Mid Essex Clinical Commissioning Group

OPERATIONAL PLAN 2014-16

VERSION 3

DRAFT IN DEVELOPMENT – SUBJECT TO BOARD APPROVAL

Version Control

Version Number	Date Approved	Author	Brief Description
2.3	14 February, 2014	Mid Essex CCG	Multiple changes including, C. Rassell, D. Davey, J. Bullion, A. Mitchell-Baker, R. Hearn, M. Crass, J. West, P. Wilkinson
2.3.1	28 February, 2014	Mid Essex CCG	Update Medicine Optimisation – P. Wilkinson Update Mental Health – M. Crass & J. West
2.3.2	9 March, 2014	Mid Essex CCG	Update Integrated Commissioning – J. Bullion
2.3.3	10 March, 2014	Mid Essex CCG	Update Quality – R. Hearn
2.3.4	11 March, 2014	Mid Essex CCG	Insert Outcomes of Colchester Cancer Review 4.7.1 – Sian Brand Inserted updated version of Building Strategy around phases of life diagram Insert Section on Maldon Service Development 4.6 Insert section on GP Access to IT 5.3
2.4	12 March, 2014	Tricordant	Format document based on text of v2.3.4 Note that page numbers and contents page are yet to be formatted
2.5	12 March, 2014	Tricordant	Page numbers and content page formatted
2.6	12 March, 2014	Tricordant	Update Public Health sections 3.1-3.3 – K. Ramkhelawon Change to MAR activity heading section 9.1
3	12 March, 2014	Tricordant	Update Starting Well, section 4.5 – M. Williamson. Final edit for submission of draft to Essex HWB.

Contents

1. Introduction

This is a draft of the key plans of the CCG and commissioning partner, ECC, for submission to Essex HWB on12/3/14. MECCG and the wider Mid Essex health and social care system faces considerable financial challenges. The draft plan has been developed at a time of organisational transition and critical short-term financial recovery and longer –term transformational planning. The final 2 year operational and 5 year strategic plans will therefore demonstrate significant developments.

Mid Essex CCG and its main acute provider, MEHT are both financially challenged. The size of the recurrent deficits in both organisations are significant and are inextricably linked. In addition Essex CC also needs to make significant financial savings. A recent sustainability review by Capita, concluded that the only chance for the CCG of reaching financial sustainability will be to look at radically reshaping services to reduce cost but maintain quality, rather than using the traditional approaches of slash and burn and/or development of small out of hospital schemes to reduce expenditure. To achieve this transformation change will not only involve time and the testing of new models of care but necessitate working hand in glove with local providers so financial sustainability can be achieved across the economy.

This plan contains the CCG's draft 5 year Plan on a Page, which is still under development, and a high level commentary on the key areas of CCG activity including those outlined in 'Everyone Counts, Planning for Patients 2014/15 to 2018/19'.

As part of the 5 year Strategic Planning process, MECCG is committed to developing a sustainable health and social care environment focussed around clinically led, evidence based services. This process will demonstrate improvement across the 5 domains and 7 key outcome measures, whilst over a period seek to achieve sustainable financial balance across the Mid Essex system.

Current work includes:

- Robust plans for the development of primary care based on the outcomes of current consultation with member practices
- Negotiation and agreement of provider contracts consistent and supportive of this ambition
- Further system planning, working closely with Essex CC, District Councils, our key providers and our vibrant local community and voluntary sector, including ensuring full local ownership, clarity around detailed scheme costs and benefits, detailed mobilisation plans and appropriate governance arrangements
- Establishing an externally supported Transformation Support Unit to drive short term financial stability whilst the longer term Sustainability Programme is developed;

- Stakeholder involvement (which has begun) to ensure full engagement and sign off of plans
- Collaborative action with local partners on improving quality, and finalising use of quality premium
- Liaison with NHSE and CCG colleagues around services where collaborative or lead commissioning arrangements are in place to ensure alignment and integration of plans
- Completing modelling and planning around activity levels, QIPP, tariff and predicted finance position
- Addressing key enablers including use of data and NHS number, and workforce
- Producing a simple and concise internal business plan outlining MECCG and partner plans underpinned by detailed SMART action plans.

From this work a single transformation programme (with identified project streams) is being developed which will enable the CCG to:

- Have a clear plan for "QIPP"/financial savings" for 2014/2015, although both sets of external advisors have already indicated that this will be limited due to savings already achieved
- Have a clear programme approach detailing how the transformation agenda can be delivered
- Have a clear trajectory over which the clinical change and financial sustainability can be achieved
- Ensure alignment of plans and effort with local providers and partners

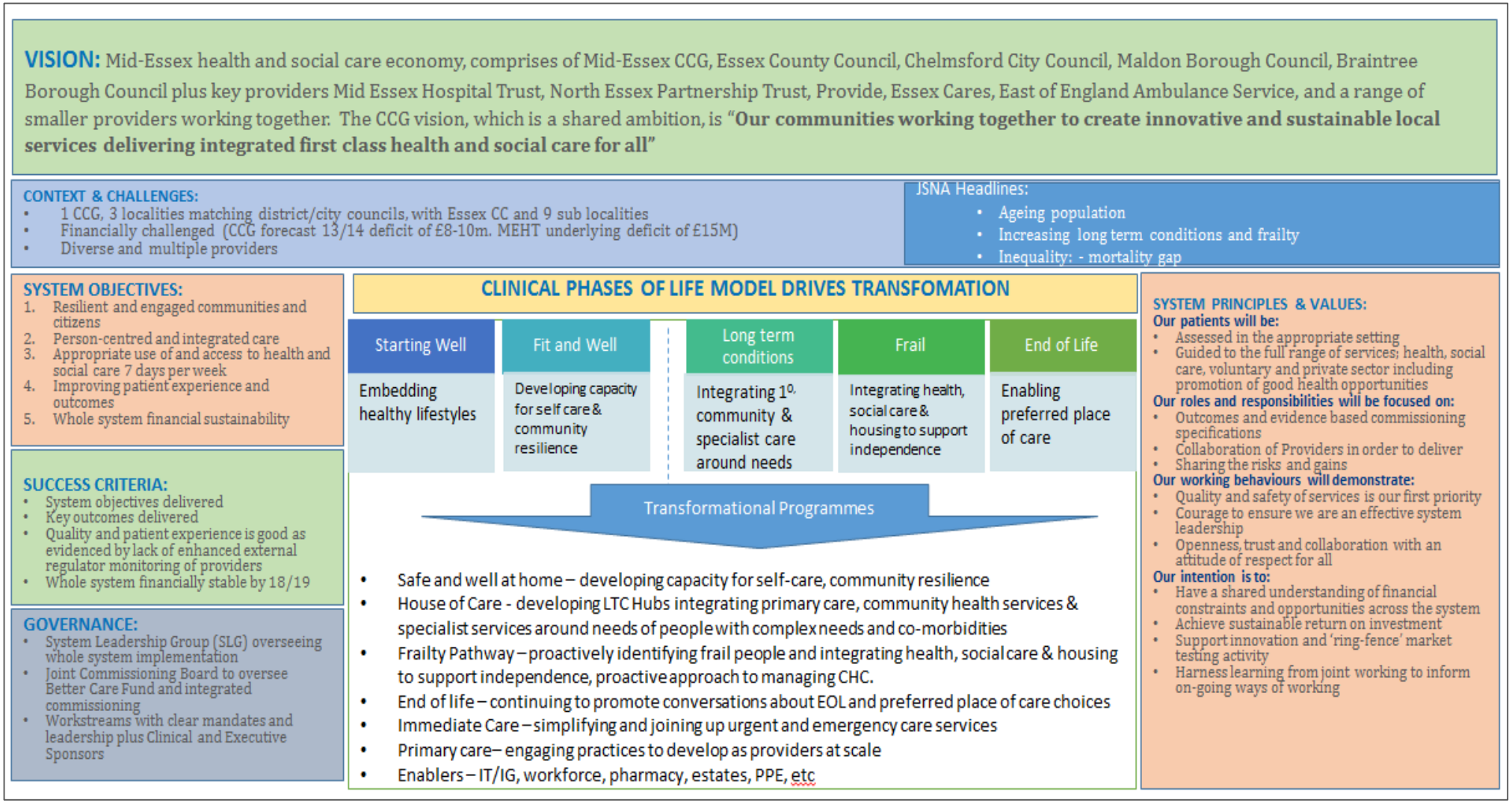
It should be noted that there is the assumption that QIPP proposals plus the transformation agenda do deliver financial sustainability over a period; if this is indeed not demonstrated by the planning then there will need to be further discussions about how this is addressed. For the CCG and partners to concentrate on the delivery of a sustainability programme, in 2014/2015 the CCG will need acceptance that financial balance will not be delivered and business rules cannot be met. Furthermore alignment with NHSE and NTDA will be required to allow the CCG transformation and financial sustainability plan, and MEHT 5 year plan to be properly aligned. Although the CCG will vigorously continue to identify and pursue QIPP opportunities, the main concentration will be on delivering 2 to 3 transformational whole system projects during 2014/2015.

These build on existing clinically led work, and are likely to be:

- Immediate care (with MEHT)
- Review of CHC assessment and procurement (with Essex County Council and CSU)
- Testing the frailty pathway (with Essex CC and all providers)

The assumption would be that they would all deliver substantial financial benefit in 2015/2016 (yet to be quantified); and that contract agreements for 14/15 will aim to provide stability to allow organisations the opportunity to start to plan and deliver sustainable change.

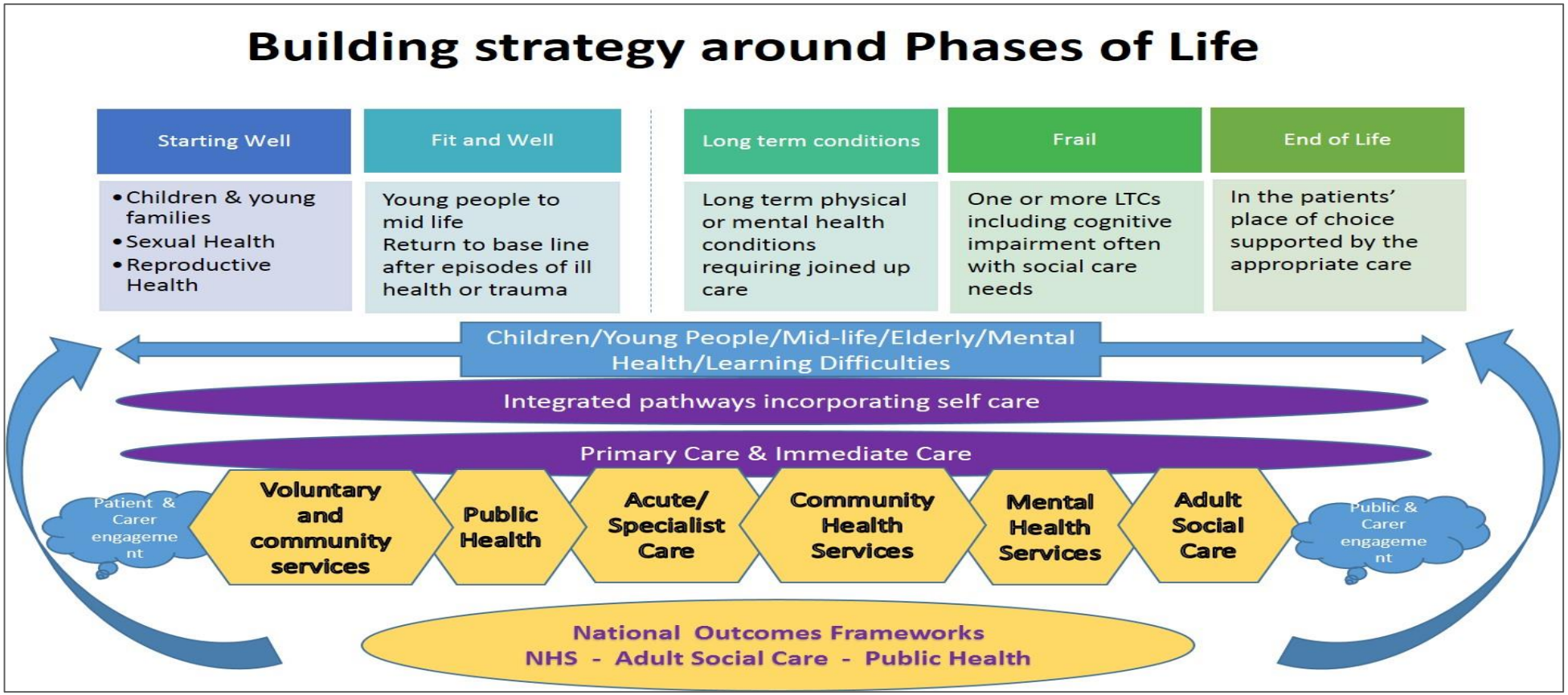
2. Plan on a Page – Mid Essex CCG 5 Year



2.1 The CCG Vision

The clinical vision for the CCG concentrates on optimal care being provided in the different "phases of life" as well seeking to reform and improve services which support this (immediate care; primary care) at less than the current cost.

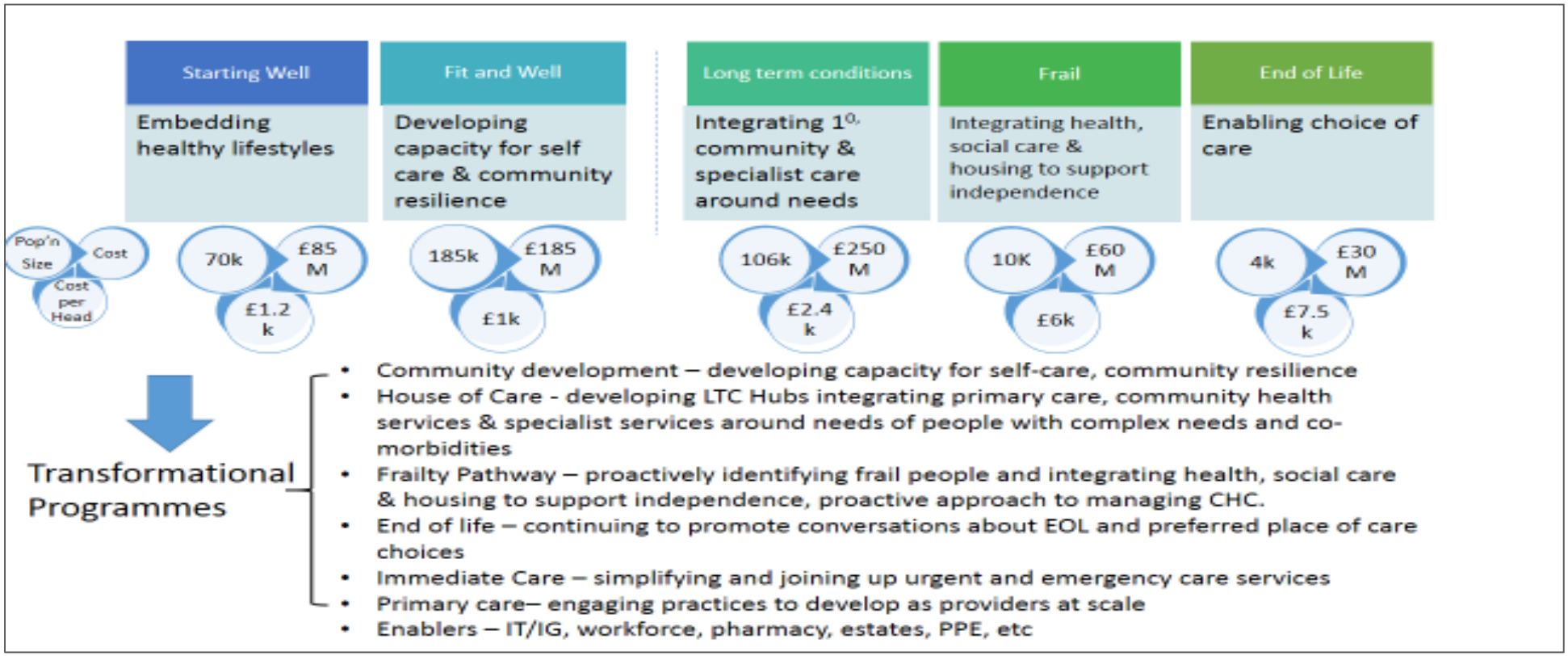
The diagram below reflects the current thinking:



2.2 Quantifying the Phases of Life

The segmentation of the population according to needs allows services to be developed through transformational programmes of work which focus on meeting those needs and thus delivering value. Work is being undertaken to quantify for each phase of life the population; cost and spend per head so that there is a baseline set prior to any service change.

Example of this below (figures are only illustrative):



We recognise that the planning timetable is challenging and the development of this 2 year plan prior to the 5 year plan being produced runs the risk of short terms measures and plans being written to satisfy a timetable rather than address the real issues. We are therefore seeking to try and get as much of the high level 5 year plan completed by the end of March to inform our final 2 year plans.

3. Outcomes

3.1 Delivery across Domains & Outcome Measures

The NHS/CCG Outcomes Framework describes the five main domains of better outcomes that the NHS and partners are expected to secure:

- A reduction in dying prematurely mortality, with an increase in life expectancy for all
- Improved quality of life for those people with long-term conditions and with mental illnesses
- Effective recovery from episodes of ill-health or following an injury
- A good patient experience in accessing all healthcare services
- A safe health service and ensure patients are protected from all avoidable harm

Our ambitions for delivery against the 5 Domains are set out below.

New interventions have been/will be informed by in-depth review of the evidence and where appropriate, well-constructed innovative approaches.

Reduction in potential years of life lost from conditions considered amenable to healthcare:

Causes considered amenable to health care are those from which premature deaths (people under 75 years) should not occur in the presence of timely and effective health care. In 2010, deaths caused from such avoidable conditions represented 24% of all deaths in England and Wales – a reduction of 25 per cent between 2001 and 2010. Some of these conditions include mortality from heart diseases, respiratory illnesses, cancers and smoking-related ill-health as well as the potential role of excluding new technology or innovation plays on quality of care.

Whilst improvements have been made in the provision of stroke care, further development is required to consistently achieve key standards, reduce overall stroke mortality and better long terms outcomes. Current performance is shown in the table below.

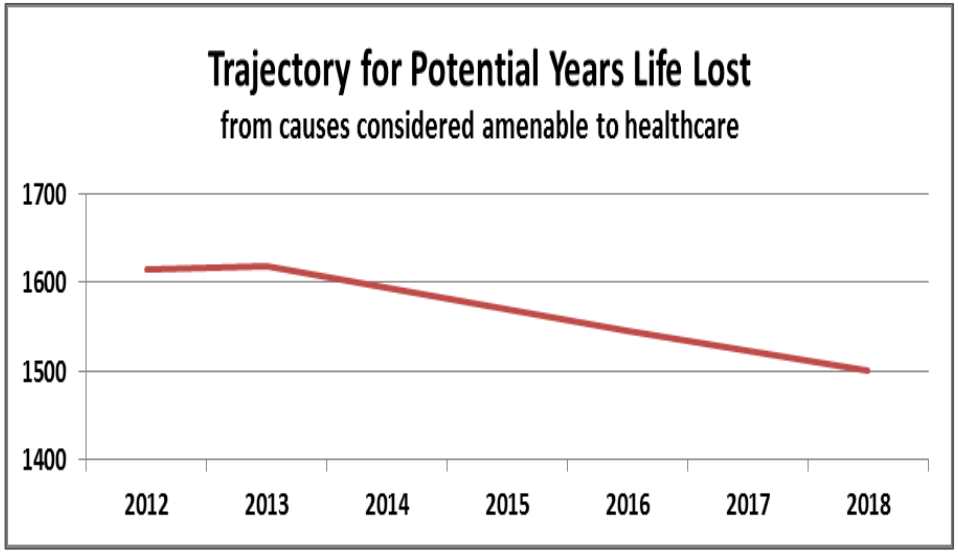
Stroke Metric	Target	Performance Q3 MEHT	Performance Q3 CCG
% non-haemorrhagic stroke patients receiving Thrombolysis within 3 hours of onset	12%	8.3%	6.4%
Proportion of people who spend at least 90% of their time on a stroke unit	80%	79.5%	81.6%
Proportion of people who have a TIA who are scanned and treated within 24 hours but not admitted	60%	73.3%	71.7%
Proportion of patients supported by a stroke skilled Early Supported Discharge team (by Acute Trust - MEHT)	40%	28.8%	34.1%
Proportion of patients admitted to an acute stroke unit within 4 hours of hospital arrival	95%	64.8%	68.8%

In Mid Essex, there is a gender difference in the potential years of life lost (PYLL) from causes considered amenable to healthcare, with a more sustained reduction amongst women. Trend analysis suggests a marginal increase of around 0.2% between 2009-2012, for all people with an overall reduction in PYLL (of 78 years) between 2011 (1,692/100,000) and 2012 (1,614/100,000). MECCG is mid-point in the best quintile in 2012 (Best CCG Surrey Downs, 1,414/100,000). There is a marked gender inequality (F=1,461; M=1,773).

Some of the key interventions that may have contributed to this reduction in PYLL include:

- An increase in the proportion of smokers, including maternal smokers, who are quitting
- Early identification and intervention in people at higher risk of CVD
- Improved uptake of screening programmes and early referral of potential cancer patients
- Better integrated provision for early supported discharge for stroke patients
- Improved advise to patients about healthier choices, including national campaigns
- Improving management of CVD to prevent secondary reoccurrence of CVD events
- Recent introduction of technological improvement

Nationally, all CCGs are expected to plan for an annual reduction of 3.2% in PYLL for their respective population. MECCG feels that having one of the lowest PYLL against all peers and under the current financial challenge that this target is inequitable and unachievable. There is also likely to be a substantial time lag between the introduction of new public health interventions and improved healthcare services and a corresponding reduction in mortality. We are therefore proposing a modest annual reduction in PYLL of 1.5%. This will equate to a reduction of 118 years in PYLL over 5 years.



Proposed plan to achieve this reduction in PYLL include:

- Targeted health messages and smoking cessation service for working-aged men, whilst continuing to improve on ante-natal smoking intervention and in most deprived areas
- Improve early detection and treatment of people at higher risk of CVD in more disadvantaged communities, with a special focus on hypertension case identification and management
- Targeted secondary prevention for CVD including cardiac rehabilitation and reviewing pathways starting with AF
- Finalise and implement new stroke services (based on Essex-wide proposed HASU model) and we will increase the provision of ESD for stroke patients (to 40%) through the BCF Work Plan
- Review of pathways for cancer care (patient transfer between providers), patient tracking through the service to tackle delays and a review of services is also in planning
- New community-led health education schemes to promote healthier lifestyles, including multi-agency development work programme on 'social mobilisation'
- Targeted mental health initiatives (such as MH case workers, health checks) to maximise prevention and improving the physical health of people with mental health conditions
- A complete review of respiratory care with a view to introduce new more cost-effective specification, implement best practice and innovative self-management scheme, and ensure annual patient reviews are undertaken
- Agreement reached with District support and led by ECC, to implement new alcohol treatment pathways
- Targeted falls prevention work in areas with high levels of falls and tackling underlining causes

Improving the health related quality of life of people with one or more long-term condition:

This overarching indicator provides a picture of the NHS contribution to improving the quality of life for people that have a long term condition (LTC). This provides the average health status (EQ-5D is the tool) scores for adults with a LTC. It assesses whether health-related quality of life is increasing over time for this cohort of the population and if people feel supported to manage their conditions.

MECCG was at the bottom of the best quintile in 2012-13 at 76.2% (no change from 2011-12); the score is not significantly different from the best performing CCG (*Surrey Heath, 79.7%*). This information is collated through the national GP Patient Survey.

More interventions have been instigated to support people with a LTC, such as:

- Improved management of respiratory illnesses especially COPD
- Some improvement in the management of people with diabetes
- Overall improvement in some quality outcome measures (as per QOF)
- Some successes with schemes aimed at keeping people with a LTC out of hospital
- Improving the uptake and success of talking therapeutic services (IAPT)
- Implementation of multi-disciplinary team in some areas with pilot step-up locality hub
- Our plans for the development of integrated services for people in the LTC and Frailty phases of life alongside those of ECC are set out in section 4c and will also significantly contribute

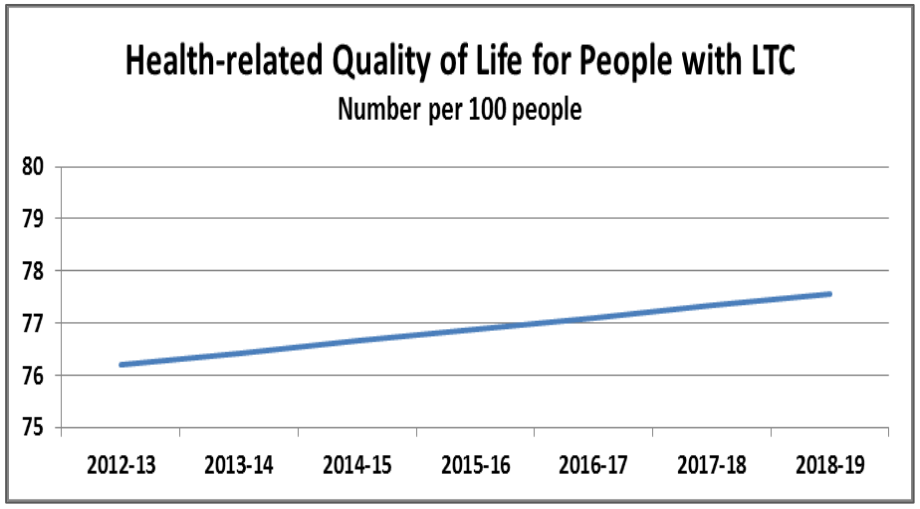
Our ambition is based on the average change between 2011-12 and 2012-13 in the top three quintiles. As this measure is based on qualitative data, it is more challenging to project future outcomes and this methodology reduces the risk of over-estimating the potential change. We will aim for a 0.23% improvement year on year to reach 77.6% in 2018/19.

With an ever-growing proportion of people projected to have a LTC, the CCG will continue to improve disease ascertainment and management by its focus on the LTC phases of life including exploring the longer term development of the 'house of care model.'

Immediate plans include:

- Improve disease ascertainment and develop local initiatives to promote effective self-management of LTC
- Ensure that all people with COPD meeting appropriate criteria are offered an effective, timely and accessible multidisciplinary pulmonary rehabilitation programme

- Ensure that all people with diabetes have received all nine care processes and referred to structured self-care programmes whilst promoting 'Dafne' courses
- Implementation of risk stratification system to prevent people with a LTC needing hospital admission
- Procurement for new IAPT service has been completed to meet local population needs and promote self-referral, with the new service due to begin in April 2014
- Implementation of an all-age Integrated Continence Care service, with clearly defined pathways with a standardised approach to the procurement of products across Essex



- Review the areas of success with MDT and expansion of step-ups beds to support this innovative approach between health and social care
- In collaboration with local providers, the CCG will pilot a 100 day "test and learn" Lead Provider process and pathway review for patients with multiple morbidities.
- Work with ECC to support the expansion of Recovery College to enhance and promote healthy integrated living for people with mental health
- Rolling out the Personal Health budgets and collaborative working with ECC to learn on best approach and maximise outcomes for residents
- Implementation of key recommendations from '*Who will Care?*' report aimed at improving support to people with multiple morbidities
- Work to improve screening and service provision as well as community support for people with dementia

Reducing avoidable emergency admissions (composite measure):

The recent policy drive through *A Call to Action* sets out the challenges and opportunities faced by the health and care systems across the country over the next five to ten years. This will require a significant shift in activity and resource from the hospital sector to the community and how the NHS and its partners can reduce unplanned hospital admissions.

This overarching composite indicator is made up of four key measures detailed in the table below. MECCG is near the top of the best quintile at 1,576/100,000 population in 2012/13 (*Best CCG Crawley, 903/100,000*). The trend is a reducing one for MECCG and the CCG has the lowest rate in Essex although this rate is above 8 of the 10 CCGs in our ONS cluster group. The better performing CCGs have been showing little improvement between 09/10 and 12/13, and the worst performing CCGs have typically been showing worsening positions. MECCG has been performing well in the measures making up this indicator (Quintile 1 is best and 'lower' is better):

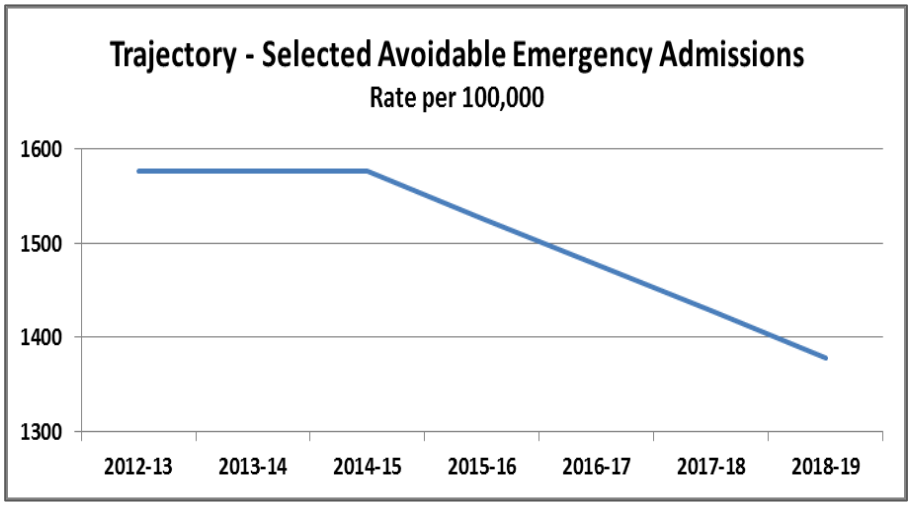
Key Measures for this Indicator	Performance in 2012-13
Unplanned admissions for chronic ambulatory care sensitive conditions (ACSCs)	Lower in Quintile 2
Unplanned admissions for under 19yrs with asthma, diabetes and epilepsy	Higher in Quintile 1
Emergency admissions for acute conditions that should not require hospitalisation	Higher in Quintile 1
Emergency admissions in children with lower respiratory tract infections (LRTI)	Lower in Quintile 1

Some of the key interventions that are and/or may be contributing to a reduction in hospital admissions:

- A variety of hospital admission avoidance schemes
- Provision of rapid response services in partnership with social care reablement services to both prevent hospital admissions and support discharge and avoid readmission.
- Home-from-hospital support scheme in collaboration with social care
- Increasing the proportion of older people living independently at home following discharge from hospital including through the reablement programme. A pilot is being introduced in 2014 to improve the integration of health input into the current ECC commissioned reablement service.
- Further development of multi-disciplinary team work in primary care settings to target patients at risk of admission, including a nominated professional lead for older people.
- Some targeted interventions to support vulnerable groups (e.g. carers, illicit substance users) in preventing unplanned admissions and for better utilisation of healthcare services
- People with diabetes with or at risk of foot ulceration receive regular review and urgent support for foot care to reduce risk of amputations

- Improved access to community mental health services (including IAPT) by people from vulnerable and ethnically diverse groups and promoting self-referrals

MECCG aims to maintain the current rate for 2013-14 and 2014-15 and reduce the rate in future years to achieve the median on this best quintile to 1,379/ 100,000. This will equate to a 12.5% improvement over 5 years to 2018-19.

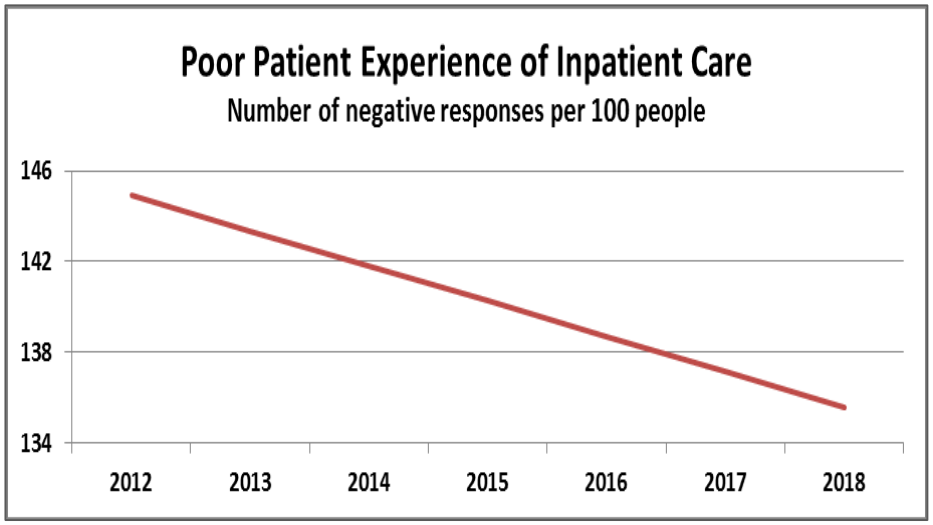


The CCG will ensure new proposals will raise the quality of care whilst diligently managing the financial gap over the next few years, through a programme of innovation and transformation, including the development of the work programme around integrated care. Plans will also provide a defined focus on helping people to recover from episodes of ill health or injury.

These include:

- The funding and implementation of the Better Care Fund to improve sustainability, put in place urgent and unplanned care services, reduce emergency admissions and raise quality
- Implementation of risk stratification system to intervene earlier with people most at risk of needing hospital admission to promote independence and minimise re-admissions
- Support the health of carers to promote independence
- Targeted interventions, including effective prevention, in areas that the CCG is an outlier with unplanned hospitalisation for chronic ambulatory care sensitive conditions in adults and children

- Improving care pathways and prevention work for people at risk of falls, needing support around continence care and who can access care and support closer to home
- Expansion of the reablement care programme whilst evaluating areas with better outcomes to ensure efficient and effective approach
- Development of Frail and Older People register to promote independence, self-care and minimise hospital re-admissions
- Targeted interventions to reduce inequity in access and utilisation of health services to reflect the community demographic profile and in line with the CCG's Equality Duty
- Integrating medicines optimisation into care pathways, supporting people to get the most benefit from their medicines and remain independent
- Implementation of the Paediatric high impact pathway revisions to improve quality and achieve better outcomes
- Improving surgical post-discharge and health outcomes especially where PROMs benchmarking shows that the CCG is an outlier (eg knee replacement)



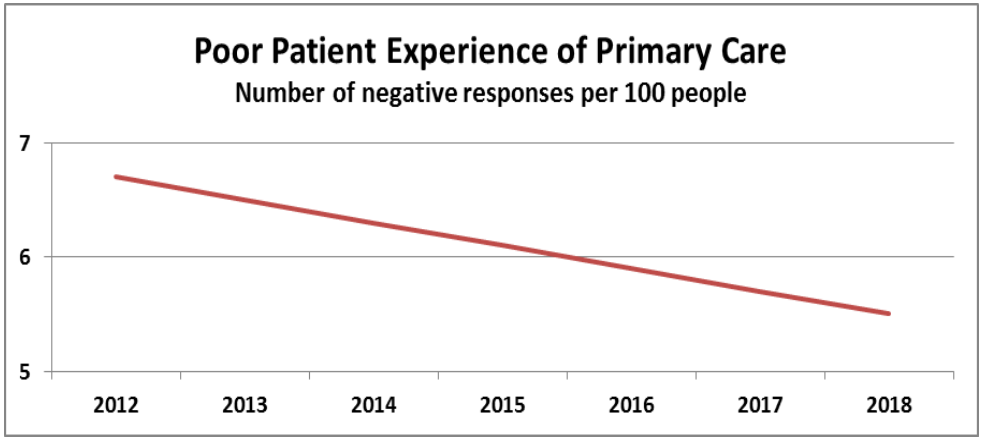
Increasing positive experience of hospital care, general practice and care in the community:

There are two indicators measuring patient experience of [i] hospital care and [ii] GP care, based on the number of negative responses per 100 patients.

In relation to the Family & Friends test MECCG has improved their response rate substantially in A&E (9.8% to 19.2%), maternity and inpatient services with a combined achievement of 25.3% against target of 15% in November.

- MECCG is on 144.9 per 100 patients in 2012 near the bottom the 3rd quintile. MECCG's position is not significantly different from CCGs in this quintile.
- MECCG aims to get to a position equal to the best CCG (*South Lincolnshire, 135.6*) in the 2nd quintile. We have modelled steady improvement over the 14/15 to 18/19.
- MECCG is on 6.7 per 100 patients in 2012; this is near the middle of the second worst performing quintile (4th quintile).
- MECCG aims to get to a position equal to the best CCG (*Tameside and Glossop, 5.5*) in the 3rd quintile. We have modelled steady improvement over the 14/15 to 18/19 and we will continue to monitor improvement through the Net Promoter scorecard and interrogate the data to ensure any issues are identified, addressed and lessons learned to continuously improve patient experience by responding to concerns in a timely manner.

The CCG will need to work with providers to increase the proportion of people who report a positive experience of their inpatient care (for both mental and physical conditions) and of their care outside hospital, in general practice and in the community, including GP out-of-hours services.



Plans are to:

- Plan to expand Family and Friends test to include outpatients and day cases services and rolling out to reach other providers
- Better use of PALS information to improve resolution, reduce reoccurrence and improve outcomes
- Improving access to hospital, primary care and community services through the implementation of the 7-day working principle
- The CCG will work with NHSE, Healthwatch Essex and other key stakeholders to support the development and implementation of a more effective Primary Care Strategy, with active involvement from the CCG's Primary Care Forum and Patient Participation Groups

Eliminating avoidable deaths in hospital:

This overarching indicator has yet to be defined nationally. However, the expectation is that this indicator will gauge the improved readiness of the NHS to report harm and to learn from it. Reporting patient safety incidents, identifying common risks to patients and eliminating hospital-acquired infection risks should aim to increase awareness and provide opportunities to improve patient safety. Acutely ill patients may die suddenly if staff fail to spot or act on changes in their conditions.

Some of the current measures that the CCG has implemented to promote patient safety include (further details in the Quality Section):

- Actively working with providers to implement the zero-tolerance on MRSA and further reducing the spread of *C.difficile*
- Providers supported to ensure that all medication incidents which have caused harm or have the potential to cause harm are reported to the National Reporting and Learning System (NRLS) and to MECCG in a timely manner and using the learning from such incidents to improve safety of care pathways

Following the publication of a number of national recommendations (such as Francis, Berwick & Winterbourne reports) and with the latest contracting round, the CCG has taken further steps to ensure that patient safety is placed at the forefront of service planning and delivery.

MECCG will aim (further details in the Quality section):

- For a zero-tolerance approach with MRSA and a *C. difficile* panel is being instigated to review all cases as part of the Harm Free Care agenda.
- MECCG working with the Essex Area Team in respect of GP practices and community pharmacies, and with Essex County Council in respect of care homes and domiciliary care, will develop processes for sharing and learning from medication incidents and optimise the safe use of medicines.
- Continue the review SHMI rate with local providers and encouraging them to explore and understand the activity which underlies their SHMI from their own data collection sources.
- Work to drive consultant cover for 7-day week in the acute setting.
- \improve the care of deteriorating patients with the introduction of new software for real time escalation (CQUIN driven).
- Improving learning through the introduction of the Global Trigger tool for a monthly random audit of patient care (both deceased and discharged).

3.2 Improving Health

Improving health and wellbeing deserve the same focus we place on treating ill-health. There is a clear understanding that Public Health is everybody's business and everyone must make sure they work with all partners as well as the public so that all the issues which affect the broader determinants of health are addressed to also help reduce inequalities.

At a local level, MECCG will actively engage in partnership with all commissioners, wider stakeholders and the local communities to facilitate and lead the most effective way of delivering against the following joint Health and Wellbeing Board's priorities:

These include:

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

These priorities map against the CCG's clinical vision around 5 phases of life. We need to ensure that the key elements of Commissioning for Prevention are delivered and that every contact really does count in taking the opportunity to promote a healthy environment and healthy lifestyles.

These are:

- A Mid Essex JSNA was completed following the publication of a high level Essex-wide JSNA to inform the CCG's commissioning intentions. Some of the key issues that have been identified for further interventions:
  - Key issues linked to causes of pre-mature mortality include liver, breast and skin cancers; cardiovascular conditions (including atrial fibrillation - AF), stroke, hypertension, diabetes and respiratory diseases
  - Key causes of chronic ill-health also include musculoskeletal disorders, falls, poor lifestyle choices and mental health problems
- MECCG has been a key stakeholder in the development of the joint Essex HWB Strategy, in developing a common set of principles for the commissioning of Public Health interventions and in developing a common approach to Integrated Commissioning. This collaborative approach continues to provide an opportunity to set common goals and priorities, such as:
  - Ensuring children and young families have a good start in life and are actively supported to lead a healthier life

- Closer working with partner agencies, Healthwatch and local groups to tackle wider health and social issues impacting on health and to ensure high safeguarding standards – some of these areas include domestic abuse, sexual exploitation/violence
- Improving disease ascertainment by implementing national and local screening programmes
- Improving health and wellbeing outcomes for people with mental health
- Improve management of long term conditions including effective self-care and secondary prevention programme
- Improving prevention and developing integrated care around falls and incontinence.
- Improve care for frail and older people to support independence and targeting vulnerable groups (e.g. BME groups, Travellers, Carers,)

- Additionally, the CCG will work to weave in the "*Who Will Care?*" recommendations focused on the five proposals for improved integration, patient centred services and better health outcomes for children and young people, especially for children with who have special educational needs.
- A number of high-impact prevention programmes have been agreed, in collaboration with stakeholders and will be progressed over the next 2 years:
  - Reduce harm from substance misuse and reduce smoking and implementing systematic approach to 'making every contact count'
  - Primary Care screening for early diagnosis and support of mental health conditions, including improving the physical health of these residents
  - Multi-agency approach to the provision of obesity prevention and reduction (including school based, new Tier 2 services and effective Tier 3 services).
  - Implementation of integrated falls prevention and continence care services.
  - Implementation of AF and hypertension screening programmes targeting high-risk groups to reduce CVD.
  - Systematic diagnosis and management of respiratory illnesses, including patient education programme to promote effective self-management.

- To support the development of this work programme, the resource planning includes:
  - A reduce in acute activity and beds with some reinvestment in high-impact prevention programmes.
  - Joint investment and re-engineering with ECC and District/City councils to support social mobilisation, early detection, self-care schemes and promote lifestyle changes.

- Plan the deployment of BCF to maximise agreed outcomes.
- Introduction of lead-provider and risk-sharing approach to contracting to improve quality and access to better prevention and support.

MECCG is keen to promote innovation and will continue to strive in ensuring new interventions are evaluated to demonstrate effectiveness and replicability. Innovative solutions will be co-produced with the patient and communities as the core stakeholders, to ensure these are sustainable and provide value for money.

3.3 Reducing health inequalities & Equality Duty

There is a substantive evidence base that shows the extent of inequalities in the factors that ultimately contribute to a differential in life expectancy. This is more pronounced in some of the Mid Essex communities where there is a high level of material deprivation.

The key communities we will focus more intervention in are (MSOA code in brackets):

- Patching Hall Ward (Chelmsford 006)
- Bocking South Ward (Braintree 008)
- Witham West Ward (Braintree 016)
- Braintree South Ward (Braintree 011)
- Maldon town area (Maldon 004) and Heybridge (Maldon 003)

Moreover, the latest CCG's JSNA has identified that Maldon and Braintree have experienced an increase in the gap in life expectancy in men in the last few years. There has also been a more marked increase in the gap for women over the latest 2 years to 2010 especially in Braintree and Chelmsford. The gap in life expectancy for women living in Braintree and Maldon as well as men living in Chelmsford has narrowed. Despite the local level of affluence in Mid Essex, there are nearly 10,000 children live in poverty; Braintree with 4,500 children, Chelmsford with 3,900 children and Maldon with 1,500 children.

The Mid Essex system's Health & Wellbeing/Integrated planning group which has high level district councils representatives, have pledged to focus their collective effort in tackling inequalities and support local communities to live healthier lives. We are currently developing a strategy and our shared approach in engaging communities through 'social mobilisation'.

The CCG's Board has tasked their Public Health Lead to review areas where the local HWB committee can make a real difference with a collective approach to tackling health inequalities.

Some of the key groups with worst outcomes and experience of care in Mid Essex include:

- Working-aged men and their higher CVD risk
- Older women and the higher incidence of stroke

- Disparity between GP practices in the level of disease ascertainment as well as management of patients on disease registers (some correlations with variation in Patients to GP ratio)
- Disparity between districts in health access and outcomes (e.g. high number of falls, access to surgical interventions) as well as in premature mortality rates
- More deprived communities with over 10,000 children living in poverty
- There is an inequity in emergency hospital admissions between ethnic groups
- Poor lifestyle choices in the most disadvantaged communities as well as between districts

Additionally, the recent publication of the Equality and Diversity System (EDS2) to support the NHS in delivering its Public Sector Equality Duty, has placed more emphasis on the workforce 'health' as well as the expectation that CCGs will use this framework to support local providers (detailed later in this plan). MECCG has completed an EDS review (January 2014) and is currently finalising a local stakeholders' consultation. A robust equality impact assessment system is in place to support decision-making at all levels and the CCG's Board will sign off the revised EDS goals in March 2014.

Working in collaboration with local partners and communities, MECCG is developing a plan to close the inequalities gaps, including the implementation of high impact and cost effective interventions.

These are as follows:

- Optimise the use of drugs to control hypertension and reduce cholesterol with a targeted intervention amongst working-aged men
- Sustained tobacco control measures and increase the number of people supported to quit smoking, including in the disadvantaged communities
- Early identification of people at risk of stroke (including AF-related stroke) and ensure effective management in primary care, with a targeted approach with older women
- Targeted approach to case finding, including defined work programmes to reach vulnerable and BME groups, with targeted health checks and local early detection schemes for CVD, alcohol harm and mental health issues
- Review and re-engineer service configuration to improve access to primary care and reduce inequity in access (such as surgical interventions) or service provision (such as falls prevention)
- Involve the local communities in replicating successful social mobilisation schemes and innovative self-care schemes to

promote healthier lifestyle choices and reduce dependency on local public sector services

- The CCG in collaboration with all local partners will endeavour to promote equality and diversity for service users and the local workforce alike by implementing EDS2

3.4 Mental Health, Learning Disabilities and Parity of Esteem

Resource allocation:

The draft North Essex Joint Mental Health Commissioning Strategy 2014 – 2017 has been subject to a period of wider consultation with service users and stakeholders during 2013/14.

It sets out to describe the vision for the commissioning and delivery of mental health services for North Essex over the next three years and recognises the importance of joint commissioning with social care, developing community well-being, delivering services closer to home in primary and community settings and the need to integrate physical and mental health services more effectively.

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

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

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

Within the proposed Service Development Improvement plan in addition to supporting primary care development, suicide prevention and the safe transition of patients in clusters 1 – 4, we are aiming to establish improved communications by exploring the development of a telephone advice line to provide general advice and guidance including medications and risk. We are also planning to monitor closely and apply contractual leverage with regards Trust communications/documentation following outpatients/admissions etc.

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

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

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

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

Reduction in gap in life expectancy:

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

- Development of a primary care mental health education programme

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

Finally MECCG is developing transformation plans for Frailty/Older People which will seek to integrate pathways more effectively involving community, acute and mental health provision.

Young people with mental health problems:

Child and Adolescent Mental Health services (CAMHS) are currently being redesigned and re-commissioned across Essex with a view to improve the emotional health and wellbeing of children and young people from conception to their twenty fifth birthday.

One of the primary aims of the redesign is to address the current gaps identified by the Emotional Health and Wellbeing JSNA in particular behaviour management which transcends both paediatric and adult services through transition. We are also working closely with current CAMHS providers with regards the improvement transition of Adolescents to older peoples' services.

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

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

Services for People with Learning Disabilities:

Work is actively underway between the three North Essex CCGs and Essex County Council around the future integration of health and

social care Learning Disability commissioning. The project is overseeing the transition of the commissioning function from health to ECC from April 2014.

The CCG will work with NHS England through the Essex Area Team to support the increased uptake of annual health checks for people with learning disabilities. This is being provided by GPs through a Directly Enhanced Service (DES). Clinical Commissioners are negotiating with HPFT, the local specialist LD Provider, to meet the demand for people who have no access to Annual Health Checks funded through the DES.

Work is on-going with MEHT to improve patient pathways in the Acute Hospital for people with LD/Autism.

The improvement plan has the following local priorities and standards:

- There is a clearly identifiable Board and Senior Management engagement in embedding LD strategy
- The Trust has policies in place that meet the specific needs of adults with LD/autism
- Adults with LD/Autism receive high standards of fundamental care
- Adults with LD/Autism are identified prior to admission for elective cases or on admission through emergency departments
- Training and Education on understanding the specific needs of people with LD/Autism is provided to all hospital staff
- Adults with LD /Autism attend A&E appropriately
- Adults with LD/Autism and their Family Carers are fully involved in preadmission planning; care planning and care delivery

4. Patient Services

4.1 Citizen engagement in service design and empowerment in self-care

Patients and Citizens have the opportunity to take control:

The CCG are currently embedding patient and public engagement in the commissioning function through a number of activities including;

- PPE training across the CCG
- PPE embedded in the PMO and commissioning sign off processes
- Maximising the synergy of PPE across a number of providers and stakeholders such as Healthwatch Essex
- Developing more proactive opportunities for PPE through more regular and increased communications; e.g. website, newsletter, Survey Monkey, an ongoing calendar of clinical priority focussed PPE events

- Developing role of PPGs across Mid Essex in PPE and their valuable contribution to the wider local health agenda

The CCG will manage the delivery of these activities through an action plan which will be monitored by the Patient Reference Group.

The CCG also aims to develop a number of commissioned health schemes that would see the emergence of individualised self-management plans in collaboration with the public (patients, communities, voluntary groups) with an approach that provides the resources, skills and community support required for individuals to live and manage their chronic ill-health.

Real time patient and citizen voice at the heart of decision making:

Active patient participation will be vital since the process of planning and implementing individual care programme will essentially rely on negotiating personalised goals within the socio-cultural context – the whole-system self-management model.

In addition to the above model of engagement we will also be developing our Patient Stories presented to the CCG Board. We will also be building on our Patient Experience measures with a mid-Essex picture of themes reported from patients through our PALS and Complaints service. These will combine with our engagement model to ensure real time patient and citizen voice is at the heart of our decision making.

Authentic Citizen Participation at the heart of our plans:

The public engagement approach will underpin the transformational agenda and seek to capture the patient perspective from within the patient life-cycle which is characterised by the following 'phases of life'.

These are:

- ***Starting Well***
- ***Fit and healthy people***
- ***Long Term Conditions***
- ***Frailty***
- ***End of life care***

Engagement and consultation will be an iterative process centred on the clinical priorities of the organisation and starting with the reconfiguration of urgent and immediate care.

This will include consideration of how to:

- Deliver care closer to the patients home
- Provide affordable and sustainable services
- Make it fit for purpose and adaptable

Transparency in local health services:

Our PPE model will promote transparency through being embedded across the CCG throughout the clinical commissioning function. PPE strategy, priorities, activity and developments are reported to the Board via the mid Essex Patient Reference Group (PRG).

The PRG has a membership of a number of external organisations and three volunteer Locality Leads ensuring transparency and delivery against the PPE work plan.

4.2 Wider Primary Care

There is a significant variation in patient to GP ratio across Mid Essex - Chelmsford (1,331/GP), Braintree (1,653/GP) and Maldon (1,849/GP). These compare with Essex and National averages of 1,515/GP and 1,351/GP respectively.

The CCG will work with NHS England through the Essex Area Team to review the level of GP provision to ensure safe and effective practice in primary care and particularly address areas of under-provision.

Within the context of the CCG's development of a transformation and sustainability programme there is a recognition of the critical need to enable and support primary care to play a key role as the 'bed rock' of local community health and social care services.

The CCG is currently out to consultation with Mid Essex Member GP practices to explore what changes and development options they see as a priority within this context. This includes consideration of the NHS Constitution Core service offer for Mid Essex as mandated by member practices and how best to support delivery of primary care at scale.

The CCG will also engage and work with other local primary care providers including community pharmacists, optometrists and dentists around their key roles in the overall CCG transformation programme as it is developed.

Medicines Optimisation;

Medicines optimisation must be placed at the heart of the sustainability agenda-improving quality by better adherence, safer care, and care tailored to individuals' expressed needs thereby freeing up the resources that better use of medicines brings. Working with individuals to set their own goals helps people regain and maintain independence, reduce avoidable readmissions into secondary care, reduce delayed discharge from hospital, improve patient clinical outcomes from prescribed medicines and reduce waste medicines.

Mid-Essex CCG will focus on medicines optimisation rather than cost-reduction, improving clinical engagement and joining up services. GPs will be supported to embed medicines optimisation within general practice, potentially through employment/attachment of clinical medicines optimisation pharmacist prescribers. Pharmacists will work with GPs to drive up the quality of medication reviews, focussing on older people and people with a long term conditions, supporting patients to get the most health benefit from their medication, and work in partnership with community pharmacists to maximise the benefit from the Medication Use Review service. General practice

pharmacists will support medicines reconciliation by secondary care clinical pharmacists, reducing risks around transfer between care settings, and utilising the New Medicines Service provided by community pharmacists.

Mid Essex CCG will work with NHS England-Essex Area Team in respect of GP practices and community pharmacies, and also with Essex County Council in respect of care homes and domiciliary care, to develop processes for sharing and learning from medication incident reports to improve the safety of patient care pathways and optimise the safe use of medicines.

Self-care of minor ailments and self-management of long-terms conditions is an effective means of improving quality of life and reducing dependency on immediate care services. Empowering and educating patients to self-care underpins the CCG's strategy for addressing immediate care needs. Utilising community pharmacy as the first port of call for the public and patients requiring healthcare advice and treatment for minor ailments and other self-limiting conditions can release GP appointments and help meet the unmet need in primary care. The CCG recognises the need to up skill the community pharmacists to support their developing clinical role, and will work with the Essex Workforce Partnership to deliver this.

4.3 A modern model of integrated care – working with partners to integrate commissioning and services to promote independence

The CCG is working closely with Essex County Council, Braintree District Council, Chelmsford City Council and Maldon District Council, to align and integrate commissioning activities particularly around the life phases typically, but not wholly, associated with later life; long term conditions, frailty and end of life care. The Better Care Fund will be used to implement integrated services which support people with health and social care services throughout those phases. Our overall model for integration is for care to be coordinated by lead professionals in multi-disciplinary teams (MDTs), with a joint assessment and agreed authority to arrange services. We will make sure that services are easily accessible with single points of triage and referral and .we will work in partnership with GPs to target support at those at risk of unnecessary admission. We will target preventative interventions to avoid health and care needs escalating. We will implement three specific initiatives over the next two years to bring this about.

Fully Integrated support & care for people with multiple long term conditions & risk factors:

MID Essex CCG, working with health and care providers and the voluntary sector, is developing a Frailty Pathway which is a transformational initiative to wrap services around the individual irrespective of provider, with a view to keeping them out of hospital and maintaining or improving their condition.

The approach being taken is to use a new provider model "The Accountable Lead Provider".
Secondly the CCG is also developing a plan for a clinically led 'House of Care' model of integrated hubs for the management of people with multiple long term conditions which will link with the frailty pathway.

Thirdly the County Council Adult Care Services are being transformed to become more personalised in accordance with the Care and Support Reforms in the Care Act. In addition the Council, to ensure service sustainability, has specific business plans for changing services for older people and people with learning disabilities. This is explain further below in this plan.

Using the Better Care Fund as a key enabler:

These 3 significant transformation schemes will be supported by the Better Care Pooled Fund (BCF) by MECCG and Essex CC.

The focus of our £21.6m pooled fund include joint commissioning and pathway reviews for:

- Supporting people at risk of losing independence with personal care services
- Rapid Response, and Immediate care services
- Reablement services – including residential reablement services and in particular increasing the coverage of reablement and enhancing the capability – see below
- Supported discharge, home from hospital and admission avoidance initiatives
- Continuing healthcare – focused around how joint commissioning will improve the quality and reduce the cost of care.
- Early supported discharge for stroke
- Access to Equipment and Assistive Technology
- Enhanced Support for Carers
- Housing and floating support

The Better Care Fund aims to provide an opportunity to make best use of resources by providing better integrated care and support. The Fund will be an important enabler to take the health and social care integration agenda forward at scale and pace, acting as a significant catalyst for change.

For 15/16 the Mid Essex system will have a pooled budget of at least £21.6m – partially funded by Social Care Sustainability funding but including at least £14.4m from CCG allocated funding.

In Mid Essex, we intend that integrated working will enable economies and efficiencies to be derived from existing expenditure and commitments which will in turn create uncommitted resources which can reinvested in further joint working and integrated services that support patients in the community and reduce/manage the demand upon acute hospital services.,

Integrated health and social care teams will operate seamlessly across the system and with all our providers and partners, in order to improve people's outcomes.

For more details on the Mid Essex BCF please refer to our detailed BCF Plan.

The draft 15/16 plan is as set out overleaf:

Indicative 15/16 BCF Investment	Fund Value £000	Benefits	
Protection of Social Care to Benefit Health:			
Baseline Social Care Sustainability Funding	*4,136*	*TBA*	*(See Note 2)*
Mid Essex Pro Rata share of £5.6m 13/14 Social Care Sustainability Grant increase	*1,550*	*Improved recovery and independence after a stroke, social care resource into MDT case management to promote and support independence including identifying and supporting frail members of the population to prevent episodes of crisis.*	*(See Note 2 - 4)*
New Social Care Sustainability Grant funding - priorities yet to be agreed	*1,595*	*TBA*	*(See Note 2 - 5)*
Community Health Services inc Admission Avoidance:			
Accountable Lead Provider/LTC (ICT & Therapies)	*3,791*		*(See Note 2)*
Reablement:			
Reablement Grant	*887*	*Reablement to support return to independence and reliance on health and social care services*	*(See Note 2)*
Other Reablement funding committed to demand management schemes	*856*	*Equipment, Rapid Response service and other measures to prevent hospital admissions or support discharge.*	*(See Note 2)*
Joint Nursing and Care Home Commissioning Inc CHC:			
Continuing Health Care (Assessment)	*717*	*Faster, comprehensive and integrated needs assessment and care package co-ordination*	*(See Note 2.6)*

Continuing Health Care (Costs)	*6,000*	*Better utilisation of resources to support return to independence and/or provide the necessary level of on-going care.*	*(See Note 1,2 & 7)*
Discharge Support:			
Early Supported Discharge for Stroke	*670*	*Supporting recovery and return to independent living*	*(See Note 2)*
Early Intervention and Prevention:			
Joint Risk Profiling (Fragility Risk Register)	*118*	*Identification of at risk patients as part of admissions avoidance.*	
Carers	*581*	*Support for carers - including carers breaks and respite arrangements to avoid the need to resort to residential care*	*(See Note 2)*
Other			
Equipment	*750*	*Equipment for use in the community to support admissions avoidance and hospital discharge.*	*(See Note 2,8)*
Total	***21,651***		
Capital Funding Including Disabled Facilities Grant	***TBA***		

Notes

1) 2015/16 expenditure by scheme has been estimated. These estimates are subject to change as plans are finalised, in particular Accountable Lead Provider/LTC, Equipment and Continuing Health Care Costs

2) Benefits from BCF expenditure/joint working are being calculated.

3) £7,281k Social Care Sustainability funding in 14/15 is transferred from NHS England to ECC

4) The £5.6m 2013/14 new investment is to support investment in Early Supported Stroke Discharge and other agreed initiatives. Utilisation of the Mid Essex share being confirmed.

5) Plans still under discussion - likely to include increasing the support to patients for maximising health outcomes and independence prior to assessment for CHC requirements.

6) Expect better decision making and more joined up outcomes from a joint assessment process.

7) Reprioritisation of Investment in order to invest in advance of the assessment and do the 3 month review of maximise patient's chance of successful outcome and return home.

8) Improvements to be driven by joint commissioning - also l.a. capital funding and social care equipment budgets?

The contribution of Essex CC to support for people in the LTC House of Care and the Frailty Pathway:

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

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

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

Within the LTC and Frailty phases, the CCG and ECC share the ambition to enable people to remain safe and independent at home and so will shift their approach to a more preventative, integrated and targeted approach to providing services for older people, expanding jointly commissioned, and reablement and intermediate services. This will minimise the need for on-going support care services, and delay or avoid demand pressures from 2014.

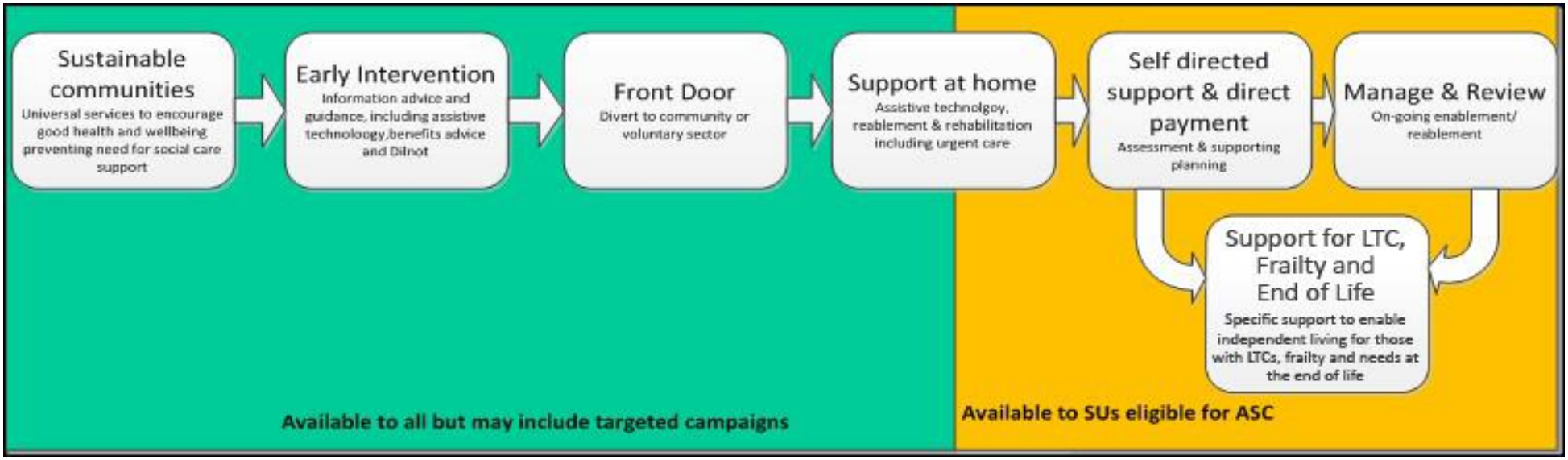
Early intervention	Intermediate care	On-going support

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

To deliver this ECC will:

- Move to a proactive model of care that addresses key areas of demand which include the high number of people going through acute care that were not previously known to have an assessed social care need
- Work with its CCG partners to redesign the intermediate care pathway to ensure that the people who use the services are getting the right level of support at the right time and the pathway is joined up to enable people to remain independent in the community
- Deliver its aims and objectives by locating its care and assessment resources and its care services to support people to stay in their homes
- Locate its hospital discharge capacity into the community and intermediate care pathways
- Be looking to benefit from health schemes that allows it to deliver its responsibilities within a cash position 30% lower than its current spend
- Move as much of its resources as possible from residential and domiciliary care into more reablement and proactive case finding to address the issue that most of ECCs demand comes from hospital discharges which is driven by peoples deterioration in heal

Mid Essex CCG will work with ECC and other partners to deliver information, advice and guidance to the citizens of Mid-Essex and develop community resilience for people that do not have eligible assessed needs under the Fair Access to Care criteria, with the aim of avoiding or delaying unnecessary entry into the statutory health and social care systems. Those with eligible needs will be supported to maintain independence or to return to a previous level of independence through communities and reablement support. This approach is underpinned by the principles of personalisation including personal budget



Those individuals with Long Term Conditions may require support specifically designed around their condition. We will be informed by the people who use our services and work closely with our health partners to integrate pathways of care wherever possible (for example, early supported discharge pathways)

Mid Essex CCG and ECC recognise that there will be changes in circumstances for an individual triggered by a range of different situations. Our aim is therefore to develop robust pathways with all partners, including the voluntary sector, that reduce the dependency on statutory services and provide high quality services that promote independence and self-management including the use of Assistive Technology.
The current thinking is that the Systems Leadership Group will be used to oversee implementation of relevant integrated programmes including the proposed BCF schemes, metrics and governance. The SLG includes the CEOs of MEHT, Provide and NEPFT, the Director of Integrated Care as well as our clinician lead and Accountable Officer. We believe that success of the fund will be optimized with this broad input into the programmes from our providers and will signal how we intend partnership working to take place.

4.4 Access to highest quality immediate care

Strategic Plan in line with Urgent & Emergency Care Review Phase One Report – Vision:

The strategic vision of Mid Essex CCG aligns with the Urgent and Emergency Care Review Phase 1 report in that it seeks to deliver a model of care that is person centered, holistic, targeted and cost effective.

It also focuses on prevention of deterioration in function wherever possible and supporting the individual to feel safe and supported in their usual place of residence.

It will provide the ability to intervene rapidly in case of destabilizing events such as infection or illness and to avoid inappropriate admissions to hospital or residential care for conditions that can be safely managed in the community.

The plan will promote service user education and provide support to assist self- management of their long term conditions, increasing independence and self-confidence.

The CCG will work to ensure that carers feel adequately supported in their role. The plan acknowledges that where help is needed for daily functions the approach to care should be based on reablement principles with the cared for person encouraged to become more self-reliant wherever possible rather than a passive recipient of help.

During 2014/15 the Mid Essex urgent and emergency care network, will be working with key partners to develop a detailed understanding of:

Patient flows:

- Based on a comprehensive analysis of activity for 2013/14, adjusted for growth anticipated in 2014/15, QIPP plans, and contract negotiation with providers
- A detailed scorecard will be monitored by the urgent care network at the monthly meetings which will focus on a number of areas including Primary Care Practice variations, A&E activity, Emergency length of stay, readmissions, and delayed transfers of care
- The attendance and membership of the urgent care network will be determined by all of the above

The number and location of emergency and urgent care facilities:

- The intention of Mid Essex CCG is to make this as simple as possible for the people of Mid Essex, providers and commissioners

- Details of emergency and urgent care services are captured in the urgent care recovery and improvement plan and will be updated according to changes in service and future redesign
- A clear and visual representation of the number and location of emergency and urgent care services will be added to the updated urgent care recovery and improvement plan for 2014/15

The services provided:

- This will be clearly highlighted in the service specifications,
- Providers will be asked to feedback to the urgent care network on services provided and comment on exceptions within the urgent care scorecard

The most pressing needs of our population:

- This is determined by the Joint Strategic Needs Assessment (JSNA), the development of a risk stratification tool and tight control of referral management and eligibility criteria in line with the NHS constitution

The CCG and partners are preparing for designation of all facilities within the local network in 2015/16 based on development of a clear strategy within Mid Essex which will determine the future direction and how services will be commissioned in 2015/16 with clear links to the integrated plan. This will align with the overall Transformation and Sustainability programme.

4.5 A Step Change Productivity of Elective Care

Achievement of a 20% productivity improvement in elective care within 5 years with better outcomes and 20% less resource:

Mid Essex CCG are working towards achieving this step change productivity of elective care through a multi-faceted approach.

One feature of achieving these improvements will be the shift of care from acute to community settings. MECCG propose focusing on the shift of low acuity, population targeted specialties, particularly those that are non-profitable for our local acute provider. In some instances, services may transfer from community settings into the acute provider in areas where quality and safety are improved or economies of scale gained.

MECCG also intend to focus on repatriation of acute services from out of area centres. Providing local services is clearly beneficial to our local population and has the added benefit of reducing spend on MFF, as well as supporting our local acute provider.

We will assess whether outcomes evidenced schemes for planned care efficiency such as the Ten High Impact Changes (MDA 2004) are in place and working in Mid Essex to ensure pathway flow is operating at

its optimum levels already. Seven day working will be developed and expanded within existing resource through negotiation with our Providers.

We will be looking to exploit PBR local flexibilities in 14/15 to ensure appropriate tariff pricing is in place to reflect the nature of activity.

4.6 Starting Well – working with partners to maximise opportunities for integrated services for maternity, children and young peoples' services

The CCG are working closely with providers and stakeholders to develop robust effective pathways for all common childhood conditions. The development of the pathways (particularly Bronchiolitis and Diarrhoea & Vomiting) are essential to ensuring that Children & Young People and their families are able to access services/treatment at the right time and in the right place, enabling where possible Children to remain at home and receive care either at home or in their local community, thus ensuring that only those children that need to be treated and cared for in hospital are able to access that facility.

The CCG are committed to working collaboratively with local authorities, school and providers in delivering the obligations and requirements as laid out in the Children and Families Bill and are working with partners to ensure implementation from September 2014. The bill will require substantial change in the way health, education and social care work together to assess, plan and provide services for children with SEND and as such the CCG in collaboration with the Other CCGs in Essex and the Local authority.

They will:

- Continue implementation and development of personal budgets for Children and Young People with Complex Needs
- Work with CCGs and partners to develop "The Local Offer"- Details the services to support children and young people with SEND and their families in a clear and transparent way so that they can understand what is available.

The CCG will clearly articulate through Service Development Improvement Plans improvements and obligations to be embedded into service delivery during 2014/15 and work with Providers to identify appropriate Key performance Indicators and information reporting to ensure compliance with the act, once enacted.

In particular providers will be required:

- To ensure that all services are accessible in line with the Children and Families Bill and SEND reform with extend services to meet the needs of SEN from birth to 25 years
- To work with all services and partners collaboratively thus ensuring an integrated approach to the assessment, care and

treatment of Children, Young People and their families Ensuring through integrated working the embedding of the early support model improving the delivery of services for disabled children, young people and their families and enabling services to coordinate their activity better and provide families with a single point of contact and continuity through key working.

- To ensure that all planning processes are Child and Young Person, outcomes driven, with a holistic understanding of the needs and expectations of the Child or Young Person.
- To work collaboratively and ensure that all relevant information is in one easily accessible place.
- To coordinate and align activities of all agencies via the plan to ensure greater efficiency; responsibilities are clear.
- To ensure that plans are communicated in a shared and easily understood language.
- To enable families to "tell us once", we listen and capture information and utilise it to inform our future engagement.
- To deliver an improved experience of the system for all involved.
- To ensure through delivery of services that all Children and Young People achieve improved and positive outcomes as a result of improvements and changes made.
- To update their own 'local offer' service information in order for the latest information is available for families. Ensuring that details are shared with all relevant LAs (e.g. Essex County Council, Southend Borough Council and Thurrock Council)

4.7. Maldon Health and Well-being Services provision

During 2013 and 14 Mid Essex PCT and more recently the CCG revisited the issue of reprovision of health services at St Peter's Hospital in Maldon. A significant piece of work was completed towards the development of a multi-agency multi-purpose health and wellbeing facility.

This work included a completing a comprehensive JSNA for Maldon, public and partner consultation, developing a NHS England Project Initiation Document (PID) which was given approval for progress to Outline and Final Business case stages,

Current services and activity were mapped against current need and also projected in to the future Local Delivery Plan (LDP) for Maldon District. This highlighted a growing need for Primary Care services particularly in the older population which is growing exponentially.

Delivery of Primary care was a key component of the future plans for local services in the District along with a greater integration of health

and wellbeing services including voluntary sector services, social care and housing.

This work was reported through both the CCGs Board and a formal Project Board hosted by Maldon District Council.

In the context of the CCG's current financial situation and the development of a 5 year, the CCG will review the Maldon Development Project and ensure alignment with the transformational plans.

4.8 Specialised services concentrated in centres of excellence

Specialised services concentrated in centres of excellence:
The CCG is committed to working closely with NHSE, local providers and stakeholders to engage with and support the NHSE-led National Review of Specialised Services. We recognise this is likely to lead to the concentration of specialist expertise in fewer centres with Academic health science centres.

Locally there is currently a consultation across Essex on a review of stroke services with the proposed creation of 3 hyper-acute stroke units including at Broomfield Hospital, which the CCG fully supports. We recognise this trend is likely to continue for services where patient outcomes are significantly improved from the concentration of specialist skills and resources. Furthermore we recognise the need for some specialist services (as well as certain NHSE commissioned specialised services) to also be reviewed in the context of the proposed development of more capable integrated primary and community health and social care services, the continuing financial pressures facing providers and the need to maintain and improve quality standards and patient outcomes.

The CCG will work collaboratively with the other Essex CCGs and acute providers to initiate an appropriate review.

4.8.1 Outcomes of Colchester Cancer Review

Mid Essex CCG acknowledges the Colchester Cancer Review and the recommendations of the review and NHS England team that an in-depth review of urology pathways and a review of anal cancer in undertaken on clinical ground and in terms of moving towards IOG compliant pathways for Essex patients.

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

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

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

Several specialist commissioning pathways are not IOG compliant and the East Anglia Specialist Commissioning group is now involved. However changes in the specialist parts of the pathways have implications for general DGH work. The Cancer Network has been approached to help in scoping IOG compliant pathways for anal cancer and for urology.

There is not currently an IOG compliant centre in Essex for urology. Mid Essex CCG and DGH will work with the Cancer Network and other partners to put in place a plan to move to IOG compliance. There will also be work undertaken to ensure that MEHT has sufficient capacity in urology to manage demand.

4.9 Continuing Healthcare and Personal Health Budgets

The CCG recognises both in terms of potential risk to patients and monetary value it is essential to ensure a robust process in place for the provision of Continuing Health Care.

The CCG contracts with the CSU for the provision of assessment and implementation of packages for patients. There is an agreed threshold for CSU staff to approve packages of care, if care costs fall above this Threshold approval is required from either the Director of Nursing or Deputy Director of Nursing.

Performance in relation to CHC has significantly improved over 2013/14. An Essex wide review and recovery action plan has been developed and implemented throughout the year and this has ensured the CCG can continue with robust processes and systems for the management of CHC in 2014/15. In addition the CCG has taken an independent view of the CHC process and has recommendations for further developments in line with the integration agenda throughout 2014/15.

The CCG has been developing systems and processes to support the implementation of personal health budgets from April 2014. The CCG is currently participating in a pilot for personal health budgets and this is being supported by the Essex Coalition of Disabled People. A number of key stakeholder events have been held for patients and clinicians across the health economy. A Personal Health Budgets Peer Support Network has been established and is chaired by a patient. In addition a monthly steering group takes place to monitor the implementation of process and ensure learning from the Pilot is being implemented. The CCG participates in both Regional and National events in relation to CHC and PHB and participates in the Regional "Markers of Progress" process.

The CCG is working in collaboration with all Essex CCGs, Local Authority colleagues and the voluntary sector to ensure the process implemented meets the needs of the local population.

5. Access

5.1 Convenient access for everyone

As the CCG develops its transformation programme we will ensure that good access is delivered to the full range of services including GP and community services, acute and mental health services.

In particular the CCG will ensure:

- That access routes and advice for the public are simplified and streamlined as far as possible through promoting the use of the 111 service locally and ensuring the directory of service is appropriately developed and maintained
- That we work with NHSE to ensure primary care access issues are addressed
- We will develop proposals for immediate / unplanned care in line with the National Review of urgent and emergency care to cover 111, 999, GP access, A&E, GP Out of Hours, mental health crisis services, rapid community services and other urgent care services, including links with social care services
- There is a single point of referral for health professionals in Mid Essex. This has been commissioned from NEPT in 2013.
- Attention in 14/15 will focus on ensuring the realisation of benefits from communicating the service and aligning and coordinating contributing services across providers including in support of the rapid response Crisis Response Service

These actions will be delivered as part of the development of the patient service strategies outlined above particular attention will be given to ensuring equity of access for minority and hard to reach groups.

5.2 Meeting the NHS Constitution standards

The CCG will continue to commission and performance manage contracts to ensure sufficient services are delivered to continue to meet the NHS Constitution rights and pledges including around access and choice.

We will have system wide escalation plans, emergency planning and coordinating mechanisms, managed by the local urgent and emergency care network and overseen by the System Leadership Group, in place to ensure that during busy times such as the winter, local services work in a coordinated and mutually supportive way to ensure patient access is maintained. The effectiveness of these

processes is demonstrated by MEHT having met the A&E 4hr target for Q3.

The CCG will also review any services which do not meet NHS Constitution requirements with a review to their transformation or decommissioning as appropriate.

CCG Performance against the NHS Constitution Standards 18 weeks Pathway:

Although the CCG recognises the achievement of 18 weeks at aggregate level there is still some work to ensure we achieve it at speciality level, mainly around general surgery which was just below target for the non-admitted pathway in December. The Trust has a trajectory to be compliant across all specialities by March 2014.

The Trust has continued to reduce the backlog of patients in 2013/14 of which the majority is Plastics and attributed to patient choice of Consultant. The CCG continues to proactively work with the Trust to ensure compliance across all specialities and ensure equity of service delivery for all patients. Contract penalties are applied to the underperformance.

Cancer standards:

The Trust has been consistently achieving all standards since July 2011. The drop in the 62 standard from October 2013 is mainly due to:

- An increase of 14% in 2 week referrals in 13/14 adding pressure on diagnostic and histology mainly in the urology pathway resulting in patients slipping the timeframe
- The loss of the local Cancer Network to coordinate changes/issues around pathways has resulted in delay in inter provider discussions/resolutions
- More complex patients on shared pathways having delays in inter provider care.
- Early indication of small movement of CHUFT referrals
- The Trust undertook an internal audit and also used the information from the NHS England CHUFT review to produce a comprehensive recovery plan and trajectory. This has provided the CCG Board with assurance that the Trust will be progressing actions which ensure this standard will be met by March 2014.

These actions include:

- Implementation of an Inter-Provider Transfer Policy to ensure a smooth transfer of patient care across South Essex Tertiary Providers minimising delays in the pathway
- Discussions around localisation of site specific “Timed pathways” implemented in Anglia
- Regular review of Patient Tracking Lists and early identification of issues arising at Trusts and in Primary Care for resolution

- Contract queries/penalties to both MEHT and CHUFT

A&E- % of Patients Seen & Treated in four hours:

During 2013/14 the CCG implemented an Urgent Care Recovery and Improvement Plan and significantly revised its Winter Plan. In addition winter schemes implemented by MEHT have enabled the system to manage the pressure across the local health economy. Supporting this approach MEHT has been delivering the A&E performance throughout the year meeting the standard in Q1 & Q2 and whilst missing it in December, good performance in October and November meant they also met Q3. At the time of writing we forecast achievement of the 4 hour standard in Quarter 4 and overall for the year.

Ambulance Trust:

Performance issues with East of England Ambulance Service NHS Trust (EEAST) continue. Whilst there is good working relationships between the Ambulance Crews and handover to Trust staff the handover target is still not met. This is similar for most Trusts in the EoE. The tripartite agreement has yet to be signed. Contract performance penalties are applied The CCG continues to work with the CCG collaborative commissioning arrangement to support EEAST to move to a more sustainable position for all national targets. Key issues of focus on are capacity and recruitment, and the ambulance service transformation.

NHS Constitution	Target 14/15	Current Performance		NHS Constitution	Target 14/15	Current Performance
18 week RTT - admitted % within 18 weeks	90%	Dec-13 95.2%		Ambulance clinical quality – Category A (Red 1) 8 minute response time	75%	Dec-13 71.6%
18 week RTT - non-admitted % within 18 weeks	95%	Dec-13 98.0%		Ambulance clinical quality – Category A (Red 2) 8 minute response time	75%	Dec-13 67.1%
18 week RTT - incomplete % within 18 weeks	92%	Dec-13 97.3%		Ambulance clinical quality - Category A 19 minute transportation time	95%	Dec-13 92.1%
Number of 52 week Referral to Treatment Pathways	0	Dec-13 1		% waiting 6 weeks or more for diagnostic tests	<1%	Dec-13 0.2%
Cancer: Two Week Wait	93%	Dec-13 94.9%		% of patients who spent 4 hours or less in A&E (MEHT)	95%	YTD to 10-Feb-14 95.6%
Cancer: Breast Symptom Two Week Wait	93%	Dec-13 93.5%		Trolley waits in A&E: Patients who have waited over 12 hours in A&E from decision to admit to admission (MEHT)	0	Jan-14 YTD 0
Cancer: 31 Day First Treatment	96%	Dec-13 97.8%		NHS Constitution Support Measures		
Cancer: 31 Day Subsequent Treatment - Surgery	94%	Dec-13 100%		Mixed Sex Accommodation (MSA) Breaches	0	Dec-13 YTD 3
Cancer: 31 Day Subsequent Treatment - Drug Treatments	98%	Dec-13 100%		Urgent operations cancelled for a second time (MEHT)	0	Dec-13 YTD 0
Cancer: 31 Day Subsequent Treatment - Radiotherapy	94%	Dec-13 95.8%		Cancelled Operations - % of patients not treated within 28 days of last minute elective cancellation (MEHT)	Reduce	Q2 2013/14 9.4%
Cancer Plan: 62 Day Standard	85%	Dec-13 80.6%		Mental Health - CPA follow up within 7 days	95%	Q2 2013/14 99.3%
Cancer: 62 Day Screening Standard	90%	Dec-13 92.3%		Ambulance - % of patients handed over within 15 minutes	85%	YTD to Dec-13 54.3%
Cancer: 62 Day Upgrade Standard	No Target	Dec-13 100%				

5.3 Consistent & Appropriate IT Access for GP Surgeries

The responsibility for the day to day management of GP Practice IT systems has been delegated by NHS England to individual CCGs.

Mid Essex CCG is in the process of a review of the strategic objectives for GP IT. The main objectives are to determine the most significant risks within the primary care environment, assess the impact and likelihood of each risk and therefore determine the priority in which those risks should be addressed.

The road-map for tackling the 'priorities will need to be set against a back-drop of financial constraints. All IT solutions that are explored and consequently planned will be prioritised by the CCG and set against other cost pressures

The CCG continues to be in discussion with the CSU and remains fully supportive of GP practices where the biggest concerns have arisen. The outcome of those discussions has resulted in the identification of three primary strategic objectives and a specific process relating to migration / systems upgrade.

Primary strategic objectives:

- Assessing IT equipment (specifically desk-side equipment e.g. PCs, printers, scanners etc.) within GP practices.
- There is a need to audit and assess the current equipment in all GP practices (including other equipment that has been purchased by the practice that is windows XP compatible) to identify any which may need replacing in the foreseeable future – i.e. PCs running Windows XP before official support from Microsoft ends for Windows XP.
- This poses a significant risk for Mid Essex due to obsolete equipment and software. The aim is to start replacing old legacy hardware.
- Review aging servers (old EMIS, Vision or PCT servers) within GP practices. Almost all practices retain a local server on-site, regardless of whether you use a hosted clinical system (e.g. SystmOne).

The likelihood of server failures within Mid Essex is high given that the age of much of the equipment is 7+ years. The impact risk is high considering approximately 75% of practices have a legacy server still in use.

The CCG requested the CSU carried out an urgent and fully comprehensive assessment regarding current server estate which will inform the necessary solutions for managing the GP IT server infrastructure for all practices. This assessment would highlight a solution with a view to all practices being connected to the new solution, circa. End of Q2 2014 (i.e. mid-summer) subject to sufficient capital funding being made available.

Review of ineffective clinical systems.

It is has been identified that there are a number of practices that operate using old legacy clinical systems. These may be perceived to be inefficient and/or drawing towards the end of their supportable live i.e. the software vendor is planning to retire the product. The CCG recognises its obligation to support practices with choosing a suitable alternative to their current ineffective product, and where funds are available the CCG should financially support the practices' decision to change clinical system when the chosen product meets the national criteria (i.e. the GPSoC framework), the local CCG-wide objectives (e.g. CCG cost savings and improved patient care) and the practices own objectives (e.g. improved practice efficiencies).

Mid Essex CGG will therefore monitor the situation with those practices and plan for the inevitable migration/upgrade of those systems. Given that upgrades/migrations can span 4-6 months and attract a price tag of approximately £20k per upgrade/migration it is critical that planning starts early to ensure funds are prioritised appropriately. .

Current Progress

The CCG is developing a 'General Practice Clinical IT Systems Strategy' document outlining the core objectives that the CCG wants to see achieved by the nominated replacement clinical system.

Submission of Templates

The overview of the collated requirements from both practices and the CCG will be made available to viable clinical system providers for them to put forward proposed solutions that cater for all requirements. This will then be followed by discussions with practices regarding individual requirements as we want to support GP practices in reaching appropriate and affordable decisions where IT equipment and systems are concerned.

6. Quality

6.1 Reflecting key findings of Francis, Berwick & Winterbourne View reports

MECCG recognise now is the time to build upon the foundations already laid in Mid Essex and make further advances in the world of safety improvement and quality so the legacy of Francis, Berwick, Keogh and Winterbourne is that of a confident and learning health system that listens to the needs of its patients and staff in order to deliver the safest and best healthcare. There is full commitment to recommendations made and the CCG has pledged to ensure that all contracts include quality performance requirements, expected core standards of care are secured contractually and Providers are challenged to make on-going improvements in the quality of care provided.

MECCG will seek contractual redress when performance does not meet expected quality and safety standards; whilst working with that Provider to improve the quality of services provided for every patient. Specific measures and monitoring processes to improve outcomes for patients with a learning disability will be consistently applied. This will be based upon the outcome of self-assessments of Learning Disability services and in the light of the Serious Case Review into abuse at Winterbourne View. Providers will be required to monitor patterns in A&E attendances from residential units for people with learning disabilities.

The focus on adequate staffing levels, including sickness absence monitoring and ensuring staff appraisal occurs annually in the national contract 2014/15 has been built on further with the development of local key performance indicators devised to assure that there are safe staffing levels reported on and practised in all areas. This has been further strengthened with investment into nursing leadership and competency, aiding assurance that care is delivered by a competent workforce. Such work streams feed directly into and from the Compassion agenda and recommendations from Patients First and Foremost. Cost improvement plans are regularly reviewed by the CQRG and providers are required to share quality impact assessments whereby staffing levels are affected.

Further work presently being undertaken in relation to Nursing Leadership in the secondary care environment, with the Royal College of Nursing (RCN), has been fully supported by the CCG and incentivised further through CQUIN.

The CCG will continue to participate in the Essex Quality Surveillance Group with attendance by the Accountable Officer and Director of Nursing. The surveillance group provides a forum for local partners to

realise the cultures and values of open and honest cooperation, whilst ensuring that supervisory, commissioning and regulatory bodies work in a more coordinated way. Thus enabling MECCG to escalate quality or risk concerns to colleagues such as the Care Quality Commission in a timely and supportive manner.

Whereby it is identified by the Care Quality Commission (CQC) that they are taking enforcement against a provider the CCG will ensure that where the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and any other relevant legislation is not being met that we will use contractual redress and monitoring to ensure the required improvement is achieved and maintained.

6.2 Patient Safety

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

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

Contracting for quality improvement will continue to be a key objective for the CCG, with a continued commitment to learning from incidents, complaints and near misses, as well as listening to and learning from others experiences. The CCG will ensure:

- We utilise transparent methodology within contracts with respect to on-site visits and inspections of premises, these may be announced or unannounced
- We expect a reasonable timeframe for the implementation of NICE Quality Standards. Where relevant Quality guidance has been identified the CCG will seek assurance that each provider has an implementation strategy
- We continue to work across the system to reduce HCAI and strive towards zero tolerance in relation to existing MRSA and Clostridium *difficile* across the system
- New initiatives will be introduced to address incidents of surgical site infections and catheter associated urinary tract infections. This will include the use of catheter passports and care pathways for managing incontinence and retention of urine

- Providers will be expected to demonstrate effective systems to identify and manage sepsis to reduce the associated mortality and improve overall patient outcomes
- Require all Providers to adopt our Policy in relation to identifying, reporting and investigation of Serious Incidents and incidents. Providers must comply with their duty of candour, being open and transparent with their process and also sharing outcomes with us in a timely manner. Reporting and learning from serious incidents across all Providers working with North Essex CCGs is formalised via the Serious Incident and Never Event Panel
- It will be expected that all Providers demonstrate evidence through the CQRG that they have implemented the National Patient safety Alerting System, which is used to disseminate patient safety information at different stages of development to NHS organisations providing care across all settings. Thus allowing more rapid dissemination of urgent information via the Central Alerting System (CAS), as well as encouraging information sharing between organisations and providing useful education and implementation resources to support providers in reducing risks to patients. Require Providers to share their level of achievement with the NHSLA
- Continue to work with Providers in managing and improving quality Re NQB report – Quality in the New Health System, reviewing the report and the implications for the new health economy
- Work with Essex County Council collaboratively to improve standards of nursing care (where commissioned) within care homes in Mid Essex. This will include a specific focus on Infection Prevention & Control (IP&C) and pressure ulcers.
- Ensure Providers continue to focus on improving safeguarding of adults at risk and children
- The CCG will support Providers to set up falls panels with the aim of recognising and determining avoidability of serious harm falls, identifying trends and intervention strategies
- Continue to promote reporting and in eliminating all avoidable health care acquired grades 3 and 4 pressure damage. This will include robust reporting of incidence and trends to establish avoidability
- Commence new work streams in relation to the identification and intervention for Grade 2 Pressure Ulcers
- All good providers have robust KPIs in place to ensure that the performance for assessment and prophylaxis of VTE is sustained and remains above the national target. Where a hospital acquired thrombosis occurs robust investigation will determine root cause, to enable improvements to be made.
- Continued use by providers of prevalence data collection through the national safety thermometer, using the data to

influence the commissioning of new care pathways. Further developments in safety thermometer methodology will be supported by the CCG including its introduction into Mental Health and Medicines Management

- To seek assurance that the early warning scoring system NEWS is effectively implemented to ensure robust mechanisms are in place to recognise the deteriorating patient
- Promote reporting of medicine management incidents, analysing incidents, identifying trends and ensuring robust action plans are established in response

6.3 Patient Experience

Patient experience is integral to providing quality care to enable understanding of quality from the unique perspective of those receiving care.

MECCG will require Providers to demonstrate that effective systems are in place to respond to patient feedback from surveys, including the Friends and Family Test, complaints and other intelligence, such as patient stories. We will improve responsiveness to complaints, identifying themes and trends to improve patient experience and perception. Alliances with our provider colleagues for PALS and complaints will be developed to ensure a robust mechanism of a timely response to complaints and trends from PALS ensuring a consistent approach for our patients.

This will include some exciting joint working with listening events to capture and utilise a rich source of patient feedback and experience, feeding directly into the executive boards, aiming, to capture information from all priority groups

The CCG recognise supporting and educating partner organisations on the variety of methodology associated with capturing and enhancing patient experience for example, experienced based design and emotional mapping, is a key patient experience objective moving forward. These methodologies will form part of the larger work plan designed to meet the Care and Compassion agenda. A key component of which will be to ensure identified patients are invited to present their story to every CCG Board. This powerful medium will be utilised to ensure as commissioners we understand our services from the unique view of the patient.

The CCG will expect that Providers gather patient experience intelligence from a variety of sources, including real time monitoring, and survey following treatment; enabling understanding of patient wellbeing following care and timely responsiveness to areas of concern. The continued requirement of providers to ensure PROMS

are used in the determination of patient experience remains with consideration of using this data to influence future decision making.

There is a continued expectation that all providers meet single sex accommodation guidance (EMSA) including reporting of any EMSA breaches, with the completion of an RCA. All patients attending hospital services will receive the same level of service regardless of age, sex, race, sexuality or disability and will require providers to comply with all existing national legislation with regard to the provision of services and for reasonable adjustments to be made to support their access to acute services. Providers will also need to meet the requirements of the Equality Act 2010 and the NHS Equality Delivery System (EDS).

Providers will also be required to maintain the EDS (or in the case on non-NHS providers) and to have in place similar arrangements that will help to progress the EDS goals.

MECCG will seek to improve services and service outcomes for people with mental health problems, working with North East Essex as lead commissioner, ensuring services are commissioned and delivered from a basis of humanity, dignity and respect. This includes measuring, assessing and improving service user and carer experience. We expect the 'No Health without Mental Health, a cross-government mental health outcomes strategy for people of all ages, February 2011 to be implemented.

The Clinical Quality Specialist Lead will work together with the CCG Engagement Lead to further establish key working partnerships with stakeholders to develop strategy and networks to ensure that patient experience is at the heart of commissioning. This will of course include enhanced working with Healthwatch and other local carer forums, to ensure the voice of all patient groups is heard.

6.4 Compassion in Practice

MECCG expect providers to respond to National Patient Safety and Quality Initiatives such as the CNO vision for Nursing and Midwifery, Compassion in Practice. This work will be supported by the Clinical Quality Specialist Lead within the CCG, whose role is to work with Providers to achieve and embed Compassion in Practice. As well as the clear focus on developing and communicating the 6Cs, MECCG is actively engaged in the six areas of action where we can concentrate our effort and create impact for our patients and the people we support.

The action areas are:

- Helping people to stay independent, maximising well-being and improving health outcomes
- Working with people to provide a positive experience of care
- Delivering high quality care and measuring the impact of care
- Building and strengthening leadership

- Ensuring we have the right staff, with the right skills, in the right place
- Supporting positive staff experience

MECCG has ensured that all contracts have embedded the requirements of the 6C's in practice. The unique role of the Quality clinical specialist lead is to continuously engage with Providers and develop exciting work streams and projects to demonstrate not only implementation in practice, but improved outcomes and experience of our patients. Supporting the competency drive within nursing, capturing rich and meaningful patient experience and the ongoing health and wellbeing of staff groups are expected reportable outcome measures from this work stream.

6.5 Staff Satisfaction

Evidence suggests that engaged staff will undoubtedly enhance quality of services and despite there being no question that patients have to be at the very heart of all service delivery, leaders must identify projects wisely and ensure that staff are protected and also fully engaged.

Moving forward MECCG will continue to monitor staff satisfaction as measured via Staff surveys, in particular the staff element for the Friends and Family Test and the National Staff survey. We will work with providers to ensure that safer staffing levels are achieved across all services, enabling staff to meet the needs of patients and that those staff are appropriately trained, competent, have supervision and are appraised– all in line with the compassion in practice action area 5.

6.6 Seven Day Services

As part of the contract round for 14/15 the CCG will be requiring all providers of acute services within their SDIP to document actions that they will take during 2014/15 to commence implementation of the recommendations of the review into 7-day services.

Confidence in delivery and progress made for 7 day working and its implications will be aligned to the strategic planning process of the CCG and a working group set up to oversee implementation.

For non-acute based urgent and emergency services outside of the hospital, implications for 7 day working is being picked up as part of the Emergency and Urgent Care Strategy (and aligns with the Urgent and Emergency Care Review Phase 1 report) with the majority of these services already operating 7 days a week.

The local Better Care Fund proposals will also support development of 7 day health and social care services including to support 7 day hospital discharge and admission avoidance.

6.7 Safeguarding

Mid Essex CCG (MECCG) is committed to delivering safe and effective safeguarding services and to strengthening arrangements for safeguarding children and adults at risk across Essex.

Our vision is to provide services to promote and protect individual human rights, independence and well-being. Everyone requiring our services will be treated with dignity and respect.

Safeguarding children, young people & adults at risk and promoting their well-being is essential for Mid Essex Clinical Commissioning Group (MECCG). MECCG will ensure safeguarding, protection and promoting well-being in all its activities with children, young people and their parents, adults at risk, carers, families and staff.

Our vision:

Children and young people and adults at risk are considered in all interactions with service users and carers. A 'Think Family' approach across adult and children's services will enhance safeguarding practice, service provision and commissioning.

Safeguarding and protecting the vulnerable will be realised as a role for all services and all staff across Mid Essex regardless of their position.

A strategy helps us reach this vision. It describes our main aims and what we will need to achieve to get there.

We will:

- Seek the views of children, young people, adults at risk and their carers to influence the commissioning of services
- Comply with statutory requirements nationally and locally including quality standards set by the Care Quality Commission and NHS England
- Provide leadership for safeguarding across NHS and partner organisations
- Have sound reporting, monitoring and accountability arrangements for safeguarding across the organisation ensuring Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework 2013 continues to be used to monitor commissioned services
- Have executive level membership of the Essex Safeguarding Children Board & Essex Safeguarding Adults Board
- Work in collaboration with Essex County Council and other partner organisations to provide where appropriate integrated services for the local population, including specialist services for disabled people, looked after children and other vulnerable groups

- Commission services which reduce the effects of domestic abuse which includes Honour Based Abuse, Forced Marriage and Female Genital Mutilation
- Promote the PREVENT anti-terrorist strategy to reduce the risks of vulnerable people becoming radicalised
- Have safeguarding children (including those who are Looked After) and adult at risk policies in place, which includes safe recruitment of staff, whistle-blowing policies
- Have a positive influence on safeguarding arrangements
- Across the NHS and partner organisations
- Make sure that all staff know how to recognise and respond to safeguarding concerns
- Take account of the views and experiences of the most vulnerable members of our communities to inform service planning
- Review serious incidents to identify lessons learned and to cascade learning across organisations
- Improve and develop safeguarding practice through learning from experience, review, research, evidence and guidance
- Continually monitor and review the quality of services to vulnerable groups through our quality assurance and governance processes to achieve the best outcomes

7. Research

7.1 Research & innovation

How we fulfil our statutory responsibility to support research:

Mid Essex CCG believes that research and innovation are important to the future of shaping local clinical services in Mid Essex. The CCG are a member of the Comprehensive Local Research Network (CLRN) and we also have a number of members of the East of England Clinical Senate including a GP Chair.

The CCG fund a Research Nurse at our local acute provider to facilitate primary care engagement in clinical research and we are actively involved in the ethical evaluation of research proposals within our acute trust.

We are exploring partnership opportunities with our local higher education institute. In particular, Anglia Ruskin University (ARU) are developing a MedTech campus within Chelmsford and the CCG are in discussion with ARU as to how a partnership could be mutually beneficial in promoting clinical research and innovation within Mid Essex.

How we will use the Academic Health Science Networks to promote research:

We are establishing links with our local HEIs as described above and we also actively engage with the Local Education & Training Board (LETB) in terms of planning and research promotion

How we will adopt innovative approaches using the delivery agenda set out in Innovation Health and Wealth: accelerating adoption and diffusion in the NHS:

In addition to the above, we adopt the Invention, Adoption, Diffusion approach set out in Innovation Health and Wealth with the Innovation Pipeline approach to business case development we have adopted in partnership with our local acute trust.

8. Organisational Development

Mid Essex CCG has, in its short life, already made a considerable impact in terms of ensuring it can fulfil its role as the commissioner of the health care for its population. An early vision laid out the following goals:

- For individuals in mid Essex to be healthy and supported to look after themselves as far as possible
- Healthcare in mid Essex will be a beacon of excellence
- As leaders of healthcare commissioning we will be respected and trusted by our peers and the communities we serve whilst demonstrating respect, care and dignity towards all
- People will feel valued, encouraged and supported to make the right choices and use services appropriately
- Services we commission will focus on quality, innovation, productivity and prevention and deliver the best possible care to communities and individuals and reduce health inequalities

The delivery of these goals is both challenging and exciting and with the leadership provided by our clinicians the CCG is aiming to achieve a sustainable and forward looking health system which operates within the resources available.

Over recent months the CCG has been working to develop a long term sustainable vision for the Mid Essex health system.

The emerging vision focuses on 5 "phases of life":

- Long Term Conditions
- Frailty
- Self-Care
- Immediate Care
- End of Life

These need to be of a high quality and affordable. In order to ensure that this can be delivered the CCG needs to be structured in such a way to support this change process while balancing both the quality and the cost agendas whilst ensuring "business as usual" continues.

As a result the CCG is currently restructuring its organisation to better and more effectively meets the needs identified as above.

The new structure is anticipated to be in place by the end of the financial year 2013/14. In addition the CCG has also secured new premises and the move to these is also anticipated during the same timescale.

The CCG has spent significant time and resource in organisational development during 2013/14 both for the CCG Board members, clinical leads and all staff. Development has been focussed primarily on achieving mandatory training levels across the organisation as well as a defined programme of core commissioning and support skills delivered through workshops. This will continue into 2014/15 and beyond

The CCG's Organisational Development Plan is due to be refreshed and will reflect the outstanding needs identified in the two Staff Away Days held in 2013/14 as well as a programme for development across the organisation, reflecting the new sustainable vision for the CCG.

9. Monthly Activity Return

MAR Submissions are based on FOT at Month 9 using contract profiles, adjusted working days for electives and outpatients and calendar days for non- elective.

14/15	15/16	16/17	17/18	18/19	Schemes/policies which will/should impact on growth % reductions
Emergency (+2%)	Emergency (0%) Flat	Emergency (-1%)	Emergency (-1%)	Emergency (-1%)	Changes to front door, RAU/EAU frailty pathway , BCF
NEL - Non emergency (+1%)	NEL Non-emergency (-1%)	NEL Non-emergency (-2%)	NEL Non-emergency (-2%)	NEL Non-emergency (-2%)	Frailty , EOL, BCF
Elective (-0.5%)	Elective (-1%)	Elective (-1%)	Elective (-1%)	Elective (-1%)	QP+ , SRP
Referrals & Outpatients (-0.5%)	Referrals & Outpatients (-1%)	Referrals & Outpatients (-1%)	Referrals & Outpatients (-1%)	Referrals & Outpatients (-1%)	QP+ , SRP

CCG's are expected to deliver challenging activity reductions over the life of the medium term plan. The CCG is working closely with system partners to identify the service delivery pathways which offer the best use of scarce resources and avoids undermining provider sustainability where possible.

The forecast activity assumptions do not yet reflect the impact of any service transformation which may be agreed as part of the System Sustainability review.

10. Delivering Value

10.1 Financial resilience, & delivering value for money

Meeting rules on business plans:

The CCG is required to meet its national and local priorities and to deliver the NHS Constitution within allocated resources. National planning assumptions identify a potential funding gap of around £30 billion by 2020/21 and CCG plans are required to demonstrate how services can be maintained in that context.

The Mid Essex system has been a historically financially challenged health economy. Assessed need to spend is low due to the relatively affluent population with relatively good health outcomes and life expectancy.

For 14/15 onwards, NHS England has adopted a revised funding formula recommended by the Advisory Committee on Resource Allocation. The new formula reduces the CCG's assessed target funding requirement (now assessed as £1,079 per head of population by 15/16 compared to £1,084 in 2013/14 using the 13/14 formula).

Whilst service quality and outcomes are good, Mid Essex Hospital Services Trust has reported a significant underlying financial deficit for a number of years and the combination of low CCG funding and the financial pressures experienced by the main acute provider means that the financial challenge for Mid Essex is escalating.

The CCG's 14/15 allocation is £1,014 per head which is in the bottom 20% of funding per head for England and 4.88% below target.

The CCG is likely to incur a deficit of £9.2m in 13/14. A number of non-recurrent resources were used to deliver that position e.g. £2.5m surplus brought forward, £1.3m Winter Pressure funding and dispensation from delivering the required target 1% surplus or holding 2% of funding for non-recurrent expenditure. These factors contribute to an opening underlying deficit in the order of £13m.

Funding allocations have been announced for 14/15 and 15/16 as follows:

	2013/14 £000	2014/15 £000	2015/16 £000
Confirmed Programme Funding	368,029	379,825	390,642
Agreed RL Adjustments	558	11,324	8,802
Return of Specialist Top-Slice	10,631	(507)	(507)
GP IT	1,223		
Winter Pressure	2,869		
Surplus Brought Forward	2,509		
Additional Better Care Funding			7,281
Total Programme Funding	385,819	390,642	406,218
Running Cost Funding	9,430	8,753	8,753
Total Funding	395,249	399,395	414,971

Meeting rules on business plans:

The following Business Plan rules have been set nationally:

2014/15	2015/16-2018/19
• Minimum 0.5% contingency • 1% cumulative surplus carry forward • 2.5% non-recurrent spend (including 1% for transformation)	• Minimum 0.5% contingency • 1% cumulative surplus carry forward • 2% non-recurrent spend • Better Care Fund spend as notified separately

The 14/15 funding increase was disappointing and is more than offset by expected new cost pressures. The CCG is not going to be able to achieve the Business Rules nor deliver a balanced financial plan in the short term.

Note: Further tables and commentary to be added once the Medium Term Financial Plan/Sustainability information is firmer. Data to be added includes 5 year overview, commentary upon the planning assumptions, sustainability plan etc

Clear & Credible plans for QIPP:

The CCG is working closely with NHSE Essex Area Team and system partners on a System Sustainability project. Timings are such that plans are not yet available to include in the plan submission.

Service transformation plans are in development but require greater granularity and assumptions require validation.

Clear link between service plans, financial and activity plans:

The CCG is in early discussion with the MEHT regarding possibility of agreeing block payments in the short term in order to create the headroom to test and implement service transformation that will enable both MEHT and MECCG to achieve financial sustainability. As a part of these discussions we are working with MEHT, NHSE Essex AT and NTDA in order to support the financial viability of MEHT.

There are key work streams are in progress to model planned acute activity and will align with service and financial plans. At this stage in the process, the modelling is still work in progress.