There are three locality groups, based in Harwich, Clacton and Colchester, which are attended by CCG Business Managers so that they can listen and respond to members' ideas and concerns. The Forum has an elected Committee which manages the work of the Forum and which has established working groups on choice and communications. The Forum is also looking at how it can work more closely with the Patient Participation Groups which are based in GP practices.

The CCG is supporting the development of the Forum and has organised training sessions for members.

Practice Forums

In 2011 North East Essex CCG worked with local practices to develop and create practice forums, as way of facilitating practices working together, sharing good practices, supporting peer review and as a forum for sharing commissioning ideas that would benefit the local population. The CCG's vision was that through the GP practices unique relationship with their patients and their carers, that the forums would be a way of reflecting their views as well, through the patient reference groups.

Three forums were set up in Colchester and three in Tendring with all 44 practices being aligned to a forum. Practices identified a clinician and a manager to represent them at these forums.

During 2012/13 the CCG supported the forums by providing resources through their internal structure, ensuring that the engagement of the practices was incentivised through the engagement scheme and ensuring that ideas and suggestions were discussed at delivery groups. The CCG also used an online meeting tool where invited participants can review papers and documents and discuss ideas.

The forums were developed on a shared geographical and demographical basis which enabled practices with similar patient groups to share ideas and to limit the time spent travelling between practices.

At least twice a year the CCG facilitated all of the forums coming together to share progress and to work on system wide challenges that needed a broader approach.

2012/13 saw the forums develop further, with regular meetings being held and relationships being made between practices. A number of patient pathways were refined and tested out through the forums and a wealth of ideas have been generated and developed. The CCG also uses a web based facility which allows invited members to review and comment documents and discuss ideas online.

CCG website

The CCG website was upgraded to make it fit for purpose for the CCG taking on its statutory role. We also took the opportunity to review how we presented information and to make sure that the website was more interactive.

SECTION 4

FIVE YEAR VISION AND STRATEGY

4.1 Introduction

The NHS has always adapted and evolved to meet the changing requirements it faces. Our population grows and ages, patterns of disease change over time and new and ever more complex treatments are developed. For example, in 1948 as the NHS was founded, TB hospitals were still a prominent part of the NHS. Today they no longer exist because modern treatments have revolutionized the way we manage this condition.

However, the NHS is facing a period of unprecedented challenge. The downturn in the global economy means that increases in public services funding are much lower than in previous years. Even though NHS funding has been protected from cuts it is not increasing as fast as the increase in costs within the service. This means that to continue improving the quality and safety of services the NHS must adapt faster and more effectively than ever before in its history. This challenge will continue for the foreseeable future.

Similarly the major challenge our key partner ECC faces is not simply one of reductions to funding levels, but inflation and demographic pressures. The Council faces demographic pressures and increased demand for services, particularly in the Adult, Health and Wellbeing service area including Learning Disability, Physical and Sensory Impairment, Older People and Mental Health services. These services alone represent close to half of ECC's controllable budget.

Facing the prospect of change in the NHS and Social care can be unsettling both for the public who use these services and for those who work in the system, but it is only through change and adaptation that we can continue to deliver higher quality treatment and better outcomes for everyone who needs it.

The way that health and social care services are commissioned and provided has changed little over past decades: the traditional splits into primary care (GP, dental, pharmacy, optometry), acute care (hospitals), community, mental health, learning disabilities, and social care still apply. People don't fit neatly into these services and often need support from several of them. This can mean that patients experience fragmented care, delivered by many different people. Patients have to tell different staff the same information over and over again. Some care is duplicated, some care is missing.

However, by commissioning services in a different way and building on the Whole Essex Community Budgets work to date, we can improve the quality of care and at the same time ensure that we make the best use of resources at a time of ever increasing demand.

4.2 Principles of commissioning and models of care

So how will we do things differently?

- We will commission care which is focused around people, not services or providers.
- We will commission for outcomes.
- And we will commission jointly with Essex County Council so that people receive seamless health and social care services

The CCG and Essex County Council share the following principles for integrated commissioning arrangements:-

- Must be sustainable and based on long term commitments
- Simplified governance arrangements which avoid dual lines of reporting and accountability
- Clarity on what commissioning authority resides at which level of the system
- A shared outcomes framework
- Clarity about the resources each partner is committing and for what period of time

Streamlined commissioning and joint procurements will release funds which will be reinvested in front line care. Patient experience, quality of care and healthy finances go hand in hand.

Features

Features of the future model of care	Tools and approaches

• Support for self-care
• Personalisation of care
• Standards of access and urgent responsiveness
• Optimisation of care including:
  ○ preventative care
  ○ risk-based planning
  ○ combined assessment between social care and nursing, generalist and specialist medical care
  ○ at the end of life, the opportunity for a good death
	• Self-service access to advice and support
	• Health coaching
	• Simplified points of access to a range of services, including combined call handling
	• Multi-skilling of staff
	• Risk stratification of the population
	• Case management of high risk patients
	• Extensive use of assistive technologies
	• Extensive use of informal communication between services and professional groups
	• Service providers increasingly offering a wide range of these services

This new model of care will benefit all patients in North East Essex but we will focus in particular on four priority populations:-

- The frail elderly
- Children
- People with mental health care needs
- People with learning disabilities

These populations were identified as priorities from the Joint Health and Wellbeing Strategy and from discussions held with Essex County Council (ECC), local patient representatives plus voluntary and community groups. We held a series of workshops with Essex County Council to identify the required outcomes for these four priority populations. The outcomes and high level action plans are shown in section XXX

4.3 OUR PROPOSED APPROACH

We believe that what matters most to our population is their experience of health and care services. This includes being treated with compassion, dignity and respect, being able to get effective support when you need it and not being confused or lost inside a very complicated system.

Traditionally, contracts have been organised around providers and the services that they can offer. This has led to a multitude of contracts which focus mainly on processes within the organisation. People often have complex requirements for support and care which span multiple providers. Contracting with each provider separately can lead to services being disjointed, duplicated in some places and lacking in others. People experience services which can be inflexible and impersonal.

This multitude of contracts, currently in excess of X,XXX separate ones, is also difficult to oversee. As commissioners, we need to be effective at buying services for our population; we need to describe clearly what is needed and to be able to check that we are getting it.

To improve this situation, we need a manageable number of contracts which buy services based around the needs of people, not the needs of the service providers. We must move to a system of funding which focuses on the outcomes and experience of people in our community, rather than measuring the number of people passing through a particular provider.

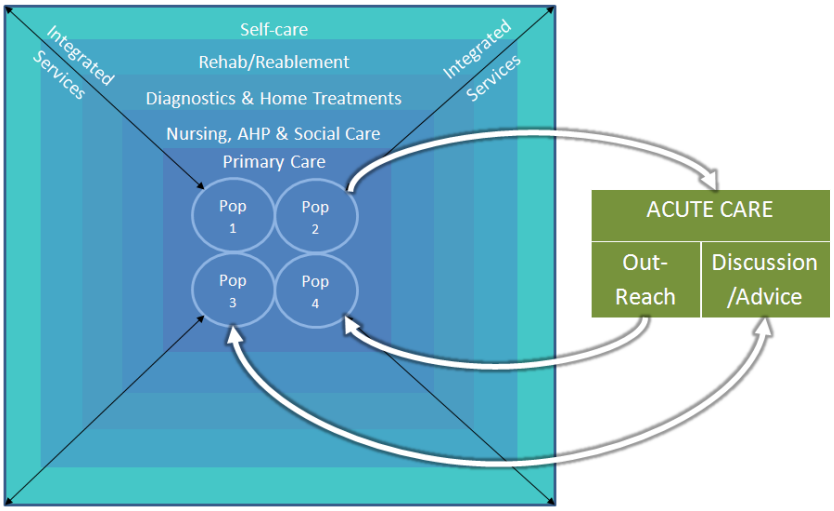
NEE CCG is proposing a new approach, based on "bundles of care" which take the needs of the patient as the starting point. There will be one specification and one contract for each bundle. The bundle could be provided by a single provider or a consortium of providers working together. The lead provider will be responsible for delivering the outcomes set out in the contract, either using their own resources or a mixture of their resources and sub-contractors. There will be incentives to improve the outcomes for our population. This is likely to include providing more integrated services which upskill and maximise the use of staff and better use of technology.

The initial three "bundles" proposed are:-

The bundles will be commissioned for specific geographical populations so that we can focus on the different needs in different areas. This means that the improvement in outcomes we require may be greater in areas, or groups of people where outcomes are poorer at present. We will focus on improving the outcomes for the four priority populations we have identified with Essex County Council: the frail and elderly, people with mental health care needs, people with learning disabilities and children.

Please note - this approach is still under development and the CCG is continuing to consult on these. The content of each bundle is not yet finalised.

This aims to wrap primary and community care services around small populations of patients. Initially these will be made up of GP practice areas, totalling populations between 25,000 and 100,000 people. Please note – these populations are still in development and have not yet been finalised. The focus will be on supporting people to remain independent in their own homes and to provide care at home and in local communities, using acute (hospital) services only where this will improve the outcome for them.



(AHP = Allied Health Professionals eg physiotherapists, dieticians, podiatrists)

Health and Wellbeing will potentially include:-

Community beds	Community Mental Health services	Health checks	Social care
Prevention and screening	Health visiting	Social care assessments	GP care advisers
Assessments and support for Carers	Community nursing	Equipment	Urgent visiting
Non-emergency patient transport	Diagnostics	Crisis response	Allied Health Professionals

Outcome measures will include

Better preventive care	Fewer admissions to hospital	Better management of long term conditions	Improved quality of life

Urgent Care

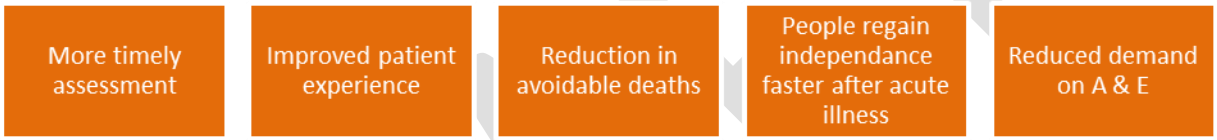
This aims to help people to choose the right urgent care service in the right place at the right time.

Currently the CCG commissions a range of urgent care services from different providers, from telephone advice (NHS 111) through to Accident and Emergency hospital services.

The urgent care bundle will be one specification and one contract and potentially will include:-

A & E	Walk In Centre	Minor Injuries Units
Children's A & E	Step up beds	Patient transport services
NHS 111	Falls service	

Outcome measures will include:-



End of Life Care

Everyone would like their relatives and indeed themselves to have a dignified death. To achieve this we need to be able to recognise when someone has a limited time left to live and to be able to sensitively discuss and plan for this eventuality.

End of life care is currently provided by a number of commissioned organisations, each specialising in their own areas. At times this causes confusion for people and the clinicians alike.

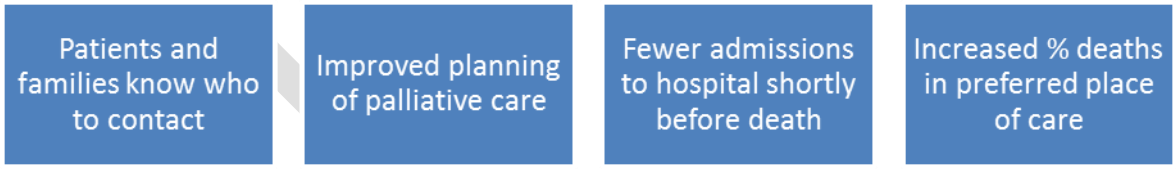
We will aim to identify people entering their last year of life. We can then plan with them the support they and their family or carers require. This will include planning where they would like to die, the sorts of treatment they might need in their last few days or weeks and the support and access to advice they will need.

The proposed model of a single point of access will make it simpler to get hold of the right support in a timely way. A single register for end of life planning will ensure that when people are seen by different services, such as Ambulance or hospital services, their plans are always accessible.

The end of life bundle will be one specification and one contract, which potentially will include:-

Hospice at Home	St Helena Hospice	Palliative care team	Community beds
GP Care Advisers	Home oxygen	Medicines Management	Falls services
Intermediate care	Non-urgent patient transport	Community nursing	Tissue viability
Marie Curie (delivering Choice)	Care UK Block Contracts	Cheviots beds	Assessments and support for Carers

Outcome measures will include:-



SECTION 5 DELIVERY PLAN FOR 2013/14 AND MEDIUM TERM

Suggested additions:

how performance will be measured

Social care outcomes framework

Public health outcomes frame work

Frail older people

High level outcomes	1. People feel safe and in control of their health and wellbeing 2. People receive the least complicated and least intrusive care necessary to meet their needs 3. People have a good quality of life and a dignified death	
Key points	Services commissioned within CCG boundaries with a joint CCG/ECC specification to meet local priorities Aim to achieve maximum independence for older people and equity of outcomes Move towards a single per capita budget per resident Supported by Draft County-wide framework for Older People joint Commissioning" – see Appendix XX	
Care need	**Action**	**Outcome**
Social Inclusion	Implement integrated approach to help people use community resources, linked with the "Strengthening Communities" work and draft strategy on "Supporting Resilience"	People know about and use community resources. Reduction in number of people accessing GP surgeries and A & E as a result of social isolation and loneliness.
Dementia	Implement Essex Dementia Strategy with focus on early intervention and demand management	Earlier identification of people with dementia leading to earlier intervention Improved access to memory assessment clinics Improved support and information following diagnosis.
Functional Mental Health	Decide joint CCG & ECC approach to supporting people Identify people at risk of developing mental health care needs along with support options	People at risk of developing mental health care needs are identified early and receive appropriate support
Falls Prevention	Develop joint Falls Prevention strategy and pathway	Identification of people at risk of falls and early interventions put in place

Continence Management	Develop continence management strategy , leading to a joint service specification with clear outcomes, to be jointly commissioned in 2014/15.	Reduce number of people presenting at A&E with Urinary Tract Infections (UTIs) Reduce number of admissions to residential and nursing care caused by UTIs Improved prevention and early intervention
Support for carers	Implement Essex Carers Strategy and embed into provider contracts. Develop business case for improved carer support and commission jointly with ECC in 2014/15	Carers receive improved support Fewer admissions to hospital, nursing and residential homes due to carer breakdown
Urgent Care	Share best practice on reducing inappropriate admissions. Analyse care economy to better understand trigger points and to shift support from reactive to proactive.	A variety of different models are in operation across Essex. People receive planned care in a timely way so that inappropriate admissions are reduced
Support for professional carers	ECC and CCG partners will work with care homes to reduce falls and improve experience at End of Life through the My Home Life Programme	Reduce number of people who present to A & E from residential and nursing homes
End of Life Care	Develop more integrated approach to improve End of Life care and support	All persons expressing a preference to die at home are enabled to do so in all but exceptional circumstances. People and families find it easier to talk about death and end of life care
Continuing health care	Partners will review Continuing Health Care arrangements and processes on an Essex-wide basis.	Suggest include a statement re: clarity in terms of people who may be subject to Section 117 Aftercare and how their needs will be met.

Children

High level outcomes	Children receive personalised, integrated care in a community setting , with hospital care only where it improves outcomes Transition from child to adult services is smooth and simple Families receive appropriate support to care for their children Children and young people are safeguarded and appropriate health intervention is provided for Children in Care and Leaving Care and on a Protection Plan.
Key points	Joint commissioning of services by ECC and CCGs on either a CCG or system level as appropriate Mid Essex CCG will be the Coordinating Commissioner for on behalf of the North system CCGs for CAMHS. ECC and CCG have agreed to discuss joint appointment for children's commissioning

Care Need	Action	Outcome
Families with complex needs	Contribute to the co-ordinated delivery of family support and parenting programmes to provide integrated support to families with complex needs who are experiencing mental health, substance misuse, violence and family relationship issues. Health visitors and adult mental health workers to be part of Family with Complex Need Teams Support and enable implementation of the Community Budgets business case re Families with Complex Needs (FCN) in 2013/14 to ensure integrated and co-ordinated support is available to families Continue to develop plans with ECC and other CCGs to ensure the outcomes are achieved and	To ensure integrated and coordinated support is provided to families with an aim to develop early intervention and preventative approaches.

	services are reshaped	
Children with complex care needs including disability and SEN	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 Continued joint planning and funding of care packages for individual children with complex needs.	Provision of clearly defined pathways and subsequent demonstrable improved outcomes for children with complex needs
Integrated CAMHS and Behaviour Service	Start delivery of integrated CAMHS and behaviour interventions for tiers 1-3	Establish joint commissioning of an integrated T2 and T3 service
Maternity and Early Years	Strengthen links with Children's centres and work closely with ECC in future re-tendering processes to facilitate increased collaborative working between acute and community providers in the early years agenda Midwifery and Community Health Services to work in effective partnership with children's centres and schools Map maternity and early years pathway from conception -> 5 years to identify scope for improving integration Further strengthen links with Public Health to reduce the potential for fragmentation of services for the early years and to identify areas for joint commissioning	Provision of seamless and robust pathways from -9months to 5 years of age to enable children to get the best start in life and promote good health for children and young people and reduce health inequalities

	,	
Integrated commissioning for children entering and leaving care	In liaison with Safeguarding Children's Clinical Network & pan Essex:- Review of Contribution to assessment and planning and provision of interventions ; GP assessments for adoptive parents and children, IHA and RHA 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 by embedding the provision of this function within the main health contracts. To ensure effective health transition for young people leaving care To ensure effective transfer of health care packages for children in care moving placements or following discharge from in-patient units	To improve the quality, speed/priority and cross District 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.. Improved CAMHS T3 provision for Children In and Leaving Care.

Preventing obesity in children and young people	Led by Public Health – cross ref to PH plan on a page	
Joint approach to safeguarding and Child protection	Maintain current commitment to County wide Safeguarding Children's Clinical network. Health providers contribute to Assessment, Planning and Review activities as required providing reports and direct interventions for Children In and Leaving Care and on a Protection Plan and this is to be embedded in the main contracts and jointly performance managed. In main stream CCG contracts Health providers will be required to recognise and deliver their role as active members of Core Groups for children subject to child protection plans Provide timely initial and review health assessments and medical advice and assessments for fostering and adoption Undertake direct intervention including parenting skills provision to support families	Improve safeguarding and health and wellbeing of looked after children and care leavers Improved CAMHS provision for Children on a Protection Plan and Children In and Leaving Care.
Vulnerable adolescents	Integrated planning and working with PH and school nursing in relation to sexual health and substance abuse	Increased targeted intervention provided for adolescents at risk
Domestic abuse	ECC to work with CCGs to develop programme in	

	13/14 identifying opportunities for effective joint screening tools, a multiagency hub to review notifications and provide IDVA support and the benefits. 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. Joint development of a detailed business case for funding in 2014/15 of the priority actions identified in the WECB business case to tackle domestic abuse	
Partnership Board	Secure active CCG involvement in Essex and Local CYP Partnership Boards Ensure that health is represented in defined and agreed initiatives and priorities	Analysis of need, shared resources, strategic service development and delivery plans for shared strategic commissioning priorities to establish a common framework for joint working around children and families
Education	Contribute to Healthy Schools agenda	Secure engagement of education and enhance effectiveness in safeguarding, improving education outcomes for children in care, tackling obesity and improving children's wellbeing
Transition and referral thresholds	Alignment of referral thresholds.	Improved transitions especially from childhood to adulthood

	The All Age Disability Strategic Framework recognises the need to commission jointly services and care pathways into adulthood	

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

People with mental health care needs

High level outcomes	• 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
Key Issues	Delivery of a primary care approach to mental health and wellbeing, focusing on prevention and early intervention. Fully integrated community-based services that support recovery, using specialised services only where they add value. People to feel empowered and to live fulfilling and independent lives in their own homes. Mental and physical health conditions are treated in a co-ordinated way with equal priority to support recovery . NE Essex CCG will be lead commissioner for North Essex CCGs with ambition to deliver joint commissioning with ECC under a single mental health commissioning strategy.

Care need	Action	Outcomes
Primary care services	Work with Public Health (ECC) to promote mental wellbeing; self-care and health lifestyles including early intervention. Physical health needs are addressed alongside mental health needs. To work with partners to strengthen communities, implement prevention strategies and optimise the use of personal health budgets and assistive technology To undertake a review of existing IAPT services including the interface with Clusters 1-4 within the current NEPFT Block Contract with a view to re-procurement in 2015.	• Early engagement to reduce level of mental distress and ill health • Fewer young people develop longer term dependency on specialist mental health services • Improved health and wellbeing outcomes • Reduced inequality in mortality rates especially where there is co-morbidity • People are equipped to manage their own care • People feel empowered • Carers are supported • Responsiveness to fluctuating conditions
Social inclusion	Joint health and social care commissioning through the use of s256 agreement to maximise the use of resources for	• People live in settled accommodation • Improved self-esteem and confidence through

	housing, employment, advocacy and engagement in mainstream community activities and services.	engagement in meaningful daytime activities • More people in employment which in turn will contribute to improved wellbeing and financial security • People are able to sustain friendships and social support networks • People are not defined by their mental health condition
Recovery oriented approaches	To implement a Recovery- based model approach in secondary healthcare services. Improve recovery orientated approaches to delivery of statutory functions of assessment and care management and the subsequent provision of support. To implement the Essex Accommodation Pathway that will support people to live more independent lifestyles. Within this, deliver enablement to prevent admission where possible and provide enhanced support to people when they are first discharged from hospital. Redesign rehabilitation services linked to the implementation of the accommodation pathway and the development of recovery approaches.	• Fewer people in long stay residential care • Fewer people in long-stay hospital beds • More people are supported in own tenancies in the community or short term supported housing • Reduced dependency on specialist care • Value for money through market development and contestability • Responsiveness to fluctuating needs • Effective S117 plans • Fewer people admitted to hospital with the risk of readmission to hospital reduced
Integrated crisis response	Redesign integrated crisis pathways	• Reduced demand on A&E and CRHT • Reduction in loss of life due to suicide • People feel safe
All age commissioning approach	To develop commissioning for all age adult service.	• Equal access • Clearly articulated therapeutic thresholds

	To develop clear transition protocols from CAMHs into adolescent and adult services. (Dementia care and support is covered in the section on Frail Older People)	• Clarity about functional and organic mental health service responses and interdependency with frailty pathway • Safe transition between services for children and adolescents
Integrated services	Develop a mental health joint commissioning strategy. To build on and strengthen engagement in commissioning of people who use services, carers and the wider public Develop and commission fully integrated physical and mental health care pathways. The development of Payment by Results and a tariff for mental health services, incorporating processes for management of personal budgets where possible. To review the S75 Partnership Agreement between ECC and NEPFT to form a view as to how this could be incorporated into a single NHS contract in the longer term. Joined up with ECC DAAT Commissioning priorities	• An agreed 3-5 year joint commissioning plan providing strategic direction to improve the health and well-being of the population of Essex and value for money. • Effective commissioning based on expert experience • Costed pathways and interventions for people with serious and enduring mental health conditions based on identified need • Mental health and substance misuse treated together where they co-exist • Mental and physical healthcare are treated with equal parity.

People with learning disabilities

High level outcomes	• People are involved in their own care and have the knowledge and skills to manage their own health and make healthy choices • People are offered a personalised integrated care plan which reflects preferences and agreed decisions. This includes a smooth transition between child and adult services • People have access to the services they need, including reasonable adjustment from main stream health services eg suitable appointment times, Easy Read information	
Key issues	Support people to be as independent as possible and to make own choices New approaches needed that maximise inclusion and individual capabilities More people living longer and more people with complex needs surviving into adulthood ECC will be lead commissioner on behalf of North Essex CCGs with ambition to work on pan Essex basis in medium term Use the 2012 Learning Disability Health Self Assessment and Improvement Plan to underpin this work	
Care need	**Action**	**Outcomes**
Challenging behaviour	Implement Winterbourne and DH requirements including local registers and person centred support/move on plans for everyone in health funded in-patient services. Implement integrated model of care, joint commissioning and procurement including pooled budget	• Fewer people are in health funded in-patient services with clear move on plans for those still in these services. • Different models of services are being jointly commissioned to maintain people in community settings in local areas. • Pooled budgets are in place. • People who have moved on from in-patient services have improved outcomes in health and quality of life. • Some people are using personal health budgets
Access to mainstream services	Ensure all providers have robust improvement plans. All providers to demonstrate they are making reasonable adjustments.	• People are identified in mainstream health service patient information systems • People have improved health and a reduction in early mortality. • Improved experience of care • Increased value for money through greater efficiency.
Health checks and health plans	• Continue implementing a DES or LES for learning disability health registers and annual health	• Everybody is offered a health check • 90% of people on a DES register has a health check and a health action plan • 100% of people with profound needs, from BME groups or with Downs Syndrome has

	checks. • Work with GPs and specialist learning disability health services to deliver more health checks and support people to complete and use their Health Action Plans. • Increase access to health screening programmes	had a health check and has a health action plan. • People have improved health and a reduction in early mortality. • Improved experience of care
Health strategy	Develop a joint health and social care strategy	An agreed health strategy providing clear strategic direction to improve learning disability commissioning for the improved health and well being of people and family carers.
All age commissioning approach	• Introduce a single birth to 25 years assessment process and individual birth to 25 years Education, Health and Care Plans through the Children and Families Bill.	• An agreed pathway and single Education, Health and Care Plans are in place to deliver a smooth transition from children's to adults health, education and social care services. • The pathway and care plans put young people and their families at the centre of planning for the future. • Fewer young people are in health funded in-patient services.

P U bl	Commissioning of :-	A mix of commissioning models is proposed for Public Health

	• Health Checks • The National Child Measurement Programme • Sexual Health. Review and development of the following services in 2013/14 so that they can be commissioned in 2014/15:- • Sexual Health Services. • School Health Services • Drugs and Alcohol misuse. Local priorities to be agreed with CCG include :- • Atrial fibrillation management • Smoking Cessation services • Reach out • Senior Health Checks • Falls Prevention pathways • Virtual wards	across Essex:- • Across Essex where this leads to optimal economies of scale. • Commission jointly with partners at a local level where it makes more sense, • Partner with Public Health England for specific programmes including screening. Further details about Public Health plans and delivery can be found in their Plan on a Page in Appendix XXX

EVIDENCE BASE FOR COLLABORATIVE COMMISSIONING

The collaborative working required to deliver the Integrated Plan needs an evidence base. Essex County Council has agreed with NE Essex CCG to use a portion of its social care sustainability monies, which will be transferred within a section 256 arrangement, to develop this evidence base alongside innovative demand management. schemes. The five priority areas will be urgent care, dementia, falls, stroke and continence.

SECTION 6

NATIONAL AND REGIONAL PRIORITIES

The task of the CCG is to commission services which meet the needs of the people of North East Essex. However it is also important that our local strategy and priorities are in line with those of the wider NHS. The key national and regional priorities which we need to meet are summarised below

NATIONAL AND REGIONAL PRIORITIES AND HOW WE WILL IMPLEMENT THEM		
	The priorities	What we will do
The NHS Constitution	The Constitution sets out the rights of NHS patient. These rights cover how patients access health services, choice, the quality of care, the treatments and programmes available, confidentiality, information and the right to complain if things go wrong.	Continue to promote the principles and values of the NHS and uphold the rights of patients. Ensure all NHS Commissioned services are accessible, free of charge and are delivered by appropriately qualified staff Continue to work with our providers of care to ensure that services are provided from a clean and safe environment, within an organisation that is continually improving quality of care. Ensure that patients are offered choice when they are referred to hospital Ensure that our commissioned services deliver care that will respect the patient, put the patient and their carers first, treat them with dignity and involve them in the planning of their treatment
	Non-emergency treatment must start within 18 weeks of referral (90-95%)	Work with our main providers to ensure that patients are seen within maximum waiting times,
	Cancer treatment must start within 62 days of referral by GP (85%)	Continue to enable the majority of our patients to start treatment for cancer within 62 days of referral
	No one should wait more than 4 hours in Accident and Emergency Departments (95%)	Continue to ensure that 95% of patients are seen within 4 hours of attending an accident and emergency department
	Emergency ambulances should be on the scene within 8 minutes of being called (75%)	• Work with our ambulance colleagues to ensure that 75% of calls from our patients result in an emergency ambulance attending on the scene within 8 minutes if appropriate.

The NHS Outcomes Framework	Preventing people from dying prematurely	• Improve our screening processes to improve our rate of early diagnosis • encourage people to look after themselves & provide them with the tools and resources • work with our GP colleagues to improve the management of long term conditions • improve communication between the different sectors of health and social care to ensure that patients receive optimum treatment • continue to commission NHS health checks
	Enhancing quality of life for people with long term conditions	• Work with social care colleagues to integrate the commissioning of services for our population • Work with our primary care colleagues to improve the management of long term conditions • Encourage our providers to work together to provide services to our population • Reduce the numbers of unplanned admissions for people who have a long term condition • Increase the numbers of patients who feel supported in managing their condition • Encourage patients to take control of their condition through personalised care plans and personal budgets
	Helping people to recover from episodes of ill health or following injury	• Ensure that more packages of care offered to patients are a combined model of health and social care support. • Reduce the numbers of emergency admissions for acute conditions that should not usually require hospital admission • Reduce the number of readmissions within 30 days of discharge from hospital by ensuring there is a co-ordination of care and support to people following their discharge. • Reduce the number of emergency admissions for children with lower respiratory tract infections
	Ensuring the people have a positive experience of care	• Ensure all providers actively encourage feedback from patients & staff and act on it • Continue to commission services to use the friends and family test • Work with the NCB to improve patient experience of primary care and out of hours services • Bring together of the experiences of patients and their carers from across the system
	Treating and caring for people in a safe environment and protecting them from avoidable harm	• Use the National Quality Dashboard to identify any potential safety failure • Actively contribute to in quality surveillance groups • Continue to work with providers to reduce the incidence of healthcare associated infection • Continue to work across the system to eliminate avoidable pressure ulcers • Ensure that all providers of services are qualified and competent • Ensure all services who should be registered with a regulator are

NEE CCG Local Objectives	Increasing the number of people with diabetes diagnosed less than one year referred to structured education	• commissioning additional structure education courses for all patients with a diagnosis of diabetes • Commission a public awareness campaign to ensure patients with diabetes are aware of the resources available to them • Ensure that communication plans reflect the need to ensure all providers are aware that education is available to patients with diabetes •
	Reducing the number of people with dementia prescribed anti-psychotic drugs	• Commissioning education sessions for clinicians including GP colleagues on prescribing anti-psychotic drugs for dementia patients • Ensuring that providers of mental health services are aware of the guidance on the prescribing of anti-psychotic drugs for patients with dementia •
	Reducing the under 75 cancer mortality rate	• Encouraging patients and public to access screening services • Work with national awareness campaigns to ensure locally we maximise the benefit of the increased national publicity • Work with CSU colleagues to ensure there is a yearly awareness campaign • Work with local providers to ensure that the cancer targets and thresholds are consistently met. • Carry out a data review to identify further pathways where action may be indicated

<table>
<tr><td rowspan="4">Everyone Counts</td><td>Move towards routine services being offered 7 days a week</td><td colspan="2">Continue to develop 7 day a week working for diagnostics and services related to urgent and emergency care. This will not only focus on the acute services but those out of hospital as well</td></tr>
<tr><td rowspan="2">Publish clinical outcome data at consultant level</td><td colspan="2">Ensure our providers publish their information on the following specialities by summer 2013:-</td></tr>
<tr><td>Adult cardiac surgery
Interventional cardiology
Vascular surgery
Upper gastro-intestinal surgery
Colorectal surgery</td><td>Orthopaedic surgery
Bariatric surgery
Urological surgery
Head and neck surgery
Thyroid and endocrine surgery</td></tr>
<tr><td>Request assurance from Essex LAT that specialist providers are publishing their data.</td></tr>
<tr><td>Use real-time patient and carer feedback. This will start with the “Friends and Family Test”</td><td colspan="2">Work with ECC and providers to ensure the capture of real time patient and carer feedback.
Ensure CHUFT continue active use of Friends and Family test and acts on feedback
Align our communications and engagement strategy with Essex Health and Wellbeing Board and ECC.
Develop our relationship with Essex Healthwatch
Continue to nurture and develop NE Essex Health Forum Committee and enable them to take a leading role in the engagement of the local population.
work with our LA colleagues to develop local metrics for evaluating the social and economic return on our collective investment.
continue to explore all opportunities to use technology and alternative ways of supporting our population to manage their care.</td></tr>
<tr><td>Improve data collection and use</td><td colspan="2">Work with commissioning and provider colleagues to:-
integrate information systems, with NHS number as primary identifier
ensure high quality data including core set of clinical data
develop and implement a strategy on data by 30th September 2013.</td></tr>
<tr><td>Improve quality of care, safety and patient experience</td><td colspan="2">Ensure recommendations of Francis and Winterbourne Reports are implemented
Work with ECC to reduce number of hospital placements for people with learning disabilities & autism.
Work with ECC and providers to ensure that Compassion in Practice is implemented – Care, compassion, competence, communication, courage and commitment</td></tr>
</table>

Essex Joint Health and Wellbeing Strategy

Essex Health and Wellbeing Strategy	NEE CCG and ECC affirm their commitment to the Essex Health and Wellbeing Strategy with the 3 priorities of: • Starting and developing well – every child has the best start in life. • Living and working well – residents make better lifestyle choices and have the opportunities needed to enjoy a healthy life. • Ageing well – older people remain as independent for as long as possible.	• promote a shift from acute services to the prevention of ill health, to primary health care, and to community-based provision; • support investment in early intervention and the prevention of risks to health and wellbeing to deliver long-term improvements in overall health and wellbeing; • support individuals in exercising personal choice and control, and influence over the commissioning of relevant services; • enable local communities to influence and direct local priorities for better health and wellbeing strengthening their resilience and using community assets to reduce demand; • promote integration across the health and social care systems to ensure that services are planned and commissioned in an integrated way where it is beneficial to do so; • ensure resources are allocated consistent with the needs within and between the communities in Essex; and • support individuals in making informed lifestyle choices and promoting the importance of individuals taking responsibility for their own health and wellbeing.

The Francis Report	Robert Francis, QC, was appointed by the Secretary of State to chair a public enquiry into the serious failings at the Mid Staffordshire NHS Foundation Trust. The full Report and an executive summary can be found on the Department of Health website. 290 recommendations with the following common themes:- A culture of compassion and putting the patient, their families and carers first A culture of openness, transparency and candour Sign up to a set of standards with zero tolerance of non-compliance Individual and organisational responsibility Improved recruitment and training Need to listen to patients Spot and act on early warning signs	• learn the lessons from the Report • continue to hold sessions for Board, staff and member practices on the issues • Our NEE CCG constitution has been reviewed following the publication of the report to ensure that relevant recommendations are incorporated • implement action plan we have drawn up, both as a corporate body and as a commissioner • review and adapt our organisational development plan to ensure that the clear messages around organisational culture are incorporated within the plan.

The Winterbourne View Recommendations	Abuse at Winterbourne View, a private hospital in Gloucestershire for people with learning disabilities and challenging behaviours, was exposed in a BBC Panorama programme. The abuse was criminal and management allowed a culture of abuse to flourish. Key recommendations:- Commission the right model of care, focusing on individual needs Commission flexible, community based services Listen to people and their families Spot and act on early warning signs Only local action can guarantee good practice, stop abuse and transform local services. Minimise number of people requiring hospital admission due to lack of early support Plan for transition from children to adult services to avoid crisis.	The following action points form part of the delivery plan for services for people with learning disabilities (see pXX) Implement Winterbourne and DH requirements including local registers and person centred support/move on plans for everyone in health funded in-patient services. Implement integrated model of care, joint commissioning and procurement including pooled budget Introduce a single birth to 25 years assessment process and individual birth to 25 years Education, Health and Care Plans through the Children and Families Bill.

Essex County Council Priorities

Responsibilities of Adult Social Care

What is Adult Social Care?

Adult social care can be defined as:

"The care and support provided by local social services authorities pursuant to their responsibilities towards adults who need extra support. (Law Commission 2011)"

This definition includes older people, people with learning disabilities, physically disabled people, people with mental health problems, drug and alcohol misusers and carers. Provision also covers people with sensory impairment.

What is the legal basis Adult Social Care?

Adult social care is a statutory system based on legislation that covers England and Wales. The key pieces of legislation are

- NHS and Community Care Act 1990 – Duty to Assess people who appear be in need of social care (Section 47), and to meet their eligible unmet needs.
- National Assistance Act 1948, – Provision of residential care under (Part 3), but this also covers persons who may be considered to be vulnerable, where social care may have to provide housing. Individuals do not have to be in receipt of social care services to be classed as vulnerable
- Mental Health Act 1983 – Leaving and Aftercare (Section 117 – support must be provided free of charge to individuals who have been compulsorily admitted to hospital under the act, until discharged by psychiatrist)
- Health and Social Services Adjudication Act1983 – Section 17 allows local authorities to charge for the provision of social care services to adults, subject to their ability to pay.

Eligibility for on-going social care services is set by each local authority in line with nation guidance set out in "Prioritising Need" (Department of Health 2010). Essex County Council currently offer support to people whose needs have been assessed as either substantial or critical.

Major reform of legislation is pending following publication of Caring for our Future White Paper (HMG 2012) with a draft Bill expected to be subjected to pre-legislative scrutiny in the autumn ahead of formal introduction to Parliament in 2014. This legislation will, if passed, embed the personalisation approach to the delivery of social care underpinned by cash payments in the form of personal budget. The legislation will stress prevention and integration with health.

DEVELOPMENT OF INTEGRATED COMMISSIONING

North East Essex Clinical Commissioning Group (NEE CCG) and Essex County Council (ECC) are committed to developing an integrated approach to commissioning services and see this as one of the key enablers for delivery of the strategic objectives of both organisations. This will also build on the Whole Essex Community Budgets work to meet the demographic pressures and requirements for financial savings together.

It is therefore the intention of the North East Essex system to co-locate commissioning capability and resources to fully support the implementation of integrated commissioning, with the ultimate aim that by commissioning in an integrated way this will encourage and enable integrated provision.

North East Essex CCG is looking to sign a memorandum of understanding with ECC to clearly define the roles and responsibilities of both organisations.

In preparation for future joint procurements, the CCG and ECC are drawing up a contestability plan, highlighting where contracts could be aligned, supported by a programme plan.

DEVELOPMENT OF THE CCG

The CCG's Organisational Development Plan is a live document which will be regularly updated to take account of emerging development needs. The CCG will continue to use external assessors to take an objective view of the CCG's development as a corporate body.

ECC DEVELOPMENT PLAN – – due April 2013

DEVELOPMENT OF PROVIDER LANDSCAPE

Voluntary sector development Strategy -

Summary

The aim of this strategy is to raise health outcomes by NEE CCG recognising that as health commissioners we need to work with our current providers and develop potential providers for the future. Then we need a plan. This plan is specific to Voluntary Sector Organisations (VSO) and addresses the following:

Aims

The strategy will focus on

- There needs to be more clarity about how the voluntary sector can influence decision making and help identify gaps in services;
- Communication between NHS and the Voluntary Sector needs to improve;
- Commissioners need to understand what service the voluntary sector can offer or what organisations exist;
- The new Health and Social Care Act 2012 puts greater emphasis on commissioners being patient centred. The voluntary sector are well placed to help understand the needs of different patient groups;
- Innovation is recognised as a means to delivery more effective services. The voluntary sector are very well placed;
- The Voluntary Sector has a place on the North East Essex Health Forum Committee. One outcome of this forum is to work with commissioners in helping them understand how improvements can be made within the health system;
- The CVS are involved with the CCG's integrated plan;

Strategy

We will achieve this by:

- **Gap analysis:** On an on-going basis gap analysis will be undertaken to help understand the gaps in the VSO's understanding of how to participate in the commissioning process
- **Training and awareness:** The Voluntary Sector is given access to training and development opportunities. These will be focused towards the needs of where gaps exist;
- **Communication:** Clear ways for the CCG and VSO to communicate with one another need to be built. Communication will take many forms and will include the VSO's helping identifying need or gaps in services, commissioning opportunities and feedback on how we can improve our partnerships;
- **Innovation:** Health commissioners and the VSO's can work together and find new ways of commissioning services that are innovative and different. The voluntary sector is in a prime position to take on this challenge where we should nurture new ideas;
- **Partnership:** The CCG will engage with the voluntary sector earlier on and seek active relationships with the sector;

- **Outcomes and added Value**: A culture change for the voluntary sector is needed to prepare them for bidding for commissioned services with outcomes and added value. The CCG and CVS will help VSO understand what they need to do to understand these. This may include evidencing outcomes, understanding need and demonstrate added value through a range of different tools;
- **Promoting the voluntary sector:** The CCG and CVS will continue to create opportunities of how current and future services available via the voluntary sector can be promoted to service users and other health professionals.

PRIMARY CARE AND PUBLIC HEALTH PLANS – TO BE ADDED INCL PLANS ON A PAGE AS APPENDICES

Sustainability

Sustainability means meeting the needs of the present without compromising the ability of future generations to meet their own needs and this needs to become part of the everyday working of the health service.

NHS North East Essex Clinical Commissioning Group is committed to tackling sustainability in the widest possible terms. We recognise that the NHS cannot be economically sustainable without considering social and environmental sustainability at the same time. We will work with all our partners to commission sustainable healthcare and help ensure that the people of North East Essex receive the highest quality services both now and into the future.

In addition to our responsibilities as a commissioner, we also have duties as a corporate body and we will work closely with our staff and members practices to use resources wisely and minimise waste in our day to day work.

The CCG is finalising a Sustainable Development Management Plan which includes an action plan based on the outcomes of the Good Corporate Citizenship assessment. The CCG plays an active role in the regional Sustainable Development Leadership Network.

In 2013/14 the CCG will continue to focus on making the organisation adaptable and resilient to environmental changes and will work with its partners and providers to ensure that the services commissioned are sustainable and contribute to the wider NHS targets around carbon reduction in England. This will include using the Asset Based Community Development (ABCD) approach, which draws on existing strengths and skills in the local community to ensure a sustainable future.

EQUALITY AND DIVERSITY

The CCG is committed to commissioning inclusive services which meet the needs of our community and ensuring that everyone has equal access to those services.

As mentioned in section 3.7, the CCG will seek views of community groups, in particular those which represent people with protected characteristics, and ask them to measure CCG progress against the previously published equality objectives.

The community groups will then be asked to assess whether the CCG needs to be set new and / or extended objectives. The CCG will then publish these and will also review its Equality and Diversity Strategy and ensure that it is fit for purpose.

Research

In line with the NHS Constitution, the CCG will implement from 1 April 2013:

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

Being a "research active" CCG includes:

- Making a commitment to the NHS Constitution requirements that patients are expected to be made aware not only about traditional treatments services but also opportunities for taking part in research.
- The need to promote research through *inter alia*:
    - Linking CCG website to NIHR CRN portfolio research website, which lists all portfolio studies eligible for support in NHS;
    - Working with E&H CLRN to promote research via display screens in waiting areas etc;
    - Working with NEE Health Forum to promote research;
    - Working with the NCB to promote primary care research and cascade information, e.g. on Research Incentive Support Scheme, to practices.
- Sharing membership of CLRN Board between the three North Essex CCGs.
- Encouraging participation in Primary care research projects and Local Specialty Groups funded by the E&H CLRN. These groups consider local feasibility matters for studies to proceed locally.

Research Governance activity includes:

- Ensuring through contracting that Providers have in place arrangements for Research Governance and issuing NHS Permission for Research.
- Ensuring CSU Medicines Management support for the Designated Signatory role for covering excess treatment costs of NIHR Portfolio research undertaken by Providers.

Implementing Evidence-Based Commissioning includes:

- Committing to ensuring best value in commissioning and promoting best use of public resources through using published evidence in commissioning, as per the NHS Constitution.
- Ensuring through its MOU with Public Health and contract with CSU that appropriate support for evidence-based commissioning and innovation is in place.
- Working with CLRN and other stakeholders to identify which Academic Health Sciences Network/s (AHSNs) it wishes to work with to promote best practice and innovation. AHSNs are intended by DH to be local partnerships between the NHS, academia and industry to lead and support innovation and improvement, and every NHS organisation is encouraged to affiliate to its local Network. Local AHSNs are Eastern AHSN and UCL Partners AHSN.

SECTION 7

NEE CCG MEDIUM TERM FINANCIAL PLAN incorporating ECC financial position

Financial Strategy

The Challenge

The future economic climate is uncertain and as such the growth assumptions in the 3 year medium term financial plan have been made at 2.5% in line with inflation. This does not therefore allow for an increase in demand for services. As a consequence, major development opportunities that require recurrent funding will only be affordable if new areas of savings are delivered from within existing budgets. Such savings will need to arise predominantly as a result of revised clinical pathways that are cost effective, safe and more appropriately delivering care closer to home.

Local government faces central government funding reductions of nearly 30% over the 4 year period to 2015 and further reductions are expected in the next Comprehensive Spending Review. As a result of this reduction in funding, ECC is forecast to shrink from being a £930M organisation in 2012/13 to an £850M one by 2016/17 (excluding new responsibilities and funding arrangements around Public Health and Learning Disability Grant). The gap between available budget and demand for ECC services is forecast to be £200M by 2016/17.
Over the last 4 years Essex County Council has embarked on an ambitious transformation programme and achieved savings of £300M per annum by 2013. This is one of the largest savings targets of any local authority in the country.

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

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

In order to deliver efficiencies of £200M per annum by 2016/17 the County Council has agreed a Transformation Mark II programme. The programme will continue the council's transformation into a commissioning-led council, separating explicitly strategy and commissioning from operations.
In re-structuring the council, the statutory roles of the Director for Children's Services (DCS) and Director for Adults Social Services (DASS) have been combined. The combined post-holder of DCS and DASS is the principal Commissioner for People Services.
ECC recognises that it is imperative to work with its health partners and build on the Whole Essex Community Budgets work to date, to address the common issues we face.

In the context of increasing uncertainty and risk, our ability as a CCG to develop and deliver sustainable QIPP is crucial. Clearly this task becomes more challenging as we continue to deliver significant change across our commissioning portfolio where opportunities potentially reduce or become more complex to achieve, especially considering significant QIPP achievement over previous years. We therefore need to work innovatively and in collaboration with commissioning partners and primary care clinicians to increase our scope for driving change, focusing on the medium to long-term.

The level of savings needed over the coming years will require radical, large scale changes that involve whole system re-design led by clinicians. In order to achieve this, the CCG will have to work closely with its partner organisations and stakeholders to ensure that solutions delivered are of benefit to the whole economy.

It is also essential for the CCG to look beyond its own system and collaborate with other CCGs to secure economies and the benefit of working together on joint commissioning arrangements.

Across the North East Essex system the challenge to both commissioners and providers of health and social care is significant. The estimated challenge for 2013/14 alone is as follows:

CCG	£9.0m
Essex County Council	£5.6m
CHUFT	£7.0m
ACE	£1.6m
NEPFT	£4.0m
Total System Savings	**£27.2m**

Whilst it is recognised that the coming years will present significant financial challenges for the CCG and local system in which it operates, remaining in financial balance is essential. The CCG must ensure that it is able to make sound financial investments and that it only commissions services that are high quality, safe and cost effective. Commissioning decisions and the investment required must be sustainable to improve health outcomes needed both now and in the future.

The CCG will ensure that all resources are utilised to gain optimal benefit to its population and where this cannot be evidenced the CCG will decommission services and re-direct resources to where they can gain most benefit.

The CCG will achieve this by:

- Rigorous financial management and predictive modelling to allow the CCG to flex its resources and shift funding
- Rigorous contract management to ensure optimal outcomes for value for money investment
- Benchmarking analysis to identify where the CCG currently invests or incurs costs disproportionately to its peers
- Innovative commissioning to ensure appropriate levers and incentives in place to gain best quality, productivity and value for money
- Effective working with all service providers
- Decommission interventions and services which fail to produce effective outcomes.

The CCG QIPP target required to balance the financial position across the 3 year period of this plan is £36m (£9m in 2013/14, £14m in 2014/15 and £13m in 2015/16).
Work on identifying savings for 2014/15 and beyond is already underway and savings will be delivered by focusing on the 3 ‘bundles of care’ contracts.

For 2013/14 the CCG remains focused on the current year QIPP challenge of £9m. Executive leads have been appointed to all of the areas identified for QIPP delivery. A summary of our QIPP plan is provided below.

Programme Board	Project	Opportunity 13/14	Opportunity 14/15
Planned Care	Neurology - Community Epilepsy Nurse	27,000	0
	Gynae GPsWI Service	40,000	0
	Ophthalmology - Community Glaucoma Pathway	251,000	0
	Community Endoscopy	50,000	0
	Audiology	100,000	0
	Pathology	400,000	1,000,000
	Urology	25,000	0
	Community beds	700,000	0
	Minor surgery	54,000	0
	Continuing healthcare	300,000	0
	MSK - (Physio/spinal) fye of 12/13	53,000	0
		2,000,000	1,000,000
Urgent Care	Ambulance contract	430,000	300,000
	Urgent Care Bundle (including 111)	0	2,000,000
		430,000	2,300,000
Primary Care	Focus on Practice	500,000	200,000
	Health & Well Being Bundle	0	500,000
		500,000	700,000
End of Life	End of Life Bundle	0	500,000
		0	500,000
Long Term Conditions	IPH Diabetes	0	100,000
		0	100,000
Medicines Management	Prescribing and other medicines management	2,000,000	1,200,000
		2,000,000	2,000,000
Mental Health	Contract QIPP	541,000	800,000
	Support the Junction	59,000	0
		600,000	800,000
Other	Estates rationalisation	200,000	600,000
	Transformation schemes	2,500,000	4,000,000
	Integrated commissioning	500,000	750,000
	Budget reviews	270,000	250,000
	Unidentified	0	1,000,000
		3,470,000	6,600,000
	TOTALS	**9,000,000**	**14,000,000**

Financial Planning

Allocations and Planning Assumptions

The resource assumptions used in this MTFP are those issued by the National Commissioning Board in 'Everyone Counts' which was published in December 2012. Overall in the NHS annual uplifts have reduced in recent years, after years of substantial growth. Public sector finances will continue to be adversely affected as the Government seeks to balance the UK economy. Revenue uplift assumptions used in planning are as follows:

Growth Uplifts Year	% Annual uplift
2013/14	2.25%
2014/15	2.5%
2015/16	2.5%

The DH Operating Framework 2011/12 established the requirement for PCTs to identify 2% recurrent funding to be invested non-recurrently. This requirement has continued for CCGs. Planning requirements issued by the National Commissioning Board state that each CCG should plan to deliver a 1% surplus in 2013/14. Where required, half of the 2% transformation fund can be used for this purpose. North East Essex CCG has already achieved the 1% surplus target through its brought forward surplus of £18.5m. It therefore is able to utilise the 2% transformation fund (non-recurrently) in full during 2013/14.

2013/14 Budgets

The CCG's recurrent baseline allocation for 2013/14 is £388.790m. This is after a deduction of £19m for changes in services that will now be commissioned by Specialist Commissioning. In addition to this the CCG has received an allocation of £7.94m for running costs. The CCG has a contingency reserve of circa 1% (£4m) available to help manage movements in expenditure during the year. It also has £1.5m headroom reserve available to mitigate any slippage on savings plans.

A review of all expenditure areas and forecast outturns has been carried out to identify any recurrent cost pressures or surpluses within the baseline budgets and the budgets have been adjusted accordingly. Baseline budgets have also been amended to reflect the transfer of additional services to Specialist Commissioning (NCB) and public health services to the Local Authority and NCB. In addition the following main assumptions have been applied:

- Inflation and Reduction on Tariff – the net price adjustment used for acute contracts is -1.1/-1.3%. This is made up of 2.7% inflation, less 4% provider efficiency, plus 0.2% tariff price increase.
- MH/LD/Ambulance/Community contract net price adjustment of -1.3%.
- An inflation uplift of 5% has been used for prescribing budgets.
- Population increase – The latest ONS data for the PCT was used (1.6% increase) and applied to the appropriate budgets.
- Technology and drugs – 3% of all prescribing and High Cost Drugs costs have been included in the main contract funding envelope for new technology and drugs.
- Residual growth ie increases in demand on services that is disease/prevalence driven rather than population driven has been applied to the acute contracts at a rate of 1.6%.

The table below provides a summary of the proposed budgets for the 3 year medium term of 2013/14 to 2015/16.

Summary 13/14 - 15-16 Budget Model

GP COMMISSIONING	2013-14 £ Budget £'000	2014-15 £ Budget £'000	2015-16 £ Budget £'000
Colchester University Hospital	166,343	170,463	174,662
Mid Essex	5,802	5,968	6,132
Addenbrookes	1,611	1,672	1,732
Barts	3,272	3,377	3,481
Barking & Havering	938	965	991
Ipswich Hospital	2,500	2,571	2,642
Other Acute NHS Contracts	3,457	3,545	3,633
Ramsay Healthcare	6,408	6,596	6,782
Other Acute Non NHS Contracts	757	870	985
Non Contracted Activity	4,290	4,309	4,327
Ambulance & Other Patient Transport	12,551	12,085	11,626
Mental Health (Including IAPT)	39,120	39,118	39,118
Learning Disabilities	6,787	6,708	6,630
Community Services Provider Contracts	31,063	31,175	31,286
GP Contracts	5,249	5,301	5,354
Continuing/Funded Nursing Care	14,690	15,153	15,632
Other Commissioning	4,373	4,488	4,608
Out of Hours Contracts	3,283	3,315	3,315
GP Prescribing	54,715	56,666	58,764
Non Tariff High Cost Drugs	2,421	2,428	2,434
Other Prescribing	3,057	3,133	3,212
Healthcare Premises	2,214	2,340	2,474
GP Commissioning Management Costs	7,949	7,958	7,967
CCG Planned Underspend	15,219	15,219	15,219
CCG Committed Reserves	10,603	20,931	33,501
CCG Contingency Reserves	(176)	(10,811)	(20,573)
CCG 2% Transformation	7,776	8,134	8,337
TOTAL CCG	416,270	423,677	434,269

North East Essex CCG 13/14 QIPP Planning at Summary Level

2% Process

The CCG has set aside 2% of its recurrent allocated resource limit to invest non recurrently in transformation. Funding is utilised to deliver transformation within the health economy eg CCG, providers and the voluntary sector. The funding is used for start up/pump priming and investments in transforming how services are delivered to benefit patients, improve quality, deliver savings and to integrate services across the economy. The CCG plans to utilise the 2% transformation funds to work towards delivering the priorities set out in the integrated plan. Presentations and meetings have been held with providers across the patch to share with them the principles and expectations for use of these funds. We are encouraging joint working and collaborative bids. The total value available for non-recurrent investment is £7.776m.

Re-admissions

The schemes that were funded in 12/13 which utilised the re-admissions funds are being de-commissioned as at 31st March 2013. The CCG has agreed to work directly with CHUFT and to use the outcomes of the recent re-admissions audit to identify the services that are required in order to help further reduce re-admissions. This work will be undertaken during February/March.

Re-ablement

The CCG has set aside its share of the national £300m funding. This equates to £1.950m. Of this sum 50% will go to ECC via S256 in support of the jointly commissioned and funded reablement service. The balance will be utilised to support our out of hospital strategy which incorporates reablement, end of life and admissions avoidance.

Risk sharing/pooling

The CCG currently risk shares on contracts such as Mental Health. Through its collaborative working arrangements with other CCGs in North Essex the CCGs will be identifying other areas of expenditure that may be beneficial to a risk share agreement. The CCG is also working with ECC as part of Whole Community Budgets projects and will be identifying areas where we can integrate commissioning, pool budgets and risk share in the future.

Running Costs

The CCG now has a separate allocation for running costs within which it must remain. The running cost allocation is based on £25 per head of registered population and for 2013/14 is £7.940m. .
The current split of running costs is as follows:

CCG staff - £3.279m
CSU costs - £2.556m
Estates £0.892m
Other non pay - £1.213m
Total £7.940m

Investment

For the CCG to deliver the strategic objectives and priorities set out in its Integrated Plan it needs to make investment into initiatives that are deemed a priority as well as invest in areas outlined within the national commissioning board 'Everyone Counts' framework. The table below outlines the investments planned for 2013/14.

2013/14 Investments	2013-14
Recurrent Investments Required in 2013/14	**£'000**
Autism services	100
Triple One (111)	980
Support for carers	50
Bone Health Assessments	55
Re-ablement	975
RAID	500
Unidentified drugs and devices	800
Telehealth	100
Other Investments	200
Total Commitments	**3,760**

Opportunities

The CCG sees the work on developing and commissioning bundles of care for groups of the population as a major opportunity for delivering cost effective and safe healthcare with improved patient experience. The recent work with the integrated plan carried out in collaboration with ECC paves the way for looking at opportunities for integrated commissioning of both health and social care services in the future.

Key Capital Schemes

The key capital scheme other than general backlog maintenance will be reconfiguration of the top floor of the primary care centre in order for it to be utilised as clinical space. An estimate of £500k has been put in at this stage however this will require review by NHS Property Services who will be managing the NHS estate going forwards.

There is also potential for reconfiguration of community beds which could require capital funding however this is at the early/scoping phase with no firm decision or commitment expected until part way through the financial year 2013/14.

The work towards commissioning bundles of care for groups of the North East Essex population may require reconfiguration of the current estates footprint. An estates plan and associated capital funding will be developed as part of this work.

SECTION 8

PROCUREMENT AND CONTESTABILITY PLAN

North East Essex CCG's approach to procurement and contestability is to operate within legal and policy frameworks and to use procurement as one of the system management tools available to strengthen commissioning outcomes.

We will work with our commissioning partners to deliver an effective commissioning and contestability practice which engages well with all stakeholders. With the overall aim that:

- Patients experience the NHS and associated social care services as a joined-up personalised service in which they can exercise choice, rather than a disconnected set of services which they are required to navigate.
- Patients and service providers are treated fairly with dignity and the respect due to them at all times
- Clinical and decision making and care delivery is in line with evidence-based best practices and takes account of value for money.
- The logistics of care delivery; within and across different care settings, are designed to meet patient clinical needs, whether long term or acute,, in the most effective way.

North East Essex CCG has defined their guiding principles for contestability and procurement as:

T**ransparency:** Making commissioning intent clear to the market place, including the use of sufficient and appropriate advertising of tenders, transparency in making decisions not to tender, and the declaration and separation of conflicts of interest;

Proportionality: Making procurement processes proportionate to the value, complexity and risk of the services contracted, and critically not excluding potential providers through overly bureaucratic or burdensome procedures;

Non-discrimination: Having specifications that do not favour one or more providers. Ensuring consistency of procurement rules, transparency on timescale and criteria for shortlist and award; and

Equality of treatment: Ensuring that all providers and sectors have equal opportunity to compete where appropriate; that financial and due diligence checks apply equally and are proportionate; and that pricing and payment regimes are transparent and fair.

The CCG has produced the first draft of our contestability plan which is in appendix XX, however, we are currently undertaking an exercise with our Essex County Council colleagues to align contract expiry dates to enable the most effective and efficient service development and procurement process.

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SECTION 9

NON-FINANCIAL RESOURCES - to be added

WORKFORCE – more to be added

CCG Workforce

The success of the CCG rests on its main asset – its staff – and one of the six domains of authorisation is "Great leaders who individually and collectively can make a real difference." NEE CCG has agreed a talent management strategy which uses a mapping tool to identify and develop the future leaders of the organisation. Talent management is a systematic process which allows an organisation to identify and develop future leaders and to enable all staff to reach their full potential. It is a cost effective way of developing the organisation, increasing staff satisfaction and reducing turnover and recruitment costs.

This strategy recognises that talent is diverse and exists at all levels of the organisation. It is based on a systematic and transparent process which is based on merit.

EDUCATION AND TRAINING - to be added

USE OF TECHNOLOGY

Assistive Technology (AT) has an important role to play in improving safety and quality of life for people, especially those with long term conditions. It is an 'enabler' to achieving a range of high level ambitions for both Health & Social Care which will be integral to the delivery of this plan:-

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

SECTION 10

ENGAGEMENT

The CCG and ECC will develop a joint approach to engagement where appropriate, but will use existing networks and outreach methods rather than creating new mechanisms. The approach is based on the following principles:-

- All user engagement activity must add value to the commissioning process – in a way which can be clearly evidenced
- All commissioning decisions will be informed by user engagement
- Service users continue to have a right to 'reasonable adjustments' in how they are engaged with, using their preferred model of communication wherever possible
- Our intention is to work with a wide range of service users, with focused pieces of engagement to support every stage of the commissioning cycle. This means engaging with current users, potential users, and carers, as well as working alongside North East Essex Health Forum and Essex HealthWatch.
- Commissioners should be flexible in how they engage

North East Essex Health Forum is aiming to increase its membership in 2013/14 and attract a wider range of members. It will be developing its own strategy and workplan which will include building on the work already undertaken on choice and communications. The CCG will organise job shadowing opportunities for members of the Forum Committee so that they can spend time with commissioning colleagues and learn more about how the CCG works

Practice Forums

During 2013/14 North East Essex CCG will continue to support the further development of these forums. The practices have indicated that they would like to consider actively managing these forums in future, rather than the CCG, which we are currently exploring with them. The CCG has actively encouraged the forums to consider how they could use the transformation fund to facilitate practices working together and with other organisations to provide services to patients in the most efficient way.

Patient Participation Groups (PPGs)

The CCG will work with the NE Essex Health Forum to help develop PPGs so that they can become part of the commissioning process.

To be added –

- System engagement
- System partnership network
- CLRN – Comprehensive Local research Network
- Academic Health Science Networks
- Development of user groups
- Using a community development worker to engage better with minority groups

SECTION 11

RISK MANAGEMENT

The Risk management strategy will follow the theme of the alignment and joint commissioning between ECC and the CCG by which risks that originate from each organisation are recognised, managed and mitigated together with those new risks specific to joint working.

High level risk summary

See the table below, an extract from the Integrated Plan Risk Log, for a list of the 10 highest ranked risks assessed to date.

In summary the major risks relate to the following themes;

- Specification of the Bundles
- Contracts to procure bundled services
- Engagement with ECC for joint commissioning
- Governance arrangements with ECC and of bundled services
- Litigation/Reputation should the bundle approach fail
- Capacity/resources around ECC working jointly with all Essex CCGs
- Financial risks

Table xx Extract from the Integrated Plan Risk Log

Basic Assessment Information				Initial Risk Rating		
Category	Sub category	Risk if Hazard Realised (Auto cal	Reason / Objective to Manage Risk	Impact (Select 1- 5)	Likelihood (Select 1 - 5)	Initial Risk Rating (Auto Calc)
Operational	Specifications	Serious	Risk that the Specifications for Bundles are too complicated, and expectations too high, and cannot be met.	5	4	20
Corporate	Contract	Serious	Not having the appropriate levers within the NHS National Contract to manage the Bundle type of contract or service operationaly	4	4	16
Corporate	Engagement	Serious	There is a risk that the core governance Cultural differences of member organisations either prevents achieving strategic goals or slows progress. May mean that key objectives are not delivered to the population.	4	4	16
Strategic	Governance	Serious	Bundled Services contract becomes too complicated to implement and manage effectively.	4	4	16
Governance	Litigation/ Reputational	Serious	Risk that a Single provider fails	5	3	15
Corporate	Operational	Serious	Risk of Unexpected Consequences from the bundle approach and/or joint commissioning.	3	5	15
Strategic	Capacity	High	Risk that ECC will not have the capacity to work collaboratively across Essex with multiple CCGs operating different models to different objectives and priorities	4	3	12
Corporate	Financial	High	There is a risk of Cost creep in the contract through variations resulting from unclear specifications.	4	3	12
Corporate	Governance	High	Multiple providers model creates unbalanced contractual arrangements	4	3	12
Corporate	Governance	High	Ownership of Bundled contract is unclear and results in confusion, lack of accountability.	4	3	12

APPENDICES –TO BE ADDED


Appendix - assisitive technology.docx


Appendix - ECC children and families c

App XX

Joint Strategic Needs Assessment

The process for producing the Essex JSNA will include -

Joint Health & Wellbeing Board - From April 2013, local authorities and CCGs will have equal and explicit obligations to prepare a JSNA, and this duty will have to be discharged by the Health and Wellbeing Board.

Health and Wellbeing Business Management Group - It is proposed that arrangements for setting the direction of travel for the JSNA and steering the associated analytical work programme should rest ultimately with the Health & Wellbeing Business Management Group.

Joint Strategic Needs Assessment Planning Group - It is also proposed that a new JSNA Planning Group be formed. This new group will be an amalgamation of the previous JSNA steering group, data group and ECC's public engagement and commissioning intelligence steering groups. The role of the JSNA Planning Group would be to:

- Recommend to the Health & Wellbeing BMG which topics should go in the work programme and which organisations will lead on them.
- Develop ideas for new JSNA products to take to the Health and Wellbeing BMG.
- Have a *hands-on role in* determining which projects are feasible, and specifying and quality assuring them
- Have an expert role in shaping and overseeing the demand modelling programme under community budgets.

Other Partners - In preparing the JSNA, there is a requirement to involve people living or working in the area, as well as the local Healthwatch, district/borough/city councils and the community and voluntary sector. Others, such as professional from outside the area or organisations, may also be involved in or invited to contribute to its development as is considered appropriate.

Initial JSNA & JHWS workplan

Members of the proposed JSNA Planning Group are currently scoping or already doing JSNA special topic reports on:

- Autism
- Carers
- Social isolation and loneliness of older people
- CAMHS Impact of the built environment on the demand for health and social care

There also needs to be a continuous process of reviewing voice/public engagement data so that it can be combined with factual data in ways that integrate the analysis, particularly working closely with Healthwatch.

Appendices

1. Process for producing the Essex JSNA
2. Public Health Plan on a Page

3. LAT's plans for primary care services
4. Draft County-wide framework for Older People joint Commissioning
5. ECC Schools Children and Families commissioning priorities
6. Primary Care Plan
7. Contestability Plan