West Essex Clinical Commissioning Group

West Essex Clinical Commissioning Group Integrated Plan 2013/14 to 2015/16

West Essex Clinical Commissioning Group

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Executive Summary

Message from the Chair and Chief Officer

Welcome to the first Integrated Plan for the West Essex Clinical Commissioning Group (CCG) which sets out our three year plan for the commissioning of health services for the people of West Essex. We are a new commissioning organisation which gives us an exciting opportunity to change how we do things.
A key driver for change is our ageing population and the numbers of people with chronic medical conditions. We need to shift our focus from the current reliance on acute and episodic care hospitals towards prevention, self care and proactive management in the community using all of the resources across health and social care. Central to this transformation is the lead role that our clinicians are now taking in the planning and commissioning of health services.

Putting patients and their families first is paramount in all that we do. Learning from the Francis Report on standards of patient care, as clinical commissioners we will improve our systems to rigorously monitor and evaluate clinical quality, listening to patient voices and their accounts of healthcare. This will play a significant part to determine what and how services are commissioned in West Essex in the future. This is a key component of our Patient Engagement and Communications Strategies.

This is with a backdrop of considerable financial challenge for the years ahead. Over the three year period 2013 to 2016 the total efficiencies needed across the West Essex health economy is estimated to be £107m. Plans are already in place to deliver some of the efficiencies required but we know we need to do far more with our partners to ensure both clinical and financial sustainability for the local health and social care system. This plan lays some of the foundations for the transformational changes required, integrated commissioning being one of the levers to deliver this.

Finally, we are determined that this Integrated plan will result in action to improve both services provided and the health of local people.

We recommend this document to you

Rob Gerlis Chair

Clare Morris Chief Officer

West Essex Clinical Commissioning Group

The CCG

West Essex Clinical Commissioning Group (CCG) is now authorised as the key statutory body responsible for the commissioning of health services in West Essex, taking over from West Essex PCT on 1st April 2013. As a CCG we have undergone a period of rapid development during 2012/13 in our preparation for this responsibility and will continue an important programme of development over the coming year.

We have made a promise to the people in West Essex in that:

"We will support you to maintain and improve your health; when you are not well we will help you to access the right care at the right place and time"

In delivering this promise we will work with our partners including providers, patients and members of the public, Local Authorities, the voluntary sector and other CCGs to:

- Be courageous and ambitious in our attempts to improve the health of our patients and will challenge the status quo
- Improve the health outcomes of our whole population at the same time caring for individual needs
- Never compromise on patient safety even if this means making difficult decisions
- Be open and transparent in our decision making and make decisions that are clinically safe
- Use NHS resources wisely, using sound judgement and effective planning
- Encourage feedback and be held to account for our actions
- Uphold the rights of the NHS Constitution

Our Three year Transformation Priorities

We are a new but ambitious organisation and have set ourselves a three year transformation target. Our success will be measured by the delivery of:

- High quality, viable local hospitals
- Integrated primary, community and social care services
- Better care for the most vulnerable
- Devolved commissioning to practices and patients
- Integrated commissioning between health and social care

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Our System Challenges

The current Health System faces significant challenges over the coming years to ensure that services are sustainable against a backdrop of limited resources, ageing population base and continuing rise in demand and activity in acute services, well above demographic based estimates. In combination, this could put a major strain on the NHS and adult care. The local health system has a combined financial challenge of £109.1m over the next three years of which the CCG is £56.6m. Our Local Authority partners at ECC have a challenge of £200m by 2016/15. The health and social care landscape will need to change over the coming years to meet this challenge.

Our main provider, Princess Alexandra Hospital own financial challenge amounts to an £18m Cost Improvement Plan predominately due to the increase in emergency demand, patients exercising choice, the loss of share of elective market; and the planned loss of services related to regional reviews. Maintaining operational performance of the Trust has also been a challenge during 2012/13.

In recognition of the growing demand on our services we commissioned a review of demand and capacity across the system. The findings of the review illustrate that the current transformation and efficiency programmes that we are implementing only go a small way to contain the impact on our services and that we will need to fundamentally change our approach to commissioning to have further impact

How are we responding to the system challenges?

➢ Commissioning for outcomes

By ensuring that our commissioning decisions deliver measurable improvements in the health outcomes for our patients, using the NHS Outcomes Framework as our guide and the Joint Strategic Needs Assessment to identify our priorities *(Section 1 & Section 2)*

➢ Commissioning for quality

By putting patients and their families in the centre of all we do, learning from Francis we will improve our systems to rigorously monitor and evaluate clinical quality, listening to patient voices and their accounts of healthcare, involve patients and public in our decisions building on the network of public and patient engagement we have developed *(Section 2.2, 2.4 & Section 7)*

Our plans will deliver against four national quality priorities including:

- ✓ Reducing lives lost through amenable mortality
- ✓ Reducing avoidable emergency admissions
- ✓ Ensuring roll out of friends and family test
- ✓ Preventing HCAIs

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➢ Involving our patients

The CCG is clear that engagement and partnership with our patients and communities is key to the delivery of our plans. Our plans for patient and public engagement in West Essex challenge the existing culture of public engagement and will develop ways to work in collaboration with our patients and the public to ensure individuals and local representatives have real decision-making and asset building power, including budget responsibility where possible. Our ambitious are laid out in our PPE Strategy "Open Doors: Public and Patient Power in Health Planning".

This strategy will be delivered through a new patient and public network that is part of our organisation. This new network, established in August 2012, enables people to influence service improvements and our annual spending plan.

The delivery of this strategy will be pivotal to our response to the recommendations of the Francis report. *(Section 7)*

➢ Integrated Commissioning

West Essex CCG is committed to working collaboratively with ECC and other health partners to develop integrated commissioning both on a pan Essex basis and locally here in West Essex. We have been working with our ECC partners over a number of months along with our North Essex colleagues scoping these opportunities and determining priorities. We expect to see a step change in integrated working in Essex between health and social care moving forward through lead commissioners, joint commissioning, lead provider models, section 256 arrangements and the procurement where necessary of agreed priority services.

The agreed priorities for integration include:

- ✓ Frail Older People *(section 3.1.1)*
- ✓ Children's Services *(section 3.1.2)*
- ✓ Learning Disabilities*(section 3.1.3)*
- ✓ Mental Health *(section 3.1.4)*

➢ Three step plan to transforming primary care

Primary Care has a pivotal role in supporting the CCG to deliver in its objectives and to provide quality, locally-accessible and cost-effective services. Primary Care is often the first access point for health services and as such is the patient's entry point onto a specific pathway or into specific services. Primary care should be easily accessible when a patient needs it. *(Section 3.6)* Our plans will support the development of primary care to:

- Be at the centre of the local healthcare system
- Provide a high quality service
- Deliver significant improvement in clinical outcomes
- To provide equity of access to all patients
- To enable the delivery of more services in primary care/locally
- For practices to receive a fair level of pay

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➢ West Essex System Transformation Programme

PAH's sustainable clinical and financial viability will be dependent on improved internal efficiency and productivity and working with its local health system partners on the development of a clear strategy for service transformation and configuration. The development of this joint commissioner and provider transformational programme will be a key priority for the CCG in the first quarter of 2013/14 that will require strong clinical leadership and stakeholder involvement.

This Integrated Plan is only a three year plan, to ensure long term sustainability the CCG recognises the need to develop a much longer term strategy for the system. Alongside this transformation programme during 13/14 the CCG will develop, with its partners, a 5-10 year strategy to address the longer term sustainability of this local health and social care system.

➢ QIPP Programme & Delivery

The CCG has developed a robust QIPP programme to deliver its £20m QIPP challenge for 2013/14 and outline plans for £15m for 2014/15. These plans both address the financial challenge, delivery of strategic objectives and commissioning intentions and also strives for improvements in the quality and outcomes of services commissioned. During 13/14 the programme of work at a system level falls into the following categories:

- ✓ Continuation of 12/13 projects that have started in year and that will deliver a full year effect during 13/14
- ✓ Building upon the work streams we have developed in 12/13 to create better integration between our community services, our GPs and Social Care.
- ✓ Planning for projects that will start later in 2013/14 or early 2014/15

Our plans have been developed through our clinically led Programme Boards with representatives from our provider organisations, social care, voluntary sector and our patients. The delivery and performance of these plans is managed robustly through our Programme Board governance structure thorugh to the CCG Board. *(Section 5)*

➢ Ensuring Delivery

Our approach to delivery outlined in section 8 is set against a number of key risks and issues including:

- Supporting and developing effective CCG Leadership
- Continuing our journey of organisational development
- Maintaining accountability and oversight
- Integrated delivery between health and social care, commissioners and providers
- Embedding public and patients experiences and views in our decision making

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Measures of success

By 2013/14 we will achieve:

- Full performance against all constitutional pledges
- Start to deliver integrated commissioning for older peoples services
- incremental delivery of lead provider model for frailty services
- All GPs practices working to level 1 core service
- Proportion of GP practices working to level 2 and 3 of primary care framework
- Improved patient experience across all of our services
- Treatment of more patients with mental health conditions in primary care setting

By 2014/15 we will:

- Full delivery of lead provider model for frailty services
- Full roll out of hospital at home care
- Growing number of GP practices working to levels 2 and 3 of primary care framework
- Further improvement in patient experience across our services
- Be working with our local acute provides to ensure capacity is in the right place
- Greater numbers of patients feeling that they are able to manage their long term condition
- Devolved budgets to some primary care localities

By 2015/16 we will:


NHS
West Essex Clinical Commissioning Group

WEST ESSEX CLINICAL COMMISSIONING GROUP – "PLAN ON A PAGE" 2013/2014

Strategic Objectives

Planning and buying services that result in improved quality of care

Improving and protecting health and well being and to improve the health of the poorest fastest

Ensuring the right care in the right place

Making efficient and best use of limited resources

Strategic Context and Scale of Challenge

Above average population growth 12.3%

Complex flows / complex borders

Extreme demographics: most affluent to most deprived

Challenged acute trust in most deprived / most populous location

£20m QIPP challenge

Quality and Performance Priorities

National Quality Priorities

Reducing lives lost through amenable mortality:
- Review data to identify specific conditions where people are dying prematurely
- New diabetes pathway in line with NICE best practice improving access to insulin pumps.

Ensuring roll out of friends and family test:
Friends and Family roll out of test in wards in 12/13 and within maternity and A&E services during 13/14 in line with national guidance.

Reducing avoidable emergency admissions:
- Identification of underlying reasons for high use of emergency services in West Essex
- Improve access to primary care and OOHs services
- Directing patients to the right services eg 111, A&E processes
- Increase in integrated community services to avoid unnecessary admission and reduce reliance on secondary care

Preventing HCAIs:
- Maintain good performance in West Essex whilst continuing to stretch and improve.
- Seek on-going improvement in antibiotic prescribing throughout the system.

Our 3 Local Priorities

- Increase proportion of people feeling supported to manage their condition.
- Improve patient experience of GP and out of hours services.
- Improved care for patients at end of life, with learning disabilities and obesity related health problems through improving and using effectively information collected on registers.

Local Performance and Quality Priorities:
- Improve Patient experience
- Reduction in pressure ulcers
- Improve Cancer Services
- Sustainable waiting times in A&E
- Improve Stroke services
- Sustainable waits for elective care at specialist level

Changing how we commission:

- Integrated commissioning with other CCGs and ECC
- Development of new commissioning models, inc integrated commissioning and lead provider model
- Primary care development framework
- Strengthen our governance arrangements
- Improved contract management and contestability where appropriate
- locality commissioning priority plans
- System organisational development
- Developing how we work with our partners in the new commissioning landscape
- Develop how we work with public health to improve the health of our population.

Transformational Change

Mental Health
- Development of single point of access for referrals
- Improved access to psychiatric liaison
- Improved identification, intervention and on-going care for people with dementia.
- Joint commissioning with social care

Strengthening of services for adolescents

OUTCOMES:
- Improved quality of care for patients with Mental Health problems in secondary care
- Earlier interventions for Dementia patients

Older Peoples
- Integrated frailty programme commissioned jointly with social care
- Low acuity medical care at home
- Integrated falls service

OUTCOMES:
- Improve quality of care for older people
- Reduced reliance on secondary care
- Reduction in inappropriate admissions into hospital

Children and Maternity
- Analysis of use of urgent care services and consideration of alternatives
- Care closer to home
- Improved end of life care
- GP education to improve diagnosis
- Integrated commission programme across range of children services with Social Care

OUTCOME:
Care in the right setting

Learning Disabilities
- Joint approach to commissioning with ECC and Essex CCGs
- Improving care for LD patients across all sectors

OUTCOME:
Improve Access to services for patients with LD.

Urgent Care
- Reduction in unnecessary use of A&E
- Improved access and signposting to alternative services
- Development of 111 service to support appropriate access to services
- Increase in response options with ambulance service

OUTCOMES:
- Access to the right services for urgent care
- Reduced unnecessary use of A&E services
- Appropriate use of ambulance services

Planned Care
- Better use of diagnostics
- Tightening treatment thresholds
- Optimising local access
- Increased referral support for GP's to improve quality of referrals

OUTCOME:
Optimum use of elective services

Medicines Management
- Targeted practice plans
- Improved poly pharmacy
- Reduced waste
- Reduced anti-psychotic prescribing

OUTCOME:
Effective and efficient prescribing

Long Term Conditions
Seamless pathways for:
- Diabetes
- Respiratory disease
- Cardiology

OUTCOME:
Reducing need for emergency admission to hospital

CCG Values	Be Courageous & ambitious in our attempts to improve the health of our patients & will challenge the status quo.	Improve the health outcomes of our whole population at the same time caring for individual needs.	Never compromise on patient safety even if this means making difficult decisions.	Be open and transparent in our decision making and make decisions that are clinically safe.	Use NHS resources wisely, using sound judgement and effective planning.	Encourage feedback and be held account for our actions.

Section 1.0 Introduction

1.1 The Purpose of this Plan

This document sets out the CCG's plans on how it will deliver the vision and priorities for west Essex CCG to meet the local needs of its patients and members of the public; at the same time drive through efficiencies to ensure it makes best use of the resources it has available; and working collaboratively with all its partners both locally and across Essex to deliver the system priorities over the next three years.

We will detail our plans to facilitate delivery of our financial objectives; sustained and improved health outcome measures; and improve the performance of our providers meeting the requirements of the National Commissioning Board's (NCB) planning framework "Everyone Counts: Planning for 2013/14"; our local commissioning priorities set out in "West Essex Clinical Commissioning Group 2012-14 Commissioning Strategy; and the Essex Health and Well Being Strategy.

1.2 Context

West Essex Clinical Commissioning Group (CCG) is now authorised as the key statutory body responsible for the commissioning of health services in West Essex, taking over from West Essex PCT on 1st April 2013. As a CCG we have undergone a period of rapid development 2012/13 in our preparation for this responsibility and will continue an important programme of development over the coming year.

From 1 April 2013 the CCG will hold a delegated authority for a budget of circa £300m. The financial challenge for the CCG over the next three years is £55m.

The current Health System faces significant challenges over the coming years to ensure that services are sustainable against a backdrop of limited resources, ageing population base and continuing rise in demand and activity in acute services, well above demographic based estimates. In combination, this could put a major strain on the NHS and adult care. The health and social care landscape will need to change over the coming years to meet this challenge.

The provision of high quality services for our patients and their families will be at the heart of everything that we do ensuring safe, effective and efficient services and real improvements in how our patients and their families experience our services.

We have additional complexities in West Essex relating to our patient flows which will require us to develop close strategic alliances with other emerging CCGs to ensure we can appropriately influence the service transformation to meet the needs of all our patients. The acute contracting in west Essex has patients flow to five main hospitals in and around the health economy. Fifty six percent of the CCGs acute commissioning budget is spent on contracts with our main provider Princess Alexandra Hospital, 11% with Cambridge University Foundation Hospital, 5% Mid Essex Hospitals and over 12% on contracts with London based hospitals such as Whipps Cross University Hospital and Barts and the London Hospitals.

1.3 Our Promise to the People of West Essex

Underpinning this plan is the commitment we made within the CCGs Commissioning Strategy to the people of West Essex:

We will support you to maintain and improve your health; when you are not well we will help you to access the right care at the right place and time.

We will do this by:

1. *Planning and buying services on your behalf that result in improved quality of care, including:*
   - *Improved quality of care at acute hospitals, in community and in mental health services*
   - *Achievement of more consistent standards and continuous improvement in quality across primary care*
   - *Improving levels of patient satisfaction with services*

2. *To improve and protect the population's health and well-being and to improve the health of the poorest fastest:*
   - *Actively working to prevent disease*
   - *Early identification of disease*
   - *Active management of long term conditions*
   - *Supporting people to make healthy lifestyle choices*

3. *Ensuring the right care in the right place by:*
   - *Re-designing care pathways to ensure simplified access to services, reduced duplication and a smooth transition between care settings*
   - *Transferring activity that currently takes place in hospital into a community and primary care setting where clinically appropriate*
   - *Making sure that the most acute care is provided by hospitals that have the necessary specialist staff and facilities*

4. Making efficient and best use of limited resources

Section 2 of this plan details the commissioning priorities for each of our programme boards, the mechanisms by which we will facilitate innovation and implementation of our QIPP programme detailed in section 5 that in turn will deliver our over-arching strategic objectives.

The values by which the CCG will by which it will work with its partners including providers, patients and members of the public, Local Authorities, the voluntary sector and other CCGs to deliver this plan are :

- Be courageous and ambitious in our attempts to improve the health of our patients and will challenge the status quo
- Improve the health outcomes of our whole population at the same time caring for individual needs
- Never compromise on patient safety even if this means making difficult decisions
- Be open and transparent in our decision making and make decisions that are clinically safe
- Use NHS resources wisely, using sound judgement and effective planning
- Encourage feedback and be held to account for our actions
- Uphold the rights of the NHS Constitution

1.4 How will we Measure our Success

We are a new but ambitious organisation and have set ourselves a three year transformation target. Our success will be measured by the delivery of:

- High quality, viable local hospitals
- Integrated primary, community and social care services
- Better care for the most vulnerable
- Devolved commissioning to practices and patients

By 2013/14 we will achieve:

- Full performance against all constitutional pledges
- Start to deliver integrated commissioning for older peoples services
- incremental delivery of lead provider model for frailty services
- All GPs practices working to level 1 core service
- Proporation of GP practices working to level 2 and 3 of primary care framework
- Improved patient experience across all of our services
- Treatment of more patients with mental health conditions in primary care setting

By 2014/15 we will:

1.5 How we will Change the way we Commission

In recognition of the growing demand on our services we have commissioned a review of demand and capacity across the system. The findings of the review have illustrated that the current transformation and efficiency programmes that we are implementing only go a small way to contain the impact on our services. The findings go on to recommend substantial changes in how we commission care through outcome and pathway based commissioning requiring a phased approach over a five year period. We will be taking forward incremental plans to commission in this way. This may have an impact on our provider landscape and we will be working with our providers to encourage the development required.

We will change the way we commission services to reflect :

- Alignment of delivery with ambitions of the NHS Outcomes Framework
- Integrated commissioning with Essex County Council
- Fair and equitable commissioning

- Collaborative commissioning with our neighbouring CCGs
- Commissioning for outcomes
- Developing Lead provider commissioning models
- Transforming Primary Care

1.6 Our Partners in West Essex

1.6.1 The Essex Local Area Team (LAT)

The CCG boundaries also cover healthcare services from 39 GP practices, 34 dentist, 49 pharmacists and 55 opticians. The National Commissioning Board (NCB) will inherit PCT responsibility for commissioning services from these organisations but will work very closely with the CCG to ensure local performance. Specialist healthcare services will also be commissioned by the NCB.

1.6.2 Essex County Council (ECC)

ECC Financial Outlook

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

Over the last 4 years Essex County Council has embarked on an ambitious transformation programme and achieved savings of £300M per annum by 2013. This is one of the largest savings targets of any local authority in the country. However, the major challenge ECC faces is not simply one of reductions to funding levels, but inflation and demographic pressures. The Council faces demographic pressures and increased demand for services, particularly in the Adult, Health and Wellbeing service area including Learning Disability, Physical and Sensory Impairment, Older People and Mental Health services. These services alone represent close to half of ECC's controllable budget. The risk is further exacerbated given the enormous efficiency savings and demand pressures within the health system. It is therefore imperative that Health and Social Care work together and build on the Whole Essex Community Budgets work to date, to address the common issues we face.

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

ECCs Commitment to Integrated Commissioning

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

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

ECC is working with Essex CCGs on future commissioning leadership models for its priority areas of Mental Health, Child and Adolescent Mental Health, All Age Disability, Learning Disabilities and Children's Services early help and starting well. ECC agrees that joint commissioning in Adult Mental Health should be on a north and south Essex systems basis. ECC has stated its offer to lead the commissioning of Learning Disability services across initially on a North Essex/South Essex systems basis with the ambition to work on a pan-Essex basis in the medium term.

ECC is committed to devolving and co-locating commissioning capability and resources to CCG areas to support integrated commissioning development with CCG partners during the course of 2013/14. The initial proposals are to use sustainability funds transferring from the NHS to ECC, which have yet to be agreed between the NCB- LAT, ECC and CCG lead Commissioners, are:-

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

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

West Essex CCG and ECC working in collaboration

West Essex CCG is committed to working in collaboratively with ECC and other health partners to develop integrated commissioning both on a pan Essex basis and locally here in West Essex. We have been working with our ECC partners over a number on months along with our North Essex colleagues scoping these opportunities and determining priorities. We commit to an on-going programme of work which takes these and future priorities forward. As a result we expect to see a step change in integrated working in West Essex between health and social care moving forward. Priority areas for integrated working during 2013/14 will include:

- Driving through transformation of the Health and Social care system in line with agreed priorities, including consideration of integrated commissioning models, single service specifications, lead provider models, personalised budgets and integrated service provision. Our key priority for 2013/14 being the commissioning for Frail Older People for which we expect to implement in a phases from April 2013.
- Continuing to work through the Health and Wellbeing Board to develop the Essex Health and Wellbeing Strategy and overseeing delivery of the Integrated Plans for North and South Essex.

1.6.3 Essex Health and Well Being Board

The Essex Health and Wellbeing Board has operated in shadow form during 2012/13 moving to its full statutory role from April 2013. The Board creates a forum for the local health and care system to collaborate, to have a common understanding of local community's needs, agree common priorities and to facilitate an integrated approach to commissioning of health and care services. Building this on the strong foundations of identified needs and priorities from the Joint Strategic Needs Assessment (JSNA).

The Essex Health and Wellbeing Board produced a strategy which sets out how the partners will work together to improve health and wellbeing in Essex over the next five years. This Integrated Plan aligns to the achievement of this strategy translating priorities into deliverables in West Essex, these are detailed in section 2.

1.6.4 Our District Council Partners

The community leaders in West Essex; Epping Forest, Harlow and Uttlesford District Councils, along with the County Council and the West Essex Clinical Commissioning Group, are committed to working in partnership, to develop and implement a Community Wellbeing Strategy for West Essex.

Whilst local partnership arrangements for wellbeing may be developed within each District Council area, the partners in West Essex are creating a West Essex Wellbeing Joint Committee to provide a governance structure for partnership working.

1.6.5 Our Main Provider Landscape

Princess Alexandra Hospital NHS Trust (PAH)

Princess Alexandra Hospital (PAH) is an aspirant Foundation Trust primarily serving the population of west Essex however given its location 34% of its 285,000 catchment population, 34% comes from south east Hertfordshire.

The Trust has an anticipated income of £171.4m for 2013/14 and it plans to break-even in 2012/13 after non-recurrent financial support. The Trust is forecast to have a planning gap of circa £18m in 2013/14 of which £6.6m relates to structural deficit and £6.6m as a consequence of tariff efficiencies. These underlying financial pressures are predominately due to the increase in emergency demand due in part to reconfiguration of services in Hertfordshire; readmission thresholds; under delivery of Cost Improvement Programmes; patients exercising choice, the loss of share of elective market; and the planned loss of services related to regional reviews.

Maintaining operational performance of the Trust has been a challenge during 2012/13, in particular performance against A&E waiting times, cancer and stroke targets. Whilst improvement has been made sustainable improvement remains the challenge.

To improve overall performance of the Trust it has as part of its operational plan identified five improvement priorities:

- Improving patient safety and reducing the incidents of avoidable harm, particularly reducing pressure sores and falls

- Improving outcomes and reducing hospital mortality rates, particularly SHIMI
- Improving patient experience
- Improving staff experience
- Achieving sustainable Emergency Department standards

The Trust has also laid out an aspiration for the organisation:

- To be a provider of first-class services built around the common DGH activities essential to support a thriving community
- To become an excellent provider of local integrated care
- To be a provider of ambulatory care services whereby an assessment can be made and management plan determined by consultant, with care continued close to home in conjunction with GPs and other community providers
- To be a local host and enabler to more specialised services delivered through planned strategic clinical networks
- To be an expert at rapid diagnostics and urgent treatment with effective handing-on and maintenance/ management of LTCs
- To be an expert local care provided as near to patients home as possible

The Trust's sustainable clinical and financial viability will be dependent on improved internal efficiency and productivity and working with its local health system partners on the development of a clear strategy for service transformation and configuration. The development of this joint commissioner and provider transformational programme will be a key priority for the CCG for 2013/14 that will require strong clinical leadership and stakeholder involvement.

South Essex Partnership Foundation Trust (SEPT)

SEPT provide the community services previously provided by the West Essex PCT. This contract commenced in August 2011 and adds to the portfolio of services already provided by SEPT. With income from the CCG of £35m in 2012/13 the organisation aims to achieve a surplus of £0.35m for the year. A Cost Improvement Programme (CIP) of £2.0m will be met in 2012/13. SEPT's CIP challenge over the next three years is £6.2m.

During 2012/13 SEPT introduced five Integrated Community Teams to provide GPs and patients with better access to effective community health services each team with a dedicated clinical team manager responsible for a cluster of practices.

The new arrangement brings together nurses, therapists, specialists and support staff working together as a single team. This is designed to enhance communication, avoid duplication and improve the experience of our patients. This approach involves integrating community teams around geographical clusters of GP practices with patients firmly at the centre of healthcare delivery.

The new integrated teams have a key role in meeting a full range of patients' needs including urgent, scheduled and preventative health care. This helps to meet patients' expectations that health workers are aware of their health as a whole and not just one particular clinical aspect, delivering better continuity of care.

The teams will be clinically led, incorporating a model of care for patients with the most complex needs. Each team will be led by a Clinical Team Manager. As a senior clinician, their role will

be to provide leadership and co-ordination as well as having an overview of the team's whole caseload and ensuring every patient has a named care co-ordinator.

The development of the Integrated Teams provide a strong foundation on which the frail elderly transformation programme referred to throughout this document will be built.

North Essex Partnership Foundation Trust (NEPFT)

The main provider of Mental Health services across north Essex is North Essex Partnership NHS Foundation Trust. In the three years, since 2010/11 the Trust, with a turnover of just over £100million, has delivered recurrent budget reductions of some £10m with almost £3m returned in cash to Commissioners through the tariff reduction. Without access to NHS capital, the Foundation Trust's "surplus for a purpose" of just 1.1% is our means to finance significant capital investment in buildings, equipment and IT systems. We have invested over £45million over the last four years into clinical settings with major refurbishment and extensions to the Derwent Centre, new builds such as the Crystal Centre, St Aubyn Centre (CAMHS) and Low Secure leaving a legacy for the health system. And our new REMEDY clinical information system will benefit mental health service users and commissioners for many years to come with a revolution in clinical information.

The Trust provides specialist mental health and substance misuse services to the one million population of north Essex. With total income of £105m in 2012/13 the Foundation Trust is on course to deliver a planned surplus of £1.6m. The Trust has an ambitious capital investment programme, using its modest surplus of 1.5% to fund long term borrowing. The most significant schemes of relevance to West Essex will be the 3-5 year remodelling and refurbishment of the Derwent Centre (£13m-£16m), the "Journey's" Care pathway programme and the £5million replacement of the Trust's clinical information system in 2013.

The Trust's planned target surplus for 2013/14 is £1.6million (same as 2012/13) and CIPs of approximately £3.3 million over the next three years.

1.7 Our Population in West Essex

Demographic Profile

West Essex has a different resident population structure to that of England as a whole, with slightly more older people and fewer 15-34 year olds. The three localities within West Essex CCG have distinct populations. Uttlesford tends to have an older population and Harlow a younger population, while Epping Forest has slightly more older people and fewer young adults.

The resident population in the area covered by the CCG is projected to increase by 12.3% between 2008 and 2025. This is above national averages. The ageing population will also be an important demographic trend over coming years with the biggest population increase in the over 85 year olds.

West Essex is less ethnically diverse than that of the England average with the highest concentration of residents from ethnic groups found in the southern end of west Essex, near London.

The average life expectancy for West Essex is above the England average. Harlow men have the lowest life expectancy across all of the three districts in west Essex. Overall, the mortality rate in West Essex PCT is well below the England average.

Despite an upward trend in life expectancy, there are inequalities with significant pockets of poorer health clearly related to deprivation, lifestyle choices and poor engagement with statutory agencies. Males have a lower life expectancy than females with a 5.1 year gap in Harlow, and the north east area of Waltham Abbey has the lowest life expectancy in west Essex. The relative inequality in life expectancy between the most deprived and least deprived areas in West Essex PCT has reduced in males over the last few years but widened in females.

West Essex has some of the most affluent and some of the most deprived areas in the country. Below Local Authority area there are small pockets of deprivation particularly in the north east area of Waltham Abbey, the Loughton Broadway area of Epping Forest and large parts of Harlow. It is therefore even more crucial that we develop locality based commissioning plans.

Health Needs

The West Essex CCG JSNA profile has highlighted the following key health issues for west Essex:

- With the **growth of an ageing population** and the drive to ensure earlier identification of long term conditions, we can expect a rise in disease prevalence and consequentially an increase in demand on health and social care services.

- **Disease Prevalence (QOF disease registers):** West Essex practices have significantly higher prevalence of heart failure, dementia and depression compared to the England average, and a lower recorded prevalence for coronary heart disease, stroke or TIA, epilepsy, mental health conditions, chronic kidney disease, obesity and learning disabilities.

- **Diabetes:** West Essex has a significantly lower mortality rate from diabetes then the England average as well as lower emergency admissions. However, over 50% of known diabetic patients are still not receiving all nine of the key care processes for diabetes care as recommended by NICE, which include measurements of weight, blood pressure, smoking status, HbA1c, urinary albumin, serum creatinine, cholesterol, and tests to assess whether the eyes and feet have been damaged by diabetes. All hospital admission diabetes and elective diabetes admissions are significantly higher than the England average.

- **Circulatory Diseases:** West Essex practices have significantly lower performance compared to the England average for a number of indicators in the management of patients on the relevant cardiovascular disease (CVD) registers, especially around the management of BP, cholesterol levels, being treated with beta blockers and influenza immunisations.

- **Cancers and Tumours:** West Essex has high incidences of some cancers including prostate cancer and breast cancer in under 75 year olds, but for most it is similar to the

England average. Cancer mortality is not significantly different to the national average but West Essex does have significantly higher use of hospital bed days and is in the top quintile for programme budget spend. Better prevention (mainly tackling lifestyle behaviours), increasing the uptake of screening programmes (e.g. addressing cervical screening variation between GP practices) and prompt diagnostics can further reduce the incidence and need for emergency hospital admissions.

- **End of Life Care:** Harlow and Epping Forest have significantly higher level of deaths occurring in hospital, with Uttlesford below the national average.

- **Emergency and Urgent Care:** People registered in Harlow are more likely to attend A&E, with 9 out of the 10 practices having rates higher than other practices in West Essex. In general, Harlow practices also have the highest hospital emergency admission rates. Four practices in West Essex (three from Harlow and one of Epping) have significantly higher admission rates compared to the national average.

- **Older people health and well-being:** People aged 65+ living on their own are the highest users of statutory services and this group will increase over time. Epping Forest has the highest rate of unpaid carers in west Essex and two thirds of people with dementia are looked after by unpaid carers. The growth in the ageing population will translate into additional pressure on all services, especially with an increase in neurological, circulatory, endocrinology, respiratory and mental health conditions.

- **Sexual health:** The rate of acute STIs varies between districts in Essex, with Harlow having the highest rate in 2010 with 1003.3 per 100,000 people and Uttlesford the lowest with 333.4 per 100,000.

- **Lifestyle Behaviours:** There is variability in the proportion of the population taking part in unhealthy life style behaviour across West Essex. Harlow tends to have a higher proportion taking part in unhealthy life style behaviour including smoking, being obese, excessive alcohol consumption, not exercising enough and drug misuse, while Uttlesford tends to have lower prevalence of these behaviours. Uttlesford saw a 28.2% increase in the under 18 year old teenage conceptions between 1998-2000 and 2007-09 though the rate reduced for 2008-10 and is still low compared to other areas.

1.8 Our Localities

The CCG has three distinct commissioning localities that are defined by their diversity from each other in terms of their demographic profiles. Each has already firmly established their identities and are on course to develop their own commissioning intentions that will inform the CCG's overall strategy in future years. The CCG works closely with the localities through attendance at locality forums and locality GP representation on the CCG Clinical Commissioning Committee. The CCG has also recently recruited to three Locality Manager posts that will support each locality whilst reporting into the CCG. It is the CCGs ambition to devolve as much commissioning as possible to locality level over time. Each locality has its own profile as follows:

1.8.1 Epping Forest Locality

Epping Forest Locality comprises 17 practices covering the populations of Abridge, Buckhurst Hill, Chigwell, Waltham Abbey, Loughton, Epping and Ongar. The overall population of the locality is 125,000. The practices also serve some 4000 patients resident in East Hertfordshire, Mid Essex, and the London Boroughs of Redbridge, Waltham Forest and possibly Enfield.

The health of people in Epping Forest is mixed compared with the England average. Deprivation is lower than average, however about 3,700 children live in poverty. About 17.5% of Year 6 children are classified as obese. Levels of teenage pregnancy and breast feeding initiation are better than the England average. Life expectancy for men is higher than the England average. Life expectancy is 6.8 years lower for men in the most deprived areas of Epping Forest than in the least deprived areas.

The population draws on the secondary care services of Princess Alexandra and Whipps Cross Hospital primarily, and also Barking & Havering (Queen's & King George), Chase Farm, North Middlesex Hospitals and significantly the central London Hospitals, particularly Barts & The London and UCL.

The district population is projected to increase to over 158,000 by 2035. The number of residents aged 65 and over is expected to increase from 22,000 people to nearly 37,000 during the same period. Epping Forest comprises some of the most affluent and most deprived wards in Essex in general and West Essex specifically and has 29 care homes with a total bed capacity of 1011, representing 48% of care home bed capacity in West Essex.

Vision*:*

- Improved support and management of long-term conditions in collaboration with other agencies
- Promoting the development of inter-practice collaboration and recognising useful innovation
- Promoting health maintenance and disease prevention initiatives
- Providing the facilities for end of life care occurring at the dying person's place of choice
- Engagement in the wider determinant of health factors agenda, e.g. housing, unemployment and education
- Creating an environment where the vulnerable feel safe and cared for
- Reduction of the carbon footprint for health provision.
- Enhance joint working with community services and the voluntary sector

1.8.2 Harlow Locality

Harlow locality comprises 10 practices and has a population of just over 90,000. The Index of Multiple Deprivation (IMD, 2010)11 ranks Harlow as the 95th most deprived area out of 326 local authorities in England (where 1 is the most deprived). This puts Harlow in the bottom 30% most deprived local authorities in England.

Harlow men have the lowest life expectancy across all of the three localities in west Essex, and the lowest across the whole of Essex County Council. There is a 5.1 year difference in life expectancy between Harlow men and Harlow women with 78 years and 83.1 years respectively.

Harlow has a higher prevalence of diabetes and COPD than is found in the other West Essex localities, together with a higher level of childhood obesity than the average in West Essex and England as a whole. In addition 1 in 5 children in Harlow live in child poverty, the highest in England.

Vision:

- To promote better integration of services across primary, secondary care health with social services and mental health to improve patient outcomes and experience.
- To work with the third sector, local government, and Harlow Health Centre's Trust to improve services to the local population
- To develop clinical leadership skills among local doctors and nurses and to encourage ownership and responsibility for CCG strategy
- To work with PAH to develop a hospital fit for the future
- To address GP access and to promote new models of GP provision

1.8.3 Uttlesford

Uttlesford comprises 12 practices and is the largest locality in terms of area, and the fastest growing in terms of population. Uttlesford has an ageing population and there are particular challenges for the rural community in terms of transport and access to Primary Care, other medical, and to local authority services and even to shops, libraries etc.

There is no single secondary care provider, with patients going to Cambridge, Harlow and Chelmsford for most care, with a few travelling further afield to London hospitals.

Uttlesford patients, for the most part, have a low rate of attendance at A&E, possibly due to distance, and of those that do attend, there is a high admission rate, demonstrating that those attending, by and large, are the right ones. Meqo data by and large demonstrates high quality care, access and QOF scores. Where performance is less good is for outpatient attendances and follow ups.

Vision

- Development of Saffron Walden Community Hospital as an integral / integrated part of local integrated services
- High degree of integration between primary, community and secondary care
- Seamless efficient services from a patient perspective
- Efficient and effective use of local services
- Improvements in patient outcomes and satisfaction levels
- Development and implementation of a 5 year plan for GP services in Saffron Walden in the context of the need to upgrade premises and services.

Section 2.0 Commissioning for Outcomes

This chapter outlines the national context and the move to commissioning for outcomes and how delivering our strategy will drive the improvements in quality and outcomes for our patients and the public or west Essex..

2.1 The National Context : Everyone Counts: Planning for Patients

Everyone Counts, Planning for Patients 2013/14 sets the framework for planning and delivery for 2013/14. The NHS Outcomes Framework and NHS Constitution continue to provide the goals and responsibilities for NHS organisations and these responsibilities are endorsed by the NHS Mandate. The approaches for delivery will vary and local commissioners now have some freedom to develop those that work in their community.

Additionally the framework introduces five offers to help commissioners deliver for the public:

1) NHS Services 7 days per week- The NHS will move towards routine services being available seven days a week. This is in recognition of the limited availability of some hospital services at certain times and the detrimental effect this can have on health outcomes. It is expected that the early focus will be on diagnostics, urgent and emergency care.

2) More transparency, more choice-It is critical that patients and commissioners understand the quality of services being delivered at healthcare settings. To enable this methodologies for casemix comparison in conjunction with NHS Choices, published activity, clinical quality measures and survival rates from national audits for every consultant will be published for specialties of adult cardiac surgery, interventional cardiology, vascular surgery, upper gastro-intestinal surgery, colorectal surgery, orthopaedic surgery, bariatric surgery, urological surgery, head and nexk surgery and thyroid and endocrine surgery.

3) Listening to patients and increasing their participation-We need to know more about what our patients think of the services we commission and act on that information in designing and delivering services. We will be working with our providers to put in place mechanisms for systematically capturing real-time patient and care feedback and comment as well as developing plans to gather public insight on local services. This will start with the Friends and Family test which we are already rolling out.

4) Better data, informed commissioning, driving improved outcomes-High quality relevant data is key to effective commissioning. Improvements will revolve around the development of universal use of the NHS number as the primary identifier by all providers from 2013/14. We are developing a core set of clinical data from GP practices to support analysis of outcomes along patient pathways while maintaining patient confidentiality.

5) Higher standards, safer care-Transforming Care: A national response to Winterbourne View Hospital and the Robert Francis review are stark reminders of the consequences to patients if their needs are not central to everything we do. We will be working to ensure that all recommendations of both reports are addressed.

These offers will underpin our approach and direction to service development over the next 12 months although some will need to develop over a period of time. For example we will start some work within our system to consider what 7 day services might look like in West Essex pending more national guidance on this. We are already starting to consider what this might look like for primary care and will be working with our other providers to consider what hospital services can offer.

We have developed our engagement strategy and see this as a key enabler to our transformation agenda with patients informing our decision making.

2.2 Commissioning for Quality

Provision of high quality services is the most important ambition held within the CCG. There are three dimensions to quality in the health system:

- Provision of safe services
- Efficient and effective services
- Good patient experience

It is the objective of the CCG to commission services which are outcome focussed. Outcomes will be considerate of the quality metrics also incorporating the views of patients their families and the communities as a whole. In order to achieve this the CCG will benchmark outcomes

aiming to sustain and improve services. We will continually seek views of our patients and public using our Patient Engagement and Communications Strategy to ensure that we can define what quality is from the patient's perspective.

Putting patients and their families first must be paramount in all that we do. Learning from Francis, as clinical commissioners we will improve our systems to rigorously monitor and evaluate clinical quality, listening to patient voices and their accounts of healthcare. This will play a significant part to determine what and how services are commissioned in West Essex in future. This is a key component of our Patient Engagement and Communications Strategies. More detail on who we will listen to the voices of our patients and involve them in our decisions is included in section 7 of this plan.

We are establishing systems and processes within the CCG to ensure improvement in the quality of care being received across West Essex. Our Patient, Safety and Quality Committee scrutinises provider performance of quality with individual quality committees (CQRG) for each main provider.

CQRG are held monthly where individual providers are held account. We use hard and soft data to understand the services being delivered and received so that we can see the fullest picture possible about the care of our patients. As clinical commissioners we are committed to visiting our provider on a regular basis to test the level of patient care that is being delivered

2.3 Our Contributions to Delivering the Essex Joint Health and Wellbeing Strategy

The first Joint Health and Wellbeing Strategy for Essex was published in August 2012. The Strategy sets out how the partners will work together to improve health and wellbeing over the next five years in Essex. The key priorities are based upon evidences from the JSNA and an extensive consultation process throughout the county. There is a good match between the priorities set out in the Health and Wellbeing Strategy and our own Commissioning Strategy, as would be expected because both documents are informed by the information included in the JSNA. There will never be a direct fit between the CCG commissioning plans and the Essex Health and Wellbeing Strategy because the scope of the Essex plan extends beyond the CCGs geography and commissioning remit.

Many of our commissioning priorities support the delivery of the three strategic priorities described in the Health and Wellbeing Strategy, and some examples of this are given below:

- **Health and Wellbeing priority 1: Starting and developing well: ensuring every child in Essex has the best start in life:** Several of our commissioning priorities will contribute to the delivery of this objective, for example our commitment to children safeguarding, our plans to improve Child and Adolescent Mental Health Services including the transition between CAMHS and adult mental health services and our plans to provide care closer to home for children by expanding the Children's Community Nursing Team and to improve links between maternity services and other early years provision.

- **Health and Wellbeing priority 2: Living and working well: ensuring that residents make better lifestyle choices and residents have the opportunities needed to enjoy a healthy life:** Our Commissioning Strategy includes several proposals to support and

empower patients to manage their own conditions, for example our plans to explore cost effective use of telehealth to enhance self-management and access timely advice.

- **Health and Wellbeing priority 3: Ageing well: ensuring that older people remain as independent for as long as possible**: There is a particularly close match between this objective and our own plans for Older People's services, including our plans to increase the provision of memory assessment services and to improve the early identification and discharge planning of patients admitted to acute hospitals with acute dementia and our plans to develop an integrated frail elderly service, with a focus upon supporting elderly people to live in their own homes.

We will continue to work in partnership with the Health and Wellbeing Board as we further develop these plans.

2.4 Delivering the Outcomes Framework in West Essex

The CCG will need to assure itself that it can deliver against all of the goals and responsibilities of the NHS Outcomes Framework and NHS Constitution. We will be working towards improvement across the four national quality priorities that are highlighted in the plan. Identification of specific areas that we are working on that will support the improvement in these outcome measures include:

Reducing lives lost through amenable mortality:
- ✓ Reviewing data to identify specific conditions where people are dying prematurely
- ✓ New diabetes pathway in line with NICE best practice improving access to insulin pumps.

Reducing avoidable emergency admissions:
- ✓ Identification of underlying reasons for high use of emergency services in West Essex
- ✓ Improve access to primary care and OOHs services
- ✓ Directing patients to the right services eg 111, A&E processes
- ✓ Increase in integrated community services to avoid unnecessary admission and reduce reliance on secondary care

Ensuring roll out of friends and family test:
- ✓ Friends and Family roll out of test in wards in 12/13 and within maternity and A&E services during 13/14 in line with national direction.

Preventing HCAIs:
- ✓ Maintain good performance in West Essex whilst continuing to stretch and improve
- ✓ Seek on-going improvement

Our Performance and Outcomes Framework in section 5 sets out how we are doing currently and how we will measure our performance against these targets.

2.5 Improving Outcomes through the Delivery of our Strategic Objectives

The CCG's three year overarching commissioning objectives supports the delivery of the Outcomes Framework as follows:

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Table 1

Strategic objectives	Alignment to Outcomes Framework	Delivery Ambition
Improved quality of care at acute hospitals and in community and mental health services	**Domain 3** Helping people to recover from episodes of ill health or following injury (reduced admissions and re-admissions to hospital) **Domain 5** Treating and caring for people in a safe environment and protecting them from harm (reducing incidence of avoidable infection)	• Development of sustainable models of delivery within emergency departments • Sustainable 18 week pathways for all specialties • Reduction in cancelled operations • Improvements in waiting times for cancer services • Elimination of mixed sex accommodation • Reduced use of secondary care services where appropriate by improved response from community and primary care services.
Achievement of more consistent standards across primary care	**Domain 4** Ensuring that people have a positive experience of care	• Improved patient experience of GP and GP Out of Hours services • Spreading good practice in access to GP services, reducing need to use hospital services inappropriately • Delivering "3 steps to Primary Care"
Maintaining high levels of patient satisfaction with services	**Domain 4** Ensuring that people have a positive experience of care	• Improved patient experience of GP and GP Out of Hours services • Improved patient experience of hospital care, further roll out of friends and family test.
Early identification of disease	**Domain 1** Preventing people from dying prematurely	• Improving mortality for under 75s from cancer.
Active management of long term conditions	**Domain 2** Enhancing quality of life for people with long term conditions	• ensuring people feel supported to manage their condition, reduced time spent in hospital for people with long term condition • Improving pathways of care for diabetes and COPD

Actively working to prevent disease Supporting people to make healthy lifestyle choices	**Domain 1** Preventing people from dying prematurely **Domain 2** Enhancing quality of life for people with long term conditions	• Improving mortality for under 75s from cancer • Improving pathways of care for diabetes and COPD
Re-designing care pathways to ensure simplified access to services, reduced duplication and a smooth transition between care settings	**Domain 4** Ensuring that people have a positive experience of care **Domain 2** Enhancing quality of life for people with long term conditions	• Improving pathways of care for diabetes and COPD • More local access to planned care services through procurements for urology, ophthalmology and ENT
Transferring activity that currently takes place in hospital into a community and primary care setting where clinically appropriate	**Domain 4** Ensuring that people have a positive experience of care	• Improving pathways of care for diabetes and COPD • More local access to planned care services through procurements for urology, ophthalmology, carpal tunnel and ENT • Improved access to primary care services to reduce inappropriate use of ED services • Re-direction of MH care within clusters 1 to 5 to primary care services
Making sure that the most acute care is provided by hospitals that have the necessary specialist staff and facilities	**Domain 5** Treating and caring for people in a safe environment and protecting them from harm	• Engagement in East of England Stroke review • Repatriation of care from London to local network of hospitals

2.6 Commissioning Priorities and Improving Quality

The CCG develops and delivers its commissioning priorities through its clinically led Programme Boards. The Programme Boards have scoped out their overarching commissioning priorities in support of the CCG's strategic objectives outlined in section 1 of this plan.

Programme Board	**Maternity, Children and Young People**
Clinical Lead	Dr Sue Humphrey

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Vision
The vision of the Maternity, Children and Young People's Programme Board is for services to be provided in partnership with agencies working together in an integrated, seamless manner, which puts pregnant women, children, young people and their families at the centre.

Key Strategic Objectives

- To ensure children and young people are seen in the 'Right Place at the Right Time, First Time'
- To deliver services for pregnant women, children and young people that are high quality, efficient, safe and value for money
- To deliver services that are easily accessible through a single point of access
- To provide early intervention whenever possible
- To bring care out of hospital into the home or community when it is clinically safe to do so

Commissioning priority & timescale	Quality outcomes
1.Care Closer to Home Provide Care Closer to Home by: • Expansion of the Children's Community Nursing team to enable admission/ A&E attendance avoidance when it is clinically safe to do so • Provision of a local ASD service • Provision of a local Bobath service • Provision of an end of Life service • Development of a single community access point for children	Increased numbers of children receive care at home or in the community Improved family experience e.g. through reduced need to travel Decreased need for children to attend or be admitted to hospital
2. Obstetric Capacity • Ensure that sufficient obstetric capacity is commissioned to meet the forecast increase in birth rate and provision of a safe service • Oversee implementation of a maternity advice phone line • Oversee implementation of the new Maternity Tariff that will commence April 13/14	Clinical safety is maintained Safe midwife:birth ratio is achieved Women receive 1:1 care in labour Women are booked before 12 weeks and 6 days Increased focus on normality of pregnancy and delivery
3 Coordinated provision for children, young people and families Ensure maternity services work closely with children's centres and other community settings and services especially health visitors and the Family Solutions Service to support breastfeeding and identify and support families with complex needs. Promote joint working between health, education and Local Authority to jointly plan, fund and deliver care packages for children with	Increase in early intervention and prevention in the community Decrease health inequalities Improve physical and mental health of the population Improve life chances of children & young people

Commissioning priority & timescale	Quality outcomes
complex and specialist needs and for children with a disability and/or Statement of Special education needs. Support development of plans for commissioning an integrated CAMHS and behaviour service across Tiers 1 to 3. Ensure appropriate provision of health assessments and interventions and contribution to planning, assessment and review for Children In and Leaving care and Children on a Protection Plan.	
4 Paediatric Speech and Language Therapy Redesign Paediatric Speech & language Therapy services by:- • Transforming model to one focused on meeting needs if children delivered primarily in their usual setting (e.g. nursery, school) • Move to 3 tier provision (Universal, targeted, specialist)	Increase in early intervention Increased child parental & school satisfaction Reduced waiting times (18 week target will be met) Decreased Tribunals Decrease in escalating volume of demand

Programme Board	**Older People**
Clinical Lead	Dr David Tideswell

Vision

Fully integrated services available to older people of West Essex to enable independent living and wellbeing.

Key Strategic Objectives

- High quality integrated holistic services to meet the needs of the local population
- Improved quality and safety with greater consistency to enable safe independent living
- Cost effective service provision and prescribing to support best clinical outcomes
- Enable people to die with dignity in their preferred place of care
- Improve outcomes for stroke patients
- To move towards integrated commissioning with social care where appropriate

Commissioning priority & timescale	Quality outcomes
1. Integrated Frail Elderly Service Design and commission an integrated frail elderly service, including single point of referral, MDTs and community geriatricians by Q1 2013 New Service Specification for Integrated Care to be produced in partnership with Social Care, based on clinical outcomes with performance standards and associated KPIs.	Increase in number of elderly people able to live in their own homes Reduction in emergency admissions > 75's Improved patient experience Reduction in delayed discharges
2. End of life: • Improve take up of palliative care registers in	Increase of patients dying in their preferred place of

Commissioning priority & timescale	Quality outcomes
general practice (per trajectory for 2012-13) • Increased uptake of PPC documents, especially in care homes during 2012-13 • Review specialist palliative care services • Produce service specifications with KPIs for Marie Curie and hospice care	care Improved patient experience
3. Falls: • Evaluate current need/service and commission best practice, e.g. prevention, falls car, community clinics, care home education programme • Integrated Community Teams linking with ambulance service falls register to support initiative in reducing falls admissions • Links with voluntary sector to support patients at risk of falling	Reduction in falls and repeat falls Reduction in fractured neck of femur for > 75's
4. Care Homes • Develop a coordinated approach for primary care input in to care homes. Integrated approach to failing homes, with Social Care and CQC	Reduced pressure sores reduction in falls Better management of Ambulatory care sensitive conditions Higher proportion of deaths take place in care home not hospital Reduced admissions from care homes
5. Stroke • Implement outcomes of East of England stroke review as appropriate • Introduce early supported discharge	Improved outcomes for stroke patients Increase number of stroke patients receiving rehabilitation services in their own homes

Programme Board	**Planned Care**
Clinical Lead	Dr Amik Aneja

Vision

To provide integrated, high quality, cost effective care in the right setting, maximising opportunities for provision of services in a community setting.

Key Strategic Objectives

Continue to reduce clinically appropriate activity that takes place in a hospital setting and support a substantial development of capacity and capability in the community and primary care setting.

Balance the need to make services locally accessible with the need to centralise services for more specialist care and actively encourage opportunities for the repatriation of services locally.

Commissioning priority & timescale	Quality outcomes	Activity impact
1. To ensure good access to diagnostic test results requested by any clinician across all settings (hospital, GP, community) to reduce duplication of time and money in supporting diagnosis and	No change, more timely access to results.	10% reduced activity

monitoring of conditions.		
2. Optimising local access – procurement for ophthalmology, urology, ENT, carpal tunnel community services, reducing duplication and unnecessary interventions/appointments in secondary care.	Increased patient satisfaction, better use of secondary care services	Reduction in first, follow up and outpatient procedure activity within specialties identified.
3. Review elective treatments of limited clinical effectiveness (TOLCE) and de-commission or agree criteria for treatments of limited clinical effectiveness and continually review to ensure policies remain up to date. Particular focus on surgical thresholds for procedures within Better Care Better Value ie. tonsillectomy, D&C, hysterectomy, lower back surgery, grommets	Evidence based treatments commissioned and provided	Reduction in inpatient care
4. Care to be shifted from day case to outpatient setting where clinically appropriate to do so.	Increased patient satisfaction, better use of secondary care resources.	Reduction in procedures taking place in day care setting, increase in procedures taking place in outpatient setting.
5. Increased referral support for GP practices with the focus on changing clinical behaviour through advice and guidance, education and peer review supported by good, timely data analysis and presentation.	Appropriate referrals passed onto the appropriate service/setting.	Reduce GP 1st OP rates.
6. Achieving optimal first to follow up ratios.	Better use of secondary care resources.	Reduction in follow ups.

Programme Board	**Urgent Care**
Clinical Lead	Dr Rory McCrae

Vision

A coherent urgent service that makes sense to patients and provides urgent medical care for the population of West Essex.

Key Strategic Objectives

- Consistent high quality integrated care delivering best outcomes and experience with as little difference as possible between in or out of hours
- Improved quality and safety with continuous improvement and meeting the clinical needs of the patient
- Improved patient experience and patient led change
- Care in the most appropriate setting

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Overall our patient and public engagement strategy is designed to support people in making changes happen, for example through various levels of involvement in projects, pilots and service redesign, and our overall strategic plan.

- Greater integration with services working together to provide seamless care, irrespective of provider
- Better value and appropriate use of NHS services

Commissioning priority & timescale	Quality outcomes
Introduce new model at PAH that integrates the UCC stream with ED as part of reconfiguration of urgent care to be implemented and operational April 2013	Improved patient flow Ensures that patients are directed to the right service Improved patient experience Improve patient safety Avoid unnecessary handovers between services Utilise resources more effectively
Re-commission see and treat part of GP OOH services as part of complete 24 hour urgent care pathway to be commissioned during Q2, implemented December 2012	Service integration with acute, community and primary care See and treat service with capacity to accept direct referral from community and acute
Develop a model for provision of urgent care in primary care setting. On-going through QP indicators	Right access model for clinical capacity and appointment mix in primary care Reduction in A & E attendances
Use 111 implementation to direct patients to the services described above (and elsewhere in this document). Anticipating Q4 2012-13.	DoS reflects local clinical provision accurately Patient signposted to correct clinical service at first contact Direct booking into clinical services
Reduce ambulance conveyance rates and implement a consistent/proactive approach to 'frequent flier' patients who use significant amount of urgent care. For implementation in Q2 2012.	Direct notification to practices from ambulance of frequent callers for action by the practice Direct notification from ED to community services for frequently admitted patients for action by community services Robust exacerbation and self-management plans for identified patients Direct notification from ED to primary care for frequent attenders at A & E for action by practices
High risk patient medication reviews, e.g. Warfarin, hypoglycaemia, NSAID, GI bleed, opiates (5-10% admissions are related to medicines management)	Patient safety Appropriate medicines use Appropriate long term disease management Appropriate monitoring

Programme Board	**Long Term Conditions**
Clinical Lead	Siobhan Jordan

Vision

Domains 1 and 2 of the Outcomes Framework, namely "Preventing People from Dying Prematurely" and "Enhancing Quality of Life for those with Long Term Conditions" provide the focus for the work of the Long Term Conditions Board.

Within West Essex we know that Mortality rates for Long Term Conditions are better than or close to the National Average rate. However spend is relatively high. Life expectancy inequalities suggest the need for focussed work within some localities and patient groups.

Enhancing Quality of Life will be the main focus of the Long Term Conditions Board.

Primary Care and Community Services will be key to delivering this and will require development of professional relationships and ways of working, and development of relationships between professionals and patients. Empowering a knowledgeable patient to self-manage and maintain good health while confidently knowing when to ask for help from an accessible skilled workforce will be the goal of the Long Term Conditions Board.

Key Strategic Objectives

1. Identify all patients with a long term condition within West Essex and be able to assign relative risk of deterioration.
2. Promote self-management.
3. Develop effective clinical teams to promote very good clinical management.
4. Develop effective working between patients and health and social care professionals to achieve best possible care.
5. Ensure money spent is focussed to produce best possible clinical outcomes and patient experience.
6. Anticipate and support integration of new knowledge with regard to improving outcomes and experience for people with Long Term Conditions.

Commissioning priority & timescale	Quality outcomes
1. Ensure case identification and coding of Long Term Conditions in all practices and consistent use of disease registers as per QOF by 1.12.12	Improved data quality Improved equity of access to services according to need
2. Introduce Case Finding to actively review patients with LTCs that may benefit from a multidisciplinary approach to case review. Encourage case review by Lead Clinician for others not needing MDT review.	Improved health outcomes and quality of life
3. Develop Primary Care based MDT meeting for 'at risk' patients to include social care and then to meet with patient.	Improved health outcomes and quality of life Production of care plan
4. Improve and integrate services for patients with diabetes to include scoping and	Improved health outcomes and quality of life

Commissioning priority & timescale	Quality outcomes
consideration of alternate models of care including virtual working for specialist advice.	
5. Improve and integrate services for patients with CHD including optimising prescribing.	Improved health and quality of life.
6. Explore cost effective use of telehealth to enhance self-management and access timely advice.	Improved quality of life. Enhanced self-management

Programme Board	**Mental Health and Learning Disabilities**
Clinical Lead	Dr Miranda Roberts

Vision

Patients will find services for mental health responsive, effective and with the exception of 'in-patient' services accessed easily in primary care thereby avoiding the stigma and discrimination that are attached to the mental health 'label'. Services for people with a learning disability will be 'mainstream' with 'reasonable adjustments' automatically built in to all pathways through both primary care and acute services.

Key Strategic Objectives

Achieve comprehensive integrated primary care mental health provision for both children and adults

Ensure services are both high quality and cost effective

Commissioning Priorities

Commissioning priority & timescale	Quality outcomes
1.Continue to develop the West Essex IAPT service in line with national targets and the national aspiration to manage those with more severe mental health problems in primary care. Developing strong links with West Essex multi-disciplinary teams to help support those with LTCs, MUS, Stroke ensuring comprehensive integrated primary care pathways	Responsive and effective patient centred interventions for people suffering from anxiety & depression delivering sustained mental well being. Positive recovery focus re management of LTC/MUS etc., and return to work or meaningful activity.
2. Review community mental health services re current efficiency, effectiveness and cost. Redesign pathways with an emphasis on patients being on 'shared care' or transferred out of secondary care. The CCG wishes to provide a significant level of direct clinical input into this work.	Better access and outcomes for patients Opportunity for GP to remain involved
3. Through close working with Urgent Care & MH/LD Programme Boards and current providers e.g. PAH/NEPFT review and develop effective psychiatric liaison services within A & E	Better access and outcomes for patients

Commissioning priority & timescale	Quality outcomes
4.Review all transition interfaces between CAMHS/Adult MH and Adult/Older Peoples services. CCG wishes to provide a significant level of direct clinical input into this work.	Better access and outcomes for patients Right service right time
5. Increase numbers of people with a learning disability who have received an annual health check to >90% of those patients on GP LD registers.	Improved health. Equitable access to major condition screening programmes. Platform for LD nurses to produce Health Action Plans Timely notification to LD liaison nurse for elective admissions. Robust response to demands of 'Six Lives Report'.
6.Full alignment of LD registers in general practice with referrals to PAH. (Flag system)	Safer and more patient-centred access in and out of secondary care. Better outcome and experience for people with learning disability.
7.Jointly work with providers and others to ensure continued progression of shadow PbR programme. This will include the CCG being provided the overall profile of NEPFT clustering data Analysis of data highlighting unexpected activity in teams of geographical variances Understand the work done on identifying care pathways within the clusters	Ability to begin to benchmark services against others and evaluate performance and cost
8.Continue to work within the North Essex Mental Health Group to provide West Essex locality focus	Drive the quality agenda Ensure equality of services on a cluster scale whilst maintaining locality focus Share good practice Ensure non-duplication of services
9.Increase early diagnosis of dementia and agree a protocol for referral. Increased provision of memory assessment services Early identification and discharge planning for patients admitted to acute hospitals with acute dementia (MH liaison) Delivery of the Essex dementia strategy	Maintaining functionality and supporting independent living as far as is practicable
10.Work with ECC to develop Integrated Commissioning opportunities for both LD and MH.	Better integration of care.

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Programme Board	**Medicines Management**
Clinical Lead	Dr Sanjeev Rana

Vision To ensure that patients get the medicines they need to achieve the greatest health outcomes for our population within available resources.

Key Strategic Objectives

- Deliver medicines with regards to NICE (guidance and national indicators), SHA (PresQIPP) / LAT, Clinical Senates, Local Clinical networks and locally agreed prescribing formularies and guidelines.
- Deliver effective systems to ensure safe and improved medicines management across interfaces.
- Deliver improved patient safety, reduce medicines risk and hospital admissions through use of Eclipse Live in primary care
- Identify gaps and develop medicines management services for the most vulnerable patients and patients at greatest risk of medicines related problems.
- Maintain effectiveness in delivering the CCG QIPP Medicines Management Plan by agreeing working on system wide QIPP projects such as stoma care and having agreed targeted individual GP practice QIPP plans
- Work on initiatives, in collaboration with the older people and mental health boards, to optimise prescribing for people with dementia to improve quality of life
- Deliver a systematic assessment and shared learning process for medicines related events across the CCG.

Commissioning Priorities

Commissioning priority & timescale	Quality outcomes
1. To maximise on the implementation of national, NICE QIPP and regional PresQIPP (primary and secondary care initiatives)	Treat more patients Equity for patients Appropriate medicines use
2. Roll out of the ECLIPSE LIVE tool, achieving improvements to patient safety and reduced admissions	Improve patient safety Appropriate medicines use Appropriate long term disease management Appropriate monitoring Empower patients to manage their medicines and their condition
3. Delivering safer medicines to patients to vulnerable patients within their homes and care homes	Improve patient safety on discharge from hospital. Appropriate medicines use Appropriate long term disease management Appropriate monitoring Empower patients to manage their medicines and their condition
4. To increase the quality of drug prescribing in primary care and to address the variation in prescribing across West Essex i.e focus on anticoagulant, antipsychotics, hypnotics and antibiotic prescribing	Improve patient safety Appropriate medicines use Appropriate monitoring
5. To support practices to make the most of available resources and treat more	Treat more patients Equity for patients Appropriate medicines use

patients by initiating the most cost-effective medicines without compromising patient safety or quality.	
6. Ensure high cost drugs commissioned from providers are managed.	Treat more patients Equity for patients Appropriate medicines use

Programme Board	**Primary Care Transformation**
Clinical Lead	Dr Rob Gerlis, Dr Kamal Bishai,

Vision

- Primary care integrating seamlessly with secondary, care, social services, mental health, third sector and local government.
- Primary care driving healthy diet and lifestyles
- Primary care promoting independence for vulnerable and older people
- Primary care giving children the best start in life
- Primary care providing quality end of life care

Key Strategic Objectives

- Improve Primary care performance using benchmarking tools e.g. GP access issues supporting unnecessary use of secondary care services
- Promote new and novel ways of GP working e.g. telephone triage

Commissioning Priorities

Commissioning priority & timescale	Quality outcomes
1. Support general practice to work towards the goals and vision of the CCG through a range of mechanisms; ensure that members are able to influence the setting of goals.	Improved integration of services for patients
2. Review all Locally Enhanced Services Schemes, building on work already completed on this	Improved cost effectiveness of LES services Patient's treated in least intensive setting.
3. Develop and nurture innovation, including new and novel ways of GP working like telephone triage/'hear and treat'	Improved patient satisfaction with primary care access
4. To establish a robust and integrated Out of Hours service, including the divestment of the TEDS service	Single, co-ordinated OOH service CCG divested of directly managed services
5. Develop a clear vision for long term conditions and the role of primary care	Improved clinical and quality outcomes
6. Benchmark the quality of primary care services, and ensure that West Essex patients receive a good quality of care, irrespective of	Improved patient satisfaction Improved clinical outcomes

where they live	
7. Act as a key enabler to many of the CCG Quality and Productivity programmes	Improve Access & Patient experience Reduce Emergency admissions Review and contact frequent attenders Support winter planning Work with the ambulance service to reduce inappropriate conveyances to Management of referrals Reduction in diagnostic tests Closer working relationship with care homes Lead multi-disciplinary team approach to managing patients Adhere to CCG drug restrictions and recommendations

Section 3.0 Changing How we Commission

The CCG is very clear that it needs to make some changes in how it commissions services. Aspirations include:

- Integrated commissioning between health and social care
- Commission for specialties and cohorts
- Fair and equitable commissioning across our providers
- Collaborative commissioning with our neighbouring CCGs
- Community Asset Building
- Transforming primary Care

This section outlines the ways in which the CCG will be developing its commissioning capability and models over the coming year and beyond.

3.1 Integrated Commissioning between Health and Social care

West Essex CCG is committed to working in collaboratively with ECC and other health partners to develop integrated commissioning both on a pan Essex basis and locally here in West Essex. We have been working with our ECC partners over a number on months along with our North Essex colleagues scoping these opportunities and determining priorities. We commit to an ongoing programme of work which takes these and future priorities forward. As a result we expect to see a step change in integrated working in Essex between health and social care moving forward through lead commissioners, joint commissioning, section 256 arrangements and the procurement where necessary of agreed priority services. This will allow both organisations to deliver services through a single commissioning approach. This document details Essex County Councils Approach to Integrated Commissioning encompassing the following priority areas where joint commissioning has most potential have been agreed as:

3.1.1 Frail Older People

The CCGs top priority over the coming year is the commissioning for Frail Older People, integration of commissioning between health and social care is a key enabler for the CCG to transform services for this vulnerable community but also to deliver its QIPP programme. There is consensus that services for frail older people should be commissioned locally rather than across a broader north Essex or pan Essex footprint but in collaboration with ECC. The common themes for outcomes for partners include, people feeling safe and in control; people receiving least complex and least intrusive care; and people have a good quality of life and a good death.

The CCG and ECC are working on the development of a joint specification for an integrated frailty service. The plan is to structure the frailty service around an Accountable Lead Provider model. This will operate as a pilot during 13/14 with a view to an expanded model for roll out in

14/15. In addition there is an agreed a process for planning and implementation around associated themes including:

- Social inclusion including prevention and early intervention- information and advice,
- Dementia,
- Falls prevention and response
- Continence management
- Support to care homes
- End of life care
- Urgent care pathways- crisis avoidance and crisis response and LTC
- Support for professional carers to raise standards in care homes, linking with providers of community services
- Continuing healthcare- children's and adults

These are all identified as CCG priorities in section 2 of this plan.

The project contract will have re-fresh points during the year to build in opportunity to develop joint pathways and approaches enabled by S256 funding (e.g. integrated falls pathway, continence management etc.)

The Frail Elderly Project Board will be the key mechanism to progress integrated commissioning and it has been agreed to review and strengthen membership to ensure the Board develops the strategic ambition to commission in an integrated way.

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

3.1.2 Children's Services

The CCG and ECC have discussed scope to commissioning jointly for children's services. Examples of system level commissioning include Joint CAMHS & Behaviour Tier 1-3 services, children with complex care needs and disabilities and safeguarding and provision/statutory duties for Looked After Children and Care Leavers. We have also recognised benefits of collaboration around safeguarding for children. In particular:

- Health providers contribute to Child Protection and Children IN and Leaving Care Assessment, Planning and Review activities and complete health and dental assessments as required and that this is embedded in the main contracts and jointly performance managed.
- In main stream CCG contracts Health providers will be required to recognise and deliver their role as active members of Core Groups for children subject to Care and Child Protection Plans, including undertaking direct intervention to improve parenting skills
- There is improved CAMHS provision for Children on a Protection Plan and Children In Care and leaving care.

The CCG commits to the implementation of the Community Budgets FCN business case in 2013/14.The opportunities identified so far together are summarised in the table below. An indication of whether the opportunity is at a local CCG level or across Essex is also shown in **Table 2:**

Table 2

Service Area	Description/Issues	Planning	Implementation	CCG/Cluster/Essex
Families with complex needs	Contribute to the 2 planned multiagency Family Solutions Service teams in West Essex to provide integrated support to families with complex needs who are experiencing mental health, substance misuse, violence and family relationship issues.	2012/13	2013/14	At local CCG Level
Children with complex care needs inc disability and special education needs	Continuing care and transition into adult services, end of life care, joint LD register, out of area children, joint commissioning of therapies; continued joint planning and funding of care packages for individual children with complex needs.	2013/14	2014/15	Mixed local CCG and pan Essex
Integrated CAMHS and Behaviour Service	Joint commissioning of integrated provision across Tiers 1 to 3	2013/14	2014/15	Cluster/pan Essex
Maternity and Early Years	Links with Children's centres, neonatal care and screening, breastfeeding support and health visiting.	2013/14	2014/15	At local CCG Level
Integrated commissioning for children entering and leaving care	Health Contribution to assessment and planning and provision of interventions ; GP assessments for adoptive parents and children, IHA and RHA	2013/14	2014/15	In liaison with Safeguarding Children's Clinical Network and pan Essex
Preventing obesity in children and young people	Public Health led	2013/14	2014/15	Pan Essex strategy tailored to local populations
Joint approach to safeguarding and Child protection	Joint approach to systems and processes, Health Contribution to assessment and planning and provision of interventions ;	2012/13	2013/14	At local CCG Level
Vulnerable adolescents	Sexual health, substance abuse	TBA	TBA	TBA
Domestic abuse	ECC to work with CCGs	TBA	TBA	TBA

	to develop programme in 13/14 identifying opportunities for e.g. effective joint screening tools, a multiagency hub to review notifications and provide IDVA support and the benefits.			

3.1.3 Learning Disabilities

The CCG accepts the priority this holds for ECC as a demand management pressure and the benefits in developing an All Age approach to Commissioning. There is recognition that there is mutuality in commissioning priorities and a strong benefit in developing a single specification to address an emergent contractual opportunity within the next 24 months. The planning process has clarified system leadership within CCG's on North and South basis and ECC has tabled its aspirations regarding a lead commissioning role. West Essex CCG is the co-ordinating commissioning for LD for the North Essex CCGs. There is a medium term ambition to work on a pan-Essex basis.

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

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

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

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

As part of scoping the opportunities for integrated commissioning the North Essex system agreed a number of priorities:

- Improving services for young people and adults with a learning disability and/or autism whose behaviour is challenging

- Improving access to mainstream services
- Improving the health of people through health checks and health action plans
- Agreeing and implementing a Learning Disability Health Strategy
- All age commissioning approach

3.1.4 Mental Health

The North Essex system partners have agreed in principle to integrated commissioning. North East Essex will be the Coordinating Commissioner on behalf of the North system CCGs and will align with ECC to lead commissioning of mental health for North System. Work will progress towards a single set of priorities. A North Essex system workshop held on 16th January agreed a number of priorities for the commissioning of mental health services with the following key outcomes and outputs deliverable by 2015/16:

- To formally agree the Essex MH Outcomes framework
- To formally agree a MH joint commissioning strategy for people who use mental health services and their carers.
- To implement the Accommodation Strategy Pathway which will support people to live more independent lifestyles and included within this, agree how to support reablement to prevent admission where possible and provide enhanced support to people when they are first discharged from hospital.
- To redesign rehabilitation services linked to the implementation of the accommodation pathway, with appropriate NHS resource and the development of Recovery approaches
- To support the primary care to focus on prevention and early engagement and ensure that physical health needs are addressed alongside mental health needs.
- To work with partners to strengthen communities, build resilience and equip people to manage their own care
- Integrated crisis response redesign.
- To improve recovery orientated approaches to delivery of statutory functions of assessment and care management and the provision of support; including S117 support plans and use of assistive technology and personal budgets, ensuring a focus on empowerment
- To enhance joint commissioning through the use of s256 agreements to maximise use of resources for advocacy (including IMHA) housing, employment and social inclusion
- To build on and strengthen engagement of people who use services, carers and the wider public
- To develop commissioning for age inclusive services, bringing together adult of working age and older Adult approaches and improving transitions from CAMHs and children services
- The development of Payment by Results and a tariff for mental health services, incorporating processes for management of personal budgets where possible
- To review the S75 Partnership Agreement between ECC and NEPFT and to put in place a new agreement from 1 October 2013 with a view to incorporating this into a single NHS contract in the longer term.

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

3.1.5 Public Health

The mandated priorities to be commissioned by public health for 2013/14 are Health Checks, the National Child Measurement Programme and Sexual Health. The delivery of the Health Checks programme is dependent upon Primary Care and expectations of Primary Care will be strengthened through NHS CB LAT Primary Care Commissioning working in collaboration with the CCG and Public Health.

The following summary of activities, impacting on the health status of CCG populations, will be funded by the ECC Public Health budget in 2013/14.

- Reach Out
- Mental Health Casework Project
- Physical Activity
- Obesity and Weight management
- Reducing smoking prevalence and tobacco control
- Increasing the prevalence of breastfeeding at 6- 8 weeks
- Improving sexual health
- NHS Health Checks
- Identification and Brief Advice (IBA) services across Essex in a range of appropriate settings and as part of the Health Checks agenda in Primary Care.
- Primary care prescribing interventions to dependent opiate users referred from specialist prescribers (Shared Care) in partnership with specialist drug treatment providers.
- Atrial Fibrilation management

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

- Essex County Traveller Unit (ECTU)
- Alcohol Liaison Nurse Specialist (ALNS) provision in acute settings to support hospital staff to identify, manage and support problematic alcohol users.
- Senior Health Checks

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

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

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

3.1.6 Funding and investment

- **Section 256 funding**

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

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

3.2 Outcomes and Pathway Based Commissioning

Linking how we commission directly to outcomes and pathways is a key enabler to delivery of our strategic objectives. Our commitment to delivering high quality care by making best use of limited resources will be at the heart of how we deliver services. There are now examples of better outcomes resulting from a whole pathway approach to managing a condition which have also demonstrated better value. The London Stroke Pathway is a specific example which is now being rolled out nationally. In West Essex we are developing an outcomes and pathway approach to diabetes care, frailty and COPD and will be looking to extend this across many of our planned care services over the next few years. In developing this type of commissioning we will be promoting a lead provider model where a single provider will oversee the entire pathway through a series of sub contracts with other providers.

3.3 Fair and Equitable Commissioning across our Providers

How we commission with different providers has developed at different pace through various historical reasons. We are aware that this means that in some cases the services our population has access to can vary in terms of quality and access. We want to seek to address this and will be looking spread examples of best practice commissioning across all of our providers. To achieve this we will need to develop our mechanisms for influencing those contracts that other CCGs lead.

3.4 Collaborative Commissioning with our Neighbouring CCGs

The CCG is establishing formal collaborative commissioning arrangements where two or more CCGs contract in line with Commissioning Board expectations set out in The NHSCB Special Health Authority guidance; A Framework for collaborative commissioning between clinical commissioning.

We have collaboration agreements in place for all our key acute contracts with, Cambridgeshire, Mid Essex, North East Essex, Hertfordshire and Tower Hamlets. We expect the benefits and opportunities of working collaboratively in the support of sustainable health systems for the benefit of the populations served to be:

To drive improvements in quality, performance and efficiencies through;

- Developing and adopting common and consistent approaches to the development of evidenced based pathways (QIPP), service integration and joint commissioning where appropriate;
- Developing and adopting common and consistent approaches to contract and performance management with common/shared providers;
- Empowering CCGs to act on behalf of others where there is formal agreement to do so; and
- Exercising group leverage with providers and other stakeholders.

To maintain resilience and effective risk management across the systems including;

- managing financial risks;
- managing regulatory and legal change;
- adopting a common approach to the management of commissioning support arrangements;
- sharing of scare resources and expertise including hosting arrangements for shared services); and
- business continuity arrangements

Our approach to collaboration with other Essex CCGs will also facilitate the effective engagement with:

- Health and Social Care providers who serve respective populations;
- Health and Wellbeing Board;
- Essex NHS Commissioning Board; and
- Essex Commissioning Support Unit.

3.5 Personal and Community Asset Building

From 2013 onwards, our ambition is to develop patient and public engagement for the next generation. We are working on a progressive approach that will give individuals and representatives decision-making and asset-building power. We will support individuals and groups, with training where necessary, to take on parts of health planning, including personal and wider budget responsibilities where possible. We also want to promote self help and self care and we will encourage and support individuals, families and communities with this.

3.5.1 Personal and community budgets

To date our PPE strategy has been about mobilising patient and public expertise. Our ambition is to develop this so that patients and public representatives may be funded, trained and empowered to make commissioning decisions, both at individual level and on a wider scale.

3.5.2 Personal budgets

On an individual level we want to work with local authority partners on the development of personal budgets, so that patients and carers may take a lead, not just in being able to indicate their needs and preferences, but in making actual commissioning decisions. This is particularly relevant to those who require complex and on-going packages of health and social care. Together with our social care colleagues, we see the potential for older people, people with mental health problems, disabilities and long term conditions to have a budget for their care, from which they decide and purchase the services they need. In diabetes care, for example, we

are putting in place a single contract for all services along the patient pathway, from which patients may be able to take charge of spending on their own care plan from point of diagnosis to the treatment provided by all the different health professionals.

3.5.3 Community Asset Building

At a group level, we see the potential for specific expert groups, or groups associated with localities or communities to be supported in devising their own health spending plans. This is already happening in terms of GP localities and practices, where we are developing devolved commissioning budgets. The principle could be applied in future to care groups and protected groups.

Over time, we envisage a substantial increase in commissioning assets for west Essex by developing the capacity and expertise of our patients and public. We see the establishment of the West Essex Locality Network as an excellent starting point and framework that will nurture innovation and progress.

3.6 Working with Members to Transform Primary Care

Primary Care has a pivotal role in supporting the CCG to deliver in its objectives and to provide quality, locally-accessible and cost-effective services. Primary Care is often the first access point for health services and as such is the patient's entry point onto a specific pathway or into specific services. For these reasons we need to ensure that our local primary care services are supported to deliver an appropriate range of services. They should be able to effectively manage patients within the practice where this is appropriate and offer support for self-management, They should be supported to offer extended services to pro-actively identify (and manage) long-term conditions and ailments within their older population and they should work in an integrated manner alongside other agencies such as social care and the voluntary sector to ensure that patients are cared for in a holistic manner. To facilitate all of this, primary care should be easily accessible when a patient needs it. Our vision for Primary Care is to:

- Be at the centre of the local healthcare system
- Provide a high quality service
- Deliver significant improvement in clinical outcomes
- To provide equity of access to all patients
- To enable the delivery of more services in primary care/locally
- For practices to receive a fair level of pay

We propose to achieve this through the development of a three step plan to delivery in primary care, level 1 being the core standard that we will expect from our practices with a programme for practices to extend beyond this to levels 2 and 3. An indication of what this could translate to is detailed below in **Table 4:**

Table 4

	URGENT CARE		PLANNED CARE	OLDER PEOPLE	
	***Access**	***A&E**	***Referrals**	***Older People**	***End of Life**
Level 1 Delivering Core Contract	Open Core Hours 8am to 6.30pm	Chronic disease management/ emergency appointments	Practice internal triage	Responsive to the needs of older people e.g. home visits, carers register	Palliative care registers
Level 2 Offering Core +	Offering extended hours	15% of attenders are classified as Minors	Locality triage/ peer review	MDTs Regular involvement with integrated teams/ community teams	Adoption of the Gold Standard framework
Level 3 Achieving Excellence	Networked practices offering 7 day services	5% of attenders are classified as Minors	Monthly analysis of referral and attendance data Actively seek consultant feedback and education	Fully integrated and flexible service e.g. 8am to 6.30pm visits, in reach support to patients and community hospitals	Advanced care planning

This development programme will be underpinned by the move towards the delegation of commissioning budgets at locality level.

Section 4.0 Improving Performance

This section outlines the performance frameworks by which the CCG monitors and is held accountable for maintaining and improving performance quality and outcome standards.

4.1 Performance Frameworks

The CCG is committed to ensuring the achievement of all performance standards for 2013/14. There are a total of four performance frameworks which are currently relevant to CCGs and their partner organisations:

- The CCG Outcomes Indicator Set 2013/14
- The NHS Constitutional pledges
- The Outcomes Framework for Adult Social Services
- The Public Health Outcomes Framework

The CCG Outcomes Indicator Set and the NHS Constitutional Pledges are directly for CCGs to implement and hold accountability for. The Outcomes Framework for Adult Social Services and The Public Health Outcomes Framework, are primarily for partner organisations to implement and monitor. However, West Essex CCG will seek to work with Local Authority and Public Health teams, to monitor and improve patient outcomes across these frameworks where relevant.

4.2 Improving Outcomes: The Outcomes Indicator Set 2013/14

The CCG Outcomes Indicator set 2013/14 is arranged over 5 domains as follows:

- Domain 1: Preventing people from dying prematurely
- Domain 2: Enhancing quality of life for people with long term conditions
- Domain 3: Helping people to recover from episodes of ill health or following injury
- Domain 4: Ensuring that people have a positive experience of care
- Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Some of the suggested metrics within the indicator set are still under development; however as part of the CCGs internal performance monitoring those indicators that we are able to monitor and implementing improvement programs where possible. CCGs are not required to submit formal trajectories for these indicators; however the CCG will endeavour to implement local ambitions for achievement and improvement. The table below details the indicators against each domain. Green shading of the indicator indicates that we are currently performing well. Red shading indicates those where improvement is needed. Those shaded blue are indicators which have not been measured to date.

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Table 5

Domain	Indicator Ref	NHS OF objectives	Indicator Description
DOMAIN 1: preventing people from dying prematurely	1ai	Overarching Indicator	Potential years of life lost from causes considered amenable to healthcare: adults [over 20 yrs]
	1aii		Potential years of life lost from causes considered amenable to healthcare: children & young people [under 20 yrs]
	1.1	Reducing premature mortality from major causes of death	Under 75 mortality rate from cardiovascular disease
	1.2		Under 75 mortality rate from respiratory disease
	1.3		Under 75 mortality rate from liver disease
	1.4		Under 75 mortality rate from cancer
DOMAIN 2: enhancing the quality of life for people with long-term conditions	2	Overarching Indicator	Health related quality of life for people with long-term conditions
	2.1	Ensuring people feel supported to manage their condition	Proportion of people feeling supported to manage their condition
	2.3i	Reducing time spent in hospital by people with long term conditions	Unplanned hospitalisations for chronic ambulatory care sensitive conditions
	2.3ii		Unplanned hospitalisations for asthma, diabetes and epilepsy in under 19s
	2.6i	Enhancing quality of life for people with dementia	Estimating the diagnosis rate of people with dementia
DOMAIN 3: helping people to recover from episodes of ill health or following injury	3a	Overarching Indicator	Emergency admissions for acute conditions that should not usually require hospital admission
	3b		Emergency re-admissions within 30 days of discharge from hospital
	3.1i	Improving outcomes from planned treatments	Increased health gain as assessed by patients for hip replacement
	3.1ii		Increased health gain as assessed by patients for knee replacement

	3.1iii		Increased health gain as assessed by patients for groin hernia
	3.1iv		Increased health gain as assessed by patients for varicose veins
	3.2	Preventing lower respiratory tract infections in children from becoming serious	Emergency admissions for children with lower respiratory tract infections
DOMAIN 4: ensuring that people have a positive experience of care	4aii	Overarching Indicator	Patient experience of GP out-of-hours services
	4b		Patient experience of hospital care
	4c		Friends and Family Test
DOMAIN 5: Treating and caring for people in a safe environment and protecting them from harm	5.2i	Reducing the incidence of avoidable harm (infections)	Incidence of healthcare associated MRSA infection
	5.2ii		Incidence of Clostridium difficile infection

4.3 Improving Outcomes: Our Three Local Priorities

"Everyone Counts, Planning for Patients 2013/14" encourages CCGs to select three local priorities for targeted improvement. Success with these targets will contribute towards the award of a financial quality premium. The CCG has selected the following areas to focus on as priorities to improve over the coming year and beyond. These are areas where we are currently under performing and we believe will contribute greatest to the health of our population:

Our 3 Local Priorities:

We have selected our 3 priorities from Outcomes Indicators that we know we are an outlier with as follows:

- Increase proportion of people feeling supported to manage their condition.
- Improve patient experience of GP and out of hour's services.
- Improved care for patients at end of life, with learning disabilities and obesity related health problems through improving and using effectively information collected on registers.

Delivery of these priorities is supported in part by our QIPP program detail in section 5.0, in particular improving how we provide services for people with long term conditions, improving access to care outside of hospital for people at the end of their life, improvements in access to primary care services through the urgent care programme supported through the Primary Care Framework.

4.4 Delivering the NHS Constitutional Pledges

CCGs will continue to monitor indicators from the NHS Constitution called The Constitution Pledges. The NHS Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and the pledges which the NHS is committed to achieve. The following indicators are the expected rights and pledges from the NHS Constitution 2013/14 including the thresholds the NHS Commissioning Board will take when assessing CCG organisational delivery. Green shading of the indicator indicates that we are currently performing well. Red shading indicates those where improvement is needed. Those shaded blue are indicators which have not been measured to date.

Table 6

Referral To Treatment waiting times for non-urgent consultant-led treatment
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%
Diagnostic test waiting times
Patients waiting for a diagnostic test should have been waiting no more than 6 weeks from referral – 99%
A&E waits
Patients should be admitted, transferred or discharged within 4hours of their arrival at an A&E department – 95%
Cancer waits – 2week wait
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%
Cancer waits – 31 days
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96%
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%
Cancer waits – 62 days
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%
Maximum 62-day wait for first definitive treatment following a consultants decision to upgrade the priority of the patient (all cancers) – no operational standard set
Category A ambulance calls
Category A calls resulting in an emergency response arriving within 8minutes – 75% (standard to be

met for both Red 1 and Red 2 calls separately)
Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%
Mixed Sex Accommodation Breaches
Minimise breaches
Cancelled Operations
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patients treatment to be funded at the time and hospital of the patient choice.
Mental health
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%.

Additional measures NHS Commissioning Board has specified for 2013/14:

Referral To Treatment waiting times for non-urgent consultant-led treatment
Zero tolerance of over 52 week waiters
A&E waits
No waits from decision to admit to admission (trolley waits) over 12 hours
Cancelled Operations
No urgent operation to be cancelled for a 2nd time
Ambulance Handovers
All handovers between ambulance and A & E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. Financial penalties, in both cases, for delays over 30 minutes and over an hour.

We are clear that we need to achieve green ratings across all of these pledges. Those that are currently at risk have improvement trajectories set against them with the provider organisation. We have specific plans in place to monitor areas of high risk in the NHS constitution pledges. In all cases data is being sourced and analysed and where appropriate meetings are held with senior managers to look into generated reports and agree action plans to bring performance back to an appropriate level. Examples of this are weekly internal meetings to hold responsible officers to account for poor performance such as A&E or cancer waits. Regular meetings are also held with the associated trusts to monitor and gain assurance that plans are in place to rectify situations of poor performance or mitigate risk.

Delivery of these priorities is supported in part by our QIPP program detailed in section 5.0 and through performance management. Specific examples of how our QIPP programme will contribute to improvements in performance are:

- Reducing unnecessary use of A&E will contribute to ability to deliver maximum 4 hour waits
- Reducing unnecessary elective referrals will contribute to ability to deliver against cancer waits and sustainability of 18 week waits for all specialties.

4.5 Partner Performance Frameworks

The NHS National Commissioning board is held to account by the Secretary of State for Health via the NHS Outcomes Framework. The NHS Commissioning board will hold CCGs to account via the CCG Outcomes Indicator Set and NHS Constitution pledges. The NHS Outcomes Framework works in harmony with the Adult Social Care Outcomes Framework and Public Health Outcomes framework, to deliver a continuous pathway of care for patients. As such it is expected that CCGs will work in partnership with local Authorities and Public Health teams in delivery of that care.

The Public Health Outcomes Framework and Adult Social Care framework contain many performance measures which would have historically been the responsibilities of PCTs to deliver. Indicators in the Public Health Outcomes framework such as prevalence 6-8 week breastfeeding, Teenage conception rates and Smoking prevalence were important PCT measures for improving the health of local populations. Likewise indicators such as delayed transfers of care are now with the Adult Social Care Outcomes framework, where once they were an important performance indicator for PCTs.

4.6 Performance Management and Accountability

We will use performance management as one of a number of tools to ensure that services being provided are safe and support continual service improvement. Clinicians and managers will use performance management to track the quality of service being provided to residents and Board Members will see how well policy decisions are being implemented and residents are being served. The CCG is implementing a performance management framework to ensure delivery is met.
There are three main aspects to NHS West Essex' performance management framework:

- Provider performance monitoring
- Internal monitoring and assurance
- Reporting to the Local Area Team (LAT) of the National Commissioning Board

4.6.1 Provider Performance Monitoring

To ensure that our providers are delivering on their objectives in the services the CGG has commissioned, regular meetings are held between CCG staff and the organisation in question. At these meetings performance is discussed, concerns raised and action plans for mitigation and turn around are provided. These meetings and documents are continuously monitored to ensure delivery is met and performance is improved. This is supported by a variety of data sets that we are apply to utilise to assist in this process.

4.6.2 Internal Monitoring and Assurance

The internal performance monitoring of NHS West Essex CCG is conducted via monthly performance reports to the Trust board and finance and performance committee. These reports detail high level data trends on metrics in the form of scorecards and also narrative on historical context and turnaround.

Weekly performance reports are produced by exception on high risk areas. These reports detail in depth performance trends and narrative for improvement. They are presented and discussed on a weekly basis with key internal stakeholders where accountability is held for delivery.

4.6.3 Reporting to the LAT

As the new commissioners of the NHS CCGs now have a duty to respond in a timely fashion to requests from the LAT as well as regular updates. The LATS capacity as the local presence of the national commission board is to ensure that CCGs are working effectively to delivery their responsibilities as per the NHS mandate. The CCG provides monthly updates to the LAT including but not limited to, latest data positions, forecasts, historical context for poor performance, local knowledge, turnaround, mitigation and time frames. This process is fed by both the internal performance management arrangements and the management processes of local providers.

West Essex Clinical Commissioning Group

Section 5.0 Our QIPP Programme

This section provides the details of our QIPP Programme to deliver the CCGs £20m QIPP challenge for 2013/14 and outline plans for the £15m for 2014/15. These plans both address the financial challenge, delivery of strategic objectives and commissioning intentions and also strive for improvements in the quality and outcomes of services commissioned.

5.1 Our Approach to QIPP

The CCG recognises that this scale of challenge requires a whole system transformation approach to move from quick impact service changes to true transformational change. We will be working collaboratively with social care, partners, and other local CCGs to achieve the required transformation where solutions lie beyond the remit of the CCG. 2013/14 will see the start of our programme to develop integrated commissioning with our Social care partners as identified in Section Three. We will also see the beginnings of a local health system transformation programme that will identify a model of the longer term clinical and financial sustainability of this health and social care system.

QIPP schemes have been developed for 2013/14 and some for 2014/15 by work stream project teams led by the clinical leads and aligned to the respective Programme Board. In accordance with our Scheme of Delegation projects have been approved by Programme Boards. At every stage of the project there has been a strong interface between the Locality Groups and the Programme Boards to create opportunities for innovation and secure ownership and engagement of any service redesign.

Our Programme Boards include clinical membership from our localities, key providers, patient representation and Social Care. They are supported by project teams and a project management office function. We work collaboratively with North Essex CCGs on Childrens & Maternity and Mental Health & Learning Disabilities

The business case planning templates that follow later in this section form the basis upon which project implementation plans (PIDS) are developed. The business cases are signed off by the clinical and executive leads for each workstream. The PIDS will be fully developed between January and March 2013,

5.2 QIPP Programmes

During 13/14 the programme of work at a system level falls into the following categories:

- Continuation of 12/13 projects that have started in year and that will deliver a full year effect during 13/14
- Building upon the workstreams we have developed in 12/13 to create better integration between our community services, our GPs and Social Care.
- Planning for projects that will start later in 2013/14 or early 2014/15

The individual QIPP workstreams are detailed in Appendix 1.

5.3 Summary of QIPP Programme

The table that follows summarises the QIPP programme for 12/13 with some early indication of our 13/14 programme.

Table 7

2013/14 QIPP Programme £(000)s	**Net Savings Target £000s**
Diagnostic Deep Dive (DA radiology & biochemistry)	654
Optimising local access	283
Decommissioning / Tolce	783
Activity shift - DC to OP	399
Best Practice FA-FUP ratios	867
Validations - Best Practice	380
Referral / Educ. Support to GPs	453
Planned Care	**3,819**
Contract Validation - A&E & Small Contracts SLAs	256
Redirection PC activity	574
Changes to model of Ambulances provision	500
Flow-through of 12/13 investment projects	250
Urgent Care	**1,580**
Diabetes pathway	355
Respiratory Services Improvement plan	265
Cardiology Service Improvement Plan	188
Telehealth	485
Cancer - reduced OPD appointments	125
Long Term Conditions	**1,418**
Care Homes Service Improvement - reduced admissions	581
Case Managed Integration - reduced admissions	1,000
Frequent Attenders improvements - reduced admissions	937
Falls - integrated service - reduced admissions	225

End of Life palliative care - reduced admissions	500
Catheter service in PC - reduced admissions	121
Frail & Elderly transformation project	1,558
Low Acuity Activity shift - care at home	250
Social Care Reablement	300
Older People	**5,472**
Meds Mgt & Prescribing 13/14 schemes	1,500
Medicines Management	**1,500**
Care Closer to Home: CDC / CCN	80
Local ASD service improvement	100
Paeds EOL care provision	40
GP Education on paeds conditions (increased confidence)	50
Essex wide Paed nurse activity shift	25
Children's and Maternity	**295**
MH Schemes - care in PC (Honos 1-4)	1,500
LD & MH Schemes - contract management - perf.	300
LD Schemes	80
Mental Health and LD	**1,880**
Flow through Enh. Services, Budget reviews, etc	100
Flow through effects of prescribing improvements Mo8-Mo11	1,500
Sundry	**1,600**

Net Savings - Identified Schemes	**17,564**
Release of QIPP headroom reserve pending work-up of additional schemes	**2,436**
Net Savings Target 2013/14	**20,000**

Additional QIPP Schemes under development for contingency

Additional Children's Services schemes
Pain / MSK pathway improvements (3 mo. effect)
INR in PC pathway improvements
Community based DVT service development
Other schemes to be developed

5.4 Managing QIPP Delivery

Delivering a £20m QIPP programme is a huge challenge for the CCG. It is critical that plans are fully developed with clear milestones followed leading to delivery and that performance is managed with strict discipline. Delivery of individual workstreams will be overseen by

Programme Boards with monthly reporting to the Clinical Commissioning Committee and the Finance and Performance Committee and bi-monthly reporting to the CCG Board. Weekly workstream meetings will take place with the Clinical Lead, Delivery Lead and PMO to ensure weekly tasks are being achieved. The CCG will continue a fortnightly accountability meeting Chaired by the Chief Officer with a rotating agenda covering each workstream with attendance relevant to workstream. The full governance arrangements for QIPP is described in Appendix 2.

The CCG will lead a System Transformation Leadership Group, which comprises leadership from each part of the local system. This group will oversee the transformation programme that is required within the system to support the QIPP programme

5.5 Enablers for Transformation

Throughout this section it is clear that delivery is dependent on a number of key enablers that will need dedicated facilitation and management. How we ensure these enablers are in place is referred to throughout the document where relevant and within section 8 Planning Delivery and Development. Most of the enablers are specifically referenced within the QIPP planning templates. These key enablers are summarised below:

Table 8

Enabler	Application
Transformation and development in primary care	A primary care framework has been developed that describes the part that primary care can play in our transformation programme. This will contribute across almost all of our work programme
Strong system leadership with common goals	The scale of our programme can only be delivered if each organisation is led at the highest level with common goals. A System Leadership forum is chaired by the Accountable Officer of the CCG
Development of Integrated Commissioning with Social Care	Several common Essex-wide enablers have been identified that need systematic development once on behalf of the whole system. They include: • Finance. • Information sharing and governance. • Procurement and contracting. • System rules (e.g. Continuing Health Care) • Human Resources.

	• Estates • Technology • Communications • Programme and project management
Leadership culture that supports system transformation	As above but extended across all tiers of clinicians and management to support common goals whilst understanding our respective challenges
Developing strong clinical leadership	Required to ensure clinical credibility to all of our plans and lead clinical engagement in delivery.
Access to clinicians to support delivery	Service re-design and delivery needs to be supported by strong clinical involvement
Getting capacity in the right place	As we move to a shift for dependence on secondary care we need to ensure that our primary care and community services have the right capacity to respond to need. At the same time we need to support our secondary care providers in their own transformation programmes.
Improving how we commission	Delivering our programme of change relies on developing new pathways and improved collaboration with partner organisations.
Contesting where appropriate	We will undertake procurements where it is necessary eg at the end of contracts and where it is clear that the current provider is unable to flex to new challenges. In many cases we will aim to work with our existing providers within the boundaries of contracts to deliver our ambitions.
Availability of timely and accurate data	It is critical that we have access to good quality data so that we can make sound planning decisions. We also need to ensure that we have access to timely data to monitor progress accurately.
Using our communication strategy effectively	Key to both informing and developing our plans, roll out and delivery and getting the message out
Improving how we use our governance structure to deliver	Ensuring that we decisions are made in the right place in a timely manner to facilitate delivery.

West Essex Clinical Commissioning Group

Section 6.0 Financial and Activity Planning Assumptions

This Section outlines the CCGs medium term financial plans incorporating QIPP, planning assumptions, expected forecast outturn 2013/14 and activity forecasts 2013/14**.** This section also provides the broader health system financial challenges of our main providers, Princess Alexandra, South Essex Partnership Trust and North Essex Mental Health Partnership Trust.

6.1 Forecast Financial Outturn 2012/13

As at December 2012 the CCG is forecasting a surplus of £1 million in line with the control total set as part of the 2012\13 financial plan. This forecast assumes that the 2012\13 QIPP programme will deliver £15 million, 75% of the £20 million target with the balance being recovered through a mix of expenditure slippage and non-recurrent use of reserves.

6.2 Key Activity Trends

The summary below references the key activity trends and likely issues for 2013/14, these are:

For **Elective Inpatients and Outpatients**, there are currently no planning expectations that an 18 week backlog clearance will be required in 2013/14.

The most significant change is the growth in elective activity presenting at a non-NHS hospital, which at a high level appears to be offset by a corresponding decrease in PAH. Changes in PbR rules in 2013/14 are likely to allow for a stronger stance to be taken in 2013/14 in negotiating lower than PbR tariffs for activity where it can be shown that providers are primarily undertaking work of a lower case mix complexity compared to the average.

There is a growth trend in the counting of unbundled activity both day case and outpatient procedures for chemotherapy and radiotherapy. This was as a result of changes in the structure of PbR for 2012/13 and should stabilise in 2013/14.

Current trends in **A&E** show an overall decrease of A&E attendances through 2012/13, the CCG will need to be aware of any changes in counting this activity through 2013/14 due to changes in the redirection of patients at the front door of the PAH A&E department.

Current trends in **Emergency Inpatients** show a circa 4% performance against plan and overall growth against prior year before factoring in assumptions on planned QIPP delivery. The current expectation is that this growth in activity will be factored into activity plans before adjusting out for QIPP programmes.

The forecast **demographic shift** as provided by Public Health based on ONS data is 1.1%, the current assumption is that this applies across all activity areas although the reality is that there will be differential impacts across the activity portfolio.

From 2013/14 **diagnostic imaging tests** will be unbundled from the standard outpatient attendance tariff. With little historical data available, planning for this activity will be potentially inaccurate. There are allowances in PbR to mitigate the financial risk.

From 2013/14 **pathway tariffs** are becoming more prevalent, most notable is the maternity pathway tariff. In terms of activity and information flows these changes bring new complexities into the planning and forecasting systems of the CCG. There are allowances in PbR to mitigate the financial risk.

NHS Trusts & FTs - 2013/14 Draft Activity Plans

Table 9

Draft Activity Plan 2013/14	Non-Elective	Elective	Outpatients			A&E	Critical Care
Trust	Spells	Spells	Attendances-1st	Attendances-follow-ups	Procedures	Attendances	Days
Royal Free London NHS Foundation Trust	77	315	468	1,114	207	122	102
The Royal National Orthopaedic Hospital NHS Trust	2	135	540	541	0		35
North Middlesex University Hospital NHS Trust	62	276	6,890	1,179	5,834	311	57
Basildon And Thurrock Univ Hosp NHS Foundation Trust	48	91	273	669	31	190	15
Colchester Hospital University NHS Foundation Trust	55	26	281	1,164	34	228	7
Barking, Havering And Redbridge University Hospitals NHS Trus	692	534	2,430	7,029	864	2,280	0
Barts Health NHS Trust	5,893	4,697	9,486	24,802	6,169	8,259	1,912
Papworth Hospital NHS Foundation Trust	47	322	308	1,083			
West Suffolk NHS Foundation Trust	37	33	122	163	59	108	
Cambridge Univ Hosp NHS Foundation Trust	3,153	4,993	9,612	22,719	6,978	6,386	438
East And North Hertfordshire NHS Trust	65	26	324	804	23	239	
Moorfields Eye Hospital NHS Foundation Trust	26	149	309	2,439	413	1,046	
Mid Essex Hospital Services NHS Trust	2,139	1,966	6,780	14,809	3,254	4,123	303
Princess Alexandra Hospital NHS Trust	17,877	17,918	48,717	90,105	25,127	51,739	1,903
Homerton University Hospital NHS Foundation Trust	65	45	236	467	18	195	21
Barnet And Chase Farm Hospitals NHS Trust	187	199	729	1,247	224	672	120
Total	30,425	31,725	87,505	170,334	49,235	75,898	4,913

This draft activity plan schedule reflect the first cut of activity plans for 2013/14 based on month 8 (Slam) full year activity by Acute provider uplifted for 2013/14 by 1.1% demographic growth. This first activity submission does not reflect changes for:

- commissioning arrangement changes
- deployment of QIPP activity
- other agreed local adjustments and PbR changes.

6.3 Financial Plans for 2013/14

The NHS reforms will see the CCG being established on 1st April together with a re-alignment of commissioning responsibilities previously undertaken by Primary Care Trusts; a baseline expenditure exercise was undertaken in the summer of 2012 to map expenditure to those organisations assuming commissioning responsibility on April 1ST 2013.

For West Essex this resulted in the following estimated expenditure shifts:

Table 10

Shift to	£ million
Essex County Council (Public Health)	£12.507

Public Health England	£ 2.361
National Commissioning Board (Specialist Commissioning and Primary Care)	£104.257
PropCo (Estates and property costs included in CCG and NCB resources)	£0.983

The total estimated expenditure adjustment for West Essex CCG was a reduction of £119 million. This was used to inform the allocations for 2013\14.

Based on the notified allocation and the assumptions outlined below, the high level financial summary for West Essex CCG is shown below

Table 11: Financial Plan 2013-2015

West Essex Clinical Commissioning Group

FINANCIAL PLAN 2012-2015

	Base Year Split Among Commissioners				CCG Integrated Financial Plan		
	Memo PCT 2012/13 £,000	NCB	PH	CCG	2013/14 £,000	2014/15 £,000	2015/16 £,000
Recurring Revenue Resource Limit							
Recurrent Resource Allocations	444,935	102,088	14,868	327,979	310,407	317,546	324,850
Running Costs	(8,092)			(8,092)	7,000	7,000	7,000
less - SCG - added services	0	14,290		(14,290)			
less - NCB Reserve Adlustment	0	2,169		(2,169)			
Underspend Reversal (Non Recurring)					719	1,552	3,175
Annual Recurring Resource Limit Allocations	**436,843**	**118,547**	**14,868**	**303,428**	**318,126**	**326,098**	**335,025**
Post SHA filing Non Recurring data & Adj's							
CCG Funding	10			10			
Winter Pressures	(1,500)			(1,500)			
Pressure ulcers project	(24)			(24)			
Child health network	(5)		(5)				
HPV	38		38				
Dementia programme	40			40			
CWG funding	126			126			
SHA Bundle - GMS dispensing	1,020	1,020					
SHA Bundle - GP dispensing (admin)	53	53					
SHA Bundle - MH Capacity Act	59			59			
SHA Bundle - Burns	69	69					
Reduction if bundle incl in growth	0						
2% cluster share	1,093	251	21	821			
Continuing care panels	(14)			(14)			
PH Transition team	91		91				
Return of Underspend / Overspend	400	92	8	300			
Other Adj (Actual vs Plan)	251	27	386	(162)			
Social Care funding	3,102			3,102			
Add Back - Running Costs CoC	*625*			625			
Add Back - Running Costs	*8,092*			8,092			
2012/13 Resource Limit	450,369	120,059	15,407	314,903	318,126	326,098	335,025
Expenditure							
Recurrent Expenditure							
Expenditures Baseline (incl N/R)	439,598	99,608	14,974	325,015	328,942		
SCG added services (Transfer assumed)	0	14,290		(14,290)	(14,290)		
sub-total					**314,652**	**321,889**	**329,292**
Inflation	9,820	2,319	221	7,280	9,408	9,662	9,923
Reduction in tariff / Provider Efficiency	(11,127)	(2,628)	(251)	(8,248)	(9,432)	(9,649)	(9,871)
Population / Demographic growth	3,466	819	78	2,569	2,939	2,998	3,058
Cost pressures/residual growth	4,522	1,068	102	3,352	3,352	3,443	3,535
New Investments/Oper Framework	3,161	747	71	2,343	2,343	2,577	2,835
Tech/Drugs	1,341	317	30	994	1,835	0	0
QIPP Headroom Reserve (part released 13/14)	3,000	709	68	2,224	564	3,000	3,000
Non Recurrent Expenditure							
Contingency (1.5% for 2013/14)	4,444	1,022	87	3,335	4,656	3,175	3,248
Transformation Fund (1%)- Non Rec Spend	8,542	2,430	192	5,920	3,104	3,175	3,248
Risk Management / Pooling					3,153	1,319	1,389
Non recurrent spend 12/13	3,102	0	0	3,102			
Sub-total Total Expenditure	**469,869**	**120,699**	**15,573**	**333,596**	**336,574**	**341,589**	**349,659**
SAVINGS/INVESTMENT REQUIREMENT							
Total Income less Total Expenditure	(19,500)	(640)	(167)	(18,693)	(18,448)	(15,491)	(14,633)
Planned surplus	1,000	230	33	737	1,552	3,175	3,248
Additional investments/(gross savings) required	**(20,500)**	**(870)**	**(200)**	**(19,430)**	**(20,000)**	**(18,667)**	**(17,882)**
QIPP							
QIPP schemes already identified (-ve figure)	(20,500)	(870)	(200)	(19,430)	(17,564)	(5,000)	(3,000)
QIPP schemes being developed (reserve released te	**0**	**0**	**0**	**0**	**(2,436)**	**(13,667)**	**(14,882)**
Savings required - QIPP plan							
Additional investments/(savings) required	**(20,500)**	**(870)**	**(200)**	**(19,430)**	**(20,000)**	**(18,667)**	**(17,882)**

6.4 2013/14 Allocations

All CCG baseline allocations have been uplifted by 2.3% for 2013\14.

The notified baseline allocation for West Essex CCG is £310.4 million inclusive of the 2.3% uplift. It should be noted that a review of the allocations formula will be undertaken during 2013 to inform allocations for 2013\14. This presents a potential risk to West Essex CCG.

As part of the allocations announcement for 2013\14 the NCB has carried out further adjustments to the baseline mapping exercise carried out by PCT's during 2012. The most significant adjustment is a reduction to CCG baseline of £3.9 billion nationally in respect of specialist services to reflect the increase in the scope of these services in 2013\14 compared to 2012\13.

The resulting adjustment for West Essex CCG is a further reduction to the baseline allocation of £14.3 million. For planning purposes it has been assumed that the reduction in allocations will be met by an equal reduction in expenditure.

It should be noted that the adjustment for specialist services was undertaken at an aggregate level and that therefore its actual impact at a local level presents a significant financial risk for 2013\14. It will be important for the CCG to have clear policies in place setting out what non-specialist services it will fund.

6.5 Quality, Innovation, Productivity and Prevention (QIPP)

Based on initial planning assumptions and subject to the outcome of the detailed contracting discussions, the QIPP target for 2013\14 is set at £20 million. This is similar to the target for 2012\13 and consistent with the target forecast in the previous medium term financial plan adjusted for non-delivery (circa £5 million) in 2012\13.

The projected targets by programme heading are detailed in table below;

Table 12: QIPP Financial Plans by Programme 13/14:

QIPP Net Savings £(000)s	Saving Target for 13/14
Planned Care	3,819
Urgent Care	1,580
Long Term Conditions	1,418
Older People	5,472
Children, Maternity & Neonates	295
Mental Health & LD	1,300
Medicines Management	1,500
Other including Flow Thru' & Contracts	2,180
Identified Schemes - sub total	17,564
Reserve released pending new schemes	2,436
Grand Total Net Savings	20,000

Detailed schemes by project are shown in Table 11. Additional QIPP schemes are being developed on a rolling basis to address the present shortfall against the target and reflecting the on-going nature of the need for QIPP efficiencies.

Table 13: QIPP Financial Plans by Project 13/14:

West Essex Clinical Commissioning Group

2013/14 QIPP Programme £(000)s	**Net Savings Target £000s**
Diagnostic Deep Dive (DA radiology & biochemistry)	654
Optimising local access	283
Decommissioning / Tolce	783
Activity shift - DC to OP	399
Best Practice FA-FUP ratios	867
Validations - Best Practice	380
Referral / Educ. Support to GPs	453
Planned Care	**3,819**
Contract Validation - A&E & Small Contracts SLAs	256
Redirection PC activity	574
Changes to model of Ambulances provision	500
Flow-through of 12/13 investment projects	250
Urgent Care	**1,580**
Diabetes pathway	355
Respiratory Services Improvement plan	265
Cardiology Service Improvement Plan	188
Telehealth	485
Cancer - reduced OPD appointments	125
Long Term Conditions	**1,418**
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Case Managed Integration - reduced admissions	1,000
Frequent Attenders improvements - reduced admissions	937
Falls - integrated service - reduced admissions	225
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Catheter service in PC - reduced admissions	121
Frail & Elderly transformation project	1,558
Low Acuity Activity shift - care at home	250
Social Care Reablement	300
Older People	**5,472**
Meds Mgt & Prescribing 13/14 schemes	1,500
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Local ASD service improvement	100
Paeds EOL care provision	40
GP Education on paeds conditions (increased confidence)	50
Essex wide Paed nurse activity shift	25
Children's and Maternity	**295**
MH Schemes - care in PC (Honos 1-4)	1,500
LD & MH Schemes - contract management - perf.	300
LD Schemes	80
Mental Health and LD	**1,880**
Flow through Enh. Services, Budget reviews, etc	100
Flow through effects of prescribing improvements Mo8-Mo11	1,500
Sundry	**1,600**

Net Savings - Identified Schemes	**17,564**
Release of QIPP headroom reserve pending work-up of additional schemes	**2,436**
Net Savings Target 2013/14	**20,000**

6.6 Other Provisions and Contingencies

- **Cost pressures:** The provision for cost pressures (£3.352m) has been set at the same percentage of turnover, adjusted for baseline movements, as 2012\13
- **Service Developments:** The provision for service developments (£2.343m) has been set at the same percentage of turnover, adjusted for baseline movements, as 2012\13
- **Contingency Reserve:** The contingency reserve initially set at 1% of turnover (£3.104m) has been increased t o1.5% in line with LAT guidance giving an opening reserve of £4.656m.
- **QIPP Contingency Reserve:** A QIPP contingency reserve has been set at £3.0m reflecting the same level of provision as 2012\13. This has been temporarily partially released whilst an additional £2.4m QIPP schemes are developed.
- **Planned Surplus:** In line with Local Area Team guidance a planned surplus has been set at 0.5% of turnover (£1.552m)
- **Commissioning for Quality and Innovation (CQUIN):**Provision for CQUIN has been set at 2.5% (£5.6m) in line with national guidance
- **2012\13 Surplus:** It has been assumed that a proportion relative to the baseline adjustments of the 2012\13 forecast surplus (£0.7m) will be returned to the CCG in 2013\14.
- **Demographic Shifts:** Provision has been made to reflect the forecast demographic shift forecasts as provided by Public Health based on ONS data. This provision is set at £2.939m

6.7 2013\14 Health System Challenge

The financial challenge to the health system is summarised below:

Table 14

£ millions	2013/14	2014/15	2015/16	Total
PAH challenge summary	16.0	15.6	11.4	43.0
South Essex Partnership University (SEPT)	2.2	2.0	2.0	6.2
North East Partnership FT (NEPFT)	1.2	1.1	1.0	3.3
CCG - challenge summary	20.0	18.7	17.9	56.6
System Challenge - Summary	39.4	37.4	32.3	109.1

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The provider element of this challenge, including PAH, SEPT and NEPFT, for 2013/14 amounts to £19.4 million, across the three years this totals £52.4 million.

Major Providers - Challenge Summary

£ millions	2013/14	2013/14	2014/15	2015/16	Total
Planned Expenditure 2013/14	257.3				
Size of challenge (sum of pay and price pressures and impact of activity and quality changes)		19.4	18.7	14.4	52.4

Princess Alexander (PAH) Challenge Table

£ millions	2013/14	2013/14	2014/15	2015/16	Total
Planned Expenditure 2013/14	179.6				
Pay and price pressure on 2012/13 base		5.4	5.4	5.4	16.2
Tariff Benefit to NHS Commissioners		2.5	2.5	2.5	7.5
Underlying 2012/13 pressure c/fwd		0.0			0.0
Productivity impact of planned activity and quality changes on 2012/13 base		3.2	2.9	0.0	6.1
Size of challenge (sum of pay and price pressures and impact of activity and quality changes)		16.0	15.6	11.4	43.0

South Essex Partnership University (SEPT) Challenge Table

£ millions	2013/14	2013/14	2014/15	2015/16	Total
Planned Expenditure 2013/14	40.0				
Pay and price pressure on 2012/13 base		1.4	1.4	1.4	4.3
Tariff Benefit to NHS Commissioners		0.6	0.6	0.6	1.7
Underlying 2012/13 pressure c/fwd		0.2			0.2
Productivity impact of planned activity and quality changes on 2012/13 base					0.0
Size of challenge (sum of pay and price pressures and impact of activity and quality changes)		2.2	2.0	2.0	6.2

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North East Partnership FT (NEPFT) Challenge Table

£ millions	2013/14	2013/14	2014/15	2015/16	Total
Planned Expenditure 2013/14	37.7				
Pay and price pressure on 2012/13 base		1.3	1.3	1.3	3.9
Tariff Benefit to NHS Commissioners		0.35	0.35	0.35	1.1
Underlying 2012/13 pressure c/fwd		0.0			0.0
Productivity impact of planned activity and quality changes on 2012/13 base					0.0
Size of challenge (sum of pay and price pressures and impact of activity and quality changes)		1.2	1.1	1.0	3.3

6.8 Acute Tariff Deflator

The tariff for acute services has been adjusted to deliver a 4% efficiency requirement. Pay and price inflation is assessed at 2.7% giving a net decrease adjustment of 1.3%. In addition tariffs will increase by 0.2% recognising providers underlying cost changes. The 1.1% adjustment will be used as the base assumption for discussions on prices outside the scope of the mandatory tariff.

6.9 Inflation Provision

Provisions for inflation have been set as follows;

Acute and non-acute contracts	2.7% (excl. Tariff adj./increase 0.2%)
Continuing healthcare	3.5%
CCG pay	1.0%
CCG non pay	2.7%

6.10 Transformation Funding

A transformation fund of 1% (£3.104k) is provided for in 2013\14 reflecting the requirement for the CCG to plan for a 1% surplus. A number of schemes were started in 2012\13 and have flow through consequences into 2013\14. In addition the CCG has been working closely with local providers, the local authority and the voluntary sector on a scheme to reduce the level of frail elderly admissions into secondary care and this is planned as a significant investment in 2013\14.

The planned use of the available transformation funding is shown at Table 13.

Table 15: Transformation Funding 2013/14:

West Essex CCG - 2013/14 Transformation Schemes	
Proposed schemes 2013/14	**Funds Required**
Major Schemes:	£(000)
Enhanced Comm Provision (Frail Elderly)	£1,700
Stroke Early Discharge (ESD)	£374
Other Identified Investment Areas	
Localities Innovation Funds	£100
Diabetes Pathway	£60
Get into Reading Groups (MH)	£21
Eclipse CCG Rollout (risk profiling)	£20
Primary Care for MH 3.5 Cohort	£100
End of Life	£100
EOE LTC Implementation Programme	£75
Improving access for patients with LTC to OOH	£70
Patient Engagement	£35
Integration / System-wide New Ways of Working	£449
Total - Proposals	**£3,104**

6.11 Running Costs

The running cost allowance (RCA) for West Essex CCG has been set at £7.0m for 2013\14 in line with the £25 per head of population cap. Total running costs are estimated at £6.206m, £794k below the national running cost allowance (RCA).

The projected running costs for 2013\14 are;

Table 16

	RCA £000	**Non-RCA £000**	**Total £000**
Service procured from Essex Commissioning Support Unit (CSU)	2,172.7	535.9	`2,708.6
Internal costs	3,971.8	1,189.1	5,160.9
Total at 2012/13 conditions	6,144.5	1,725.0	7,869.5
Total at 2013/14 conditions	**6,206.0**	**1,765.0**	**7,971.0**

6.12 Activity Trends and Assumptions - Key Financial Risks

The principle financial risks facing the CCG in 2013\14 are;

6.12.1 Baseline mapping

The CCG was required in 2012 to align expenditure within its baseline to reflect revised commissioning responsibilities. The key adjustments which resulted in a reduction of £119 million to the baseline have been used to inform the notified allocation for 2013\14.

To the extent that the mapping exercise contains and errors or omissions, these could present a financial risk in 2013\14 which will need to be managed within existing resources.

Of more significant risk is an additional reduction to the CCG baseline of £14.3 million to reflect and expansion of activity that will be classified as specialist activity and will therefore be commissioned by the NCB.

As this transfer was not based on actual activity there is a significant risk that the level of financial adjustment will not align with the levels of activity that are identified to transfer following additional analysis.

The CCG will work with provider and NCB colleagues to quantify these risks and identify appropriate risk mitigation plans.

6.12.2 Activity assumptions

The CCG's activity forecast is based on projections based on November actual activity to date and is adjusted to reflect forecast demographic shifts, identified trends, specific initiatives and QIPP proposals.

To the extent that activity exceeds these forecasts, a financial risk will arise that will need to be managed within existing resources.

6.12.3 QIPP

The CCG's efficiency target is set at £20 million.

This represents a significant challenge and risk to the organisation and will require focussed implementation and monitoring throughout the year to ensure any risks to delivery are mitigated.

Delivery will be monitored by the Finance and Performance committee as well as the Executive committee and clinically led programme boards.

6.13 Capital

Whilst the regime for capital funding in 2013\14 has yet to be announced the CCG's initial financial submission includes a capital plan comprising forecast expenditure of £1.9M as advised by the Cluster Estates Team.

Schemes included are in Table 17.

Table 17

Planned Capital Expenditure (Schemes)	Business Case Submitted (Y/N)	Value £'000s
St Margarets Comm Hospital - refurbishment	N	650,000
Rectory Lane Health Centre - refurbishment	N	300,000
Osler House Community Clinic	N	200,000
Saffron Waldon - Community Clinic	N	175,000
Saffron Waldon - Endoscopy suite	N	102,000
Sydenham Ho refurbishment	N	200,000
Backlog maiantenance	N	200,000
Energy efficiency schemes	N	100,000
TOTAL		**1,927,000**

6.14 Assurance

The CCG's initial financial submission has been reviewed by the Local Area Team of the National Commissioning Board and has been rated Green in respect of financial governance and amber in respect of financial sustainability.

The initial financial sustainability amber rating will be reflects the current status of the CCG QIPP programme requiring a further £2.4M of schemes to be identified, and agreement of the main provider (Princess Alexandra Hospital) cost improvement programme for 2013\14.

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Section 7.0 How we are Involving the Public and Patients of West Essex

This section outlines the CCGs ambitious plans for public and patient engagement and highlights how they have been able to influence the development of this plan. The CCG is clear that engagement and partnership with our patients and communities is key to the delivery of our plans. Our plans for patient and public engagement in West Essex challenge the existing culture of public engagement and will develop ways to work in collaboration with our patients and the public to ensure individuals and local representatives have real decision-making and asset building power, including budget responsibility where possible. Our ambitious are laid out in our PPE Strategy “Open Doors: Public and Patient Power in Health Planning”.

This strategy will be delivered through a new patient and public network that is part of our organisation. This new network, established in August 2012, enables people to influence service improvements and our annual spending plan.

The delivery of this strategy will be pivotal to our response to the recommendations of the a Francis report.

7.1 Engaging People in making Change Happen

Our job as commissioners is to make the most of our resources and innovation and to lead the local NHS in making changes to deliver the best of modern healthcare to local people. Patients and people are vital to this process:

- People who are well-informed and supported can better manage their own good health and health care
- Patients and their carers bring the benefits of their experience and perspective to improving services and health outcomes

- Patients and members of the public can act as our “key communicators” and advocates for service changes

- Communities and services can achieve more by working and planning together.

Because the CCG is made up of general practices and has clinicians leading decision-making, this in itself brings decisions closer to patients. GPs and other clinicians are able to use their clinical expertise and their day-to-day contact with patients to inform and influence commissioning decisions. Our patient and public engagement (PPE) strategy builds on this to make sure that people in Epping, Harlow and Uttlesford are connected and can contribute to developments in their local NHS.

7.2 Our Strategy to engage people

Patient and public engagement is not just written into our constitution – it will be embedded as part of our culture. Our strategy is to engage people on several levels:

- **Listening-** to people’s views and experiences and feeding these into our routine business**.**
- **Informing** – about services, performance and plans, feeding back the views and experiences shared and how we have acted on them.
  Consulting – about a particular service area or commissioning decision.
- **Involving** – in service developments and commissioning plans. We will seek views at an early stage to inform our proposals with a range of perspectives and expertise.
- **Collaborating** – on service redesign and annual commissioning plans. We will create partnerships to achieve breakthrough changes.
- **Asset-building** – by giving budgets and decision-making power to people and families to manage their own care and to representatives working within our planning and governance structures.

Overall our patient and public engagement strategy is designed to support people in making changes happen, for example through various levels of involvement in projects, pilots and service redesign, and our overall strategic plan.

7.3 How we are Involving Local People

The CCG is adopting a number of approaches to involve local people in decisions about healthcare these include:

- **Information exchange** - receiving, analysing and responding to feedback as well as publishing information about services and patient issues on a continuing and systematic basis.
- **A new systematic engagement network** of partners, groups and forums involved in the work of projects, planning groups and board level decisions.

- **Annual engagement cycle** as part of the annual commissioning cycle. The CCG has developed an annual planning cycle incorporating
- **Leadership and champions** for patient and public engagement on the CCG Board and through a Patient Reference Group

Examples:

- At the centre of the engagement network is the West Essex Patient Reference Group which has the responsibility for ensuring effective representation and engagement reporting directly to the CCG Board. This has been established since August 2012 and role is to ensure that the CCG board is informed by the Patient and Public perspective on experiences and expectations of local health service delivery, ensure patients and members of the public are given opportunities to contribute and influence the decision making and planning processes of the CCG and to monitor the impact and effectiveness of the CCGs patient and public engagement, identifying and making recommendations to the CCG for improvement

- Locality Patient Forums have been established in Epping Forest, Harlow and Uttlesfords and during November 2012 these forums held planning workshops to inform our planning processes and priorities. A key theme that emerged from these forums was the need to have a more joined up approach to the delivery of services with a smooth more joined up transitions and communication between agencies.

- Patient Representatives have also had active involvement in service re-design through their membership on our Programme Boards. The West Essex Patient Reference Group reports to the CCG Board.

We have further work to do in truly embedding patient and public engagement in our activities, building on our achievements to date our priorities for the coming year include**:**

- **Developing our Patient participation groups at GP practice level** having a new role in clinical commissioning
- **Developing closer working relationships with statutory representative bodies**, such as local HealthWatch, Essex County Council Health and Wellbeing Board and Essex Health Overview and Scrutiny Committee and building on existing engagement networks of our partners.
- **Developing more innovative and effective ways to research and consult** with patients, public and hard to reach groups, using surveys, social marketing and consultation techniques

- **Asset-building research, development and piloting** with local authority and voluntary sector partners, to determine how people and groups could manage their own budgets and wider healthcare decisions.


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Section 8.0 Planning, Delivery and Development

8.1 Introduction

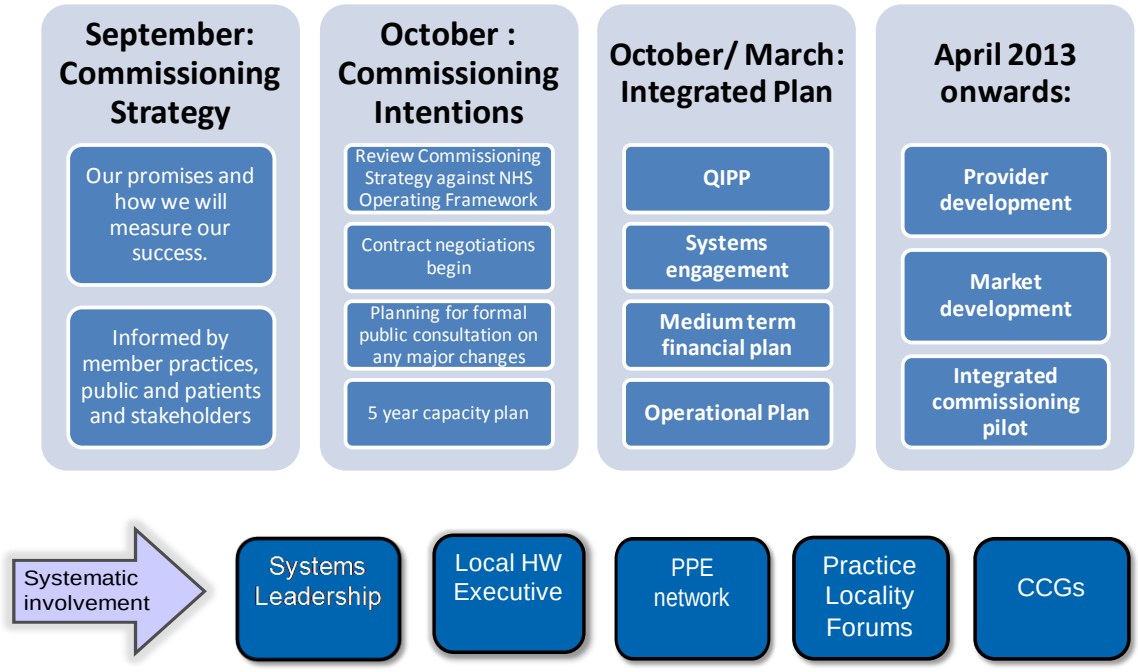
This chapter details the governance arrangements, supporting business processes and the organisations programme of development required to underpin the delivery of the Integrated Plan and the wider context of the CCGs development as a sustainable commissioning body.

Our approach seeks to ensure delivery against a number of key risks and issues including:

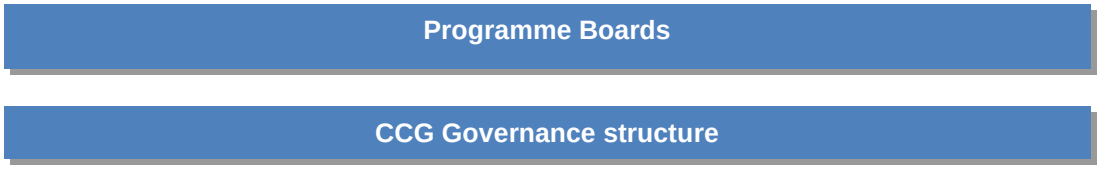
- Supporting and developing effective CCG Leadership
- Maintaining accountability and oversight
- Integrated delivery between health and social care, commissioners and providers
- Embedding public and patients experiences and views in our decision making
- Mitigating the additional risks presented by organisational change

8.2 Planning with our Partners

As part of our annual planning cycle we have involved our providers, patients and members of the public, and member practices in the development of this plan. This has been undertaken through a network of engagement activities during November to January including, our Locality Patient Forums, Provider Stakeholder Workshop and our Locality Members Forums.



The CCG governance model during transition will underpin the proposed governance



8.3 Systematic Involvement

The successful implementation of this Integrated Plan is essential to the delivery of the CCGs strategic aims. Key dependencies are the strength of our collaboration and engagement with our partners and our governance structures.

8.3.1 Local Systems Leadership Forum

The CCG has established a Local Systems Leadership Forum that represents all the local systems partners including Social Care, Public Health, Princess Alexandra Hospital, South Essex Partnership Trust and North Essex Partnership Foundation Trust. This group provides the leadership for the development and implementation of this plan and to review, test and challenge its outputs.

8.3.2 Joint Wellbeing Executive Group

The CCG is establishing with its partners, Epping Forest District Council, Harlow District Council, Uttlesford District Council and County including Public Health a West Essex Wellbeing Executive. The focus of this group is the development of a West Essex Wellbeing Strategy and through collaboration and the commitment of partners to jointly improve the wellbeing in West Essex.

8.3.3 Public and Patient Network

Section seven details our plans for embedding public and patient engagement in the activities of the CCG . This is routinely delivered through our locality membership model The model integrates different stakeholders into a single entity allowing us to engage meaningfully with the right people at the right time. The CCGs is creating a membership network of partners, groups and Locality forums that offers a flexible range of engagement and provides the assurance that all engagement leads to an impact on commissioning decisions, with links to planning groups i.e. Programme Boards and ultimately to the CCG Board. In addition to recognising existing groups and networks that have an interest in health issues, we invite individuals and groups to join our network of members and subscribers.

8.3.4 Locality Members Forums

There are three Locality Forums of the CCG, Epping Forest, Harlow and Uttlesford reporting to the CCG Commissioning Committee. All practices has part of the CCG Constitution are required to be members of a forum. The primary function of these forums are to:

- Ensure that the CCGs strategy is reflective of the priorities of the health needs of the locality
- Ensure that the QIPP programmes are responsive to the different needs of the localities
- Provide the clinical support to specific QIPP projects, this can be provided on an adhoc project specific basis or on a group consultative basis
- Provide the forum for sharing of good practice, offering peer support and peer review of practices and locality performance against financial plans/notional budgets and fulfilling the terms of this agreement
- Ensure that all voices and concerns of members are heard and fairly addressed
- Keep members informed on the business of the board
- Provide a forum to inform the board on provider experiences

8.3.5 Programme Boards

The Programme Boards have been developed to cover the system in its widest sense and structured activities in order to maximise engagement. The membership of the Programme Boards includes:

- CCG Clinical Leadership
- Princess Alexandra Hospital
- South Essex Partnership Trust
- Essex County Council
- Voluntary services
- Patient representatives
- Partnership of East London Co-operatives (PELC) – GP out of hours provider
- Whipps Cross hospital
- North Essex Mental Health Partnership Trust
- Hertfordshire CCG
- EOE Ambulance Service
- Addenbrookes Foundation hospital

Each Programme Board is assigned objectives to support the delivery of QIPP and performance by which they will be held to account by the CCG Commissioning Committee. The Programme Boards are based around our priorities:

- Urgent Care
- Planned Care
- Long Term Conditions
- Older people
- Medicines Management
- Mental Health & LD
- Children and Maternity

8.3.6 Collaborating with CCGs

Chapter 3 identifies the way in which the CCG will collaborate with other neighbouring CCGs on commissioning and contracting where patient flows are shared. These relationships are key and formalised through Collaboration Agreements which secures the on-going involvement of all parties in the performance management of contracts but also the development and implementation of new clinical pathways and service transformation.

8.4 Organisational development- Building our Capacity and Capability

8.4.1 Our development journey so far

The CCG has made great leaps forward over the last twelve months laying the foundations for our future success and a sustainable commissioning organisation. We have successfully recruited to our Board, our Clinical Leadership Team; we have worked closely with the Essex Commissioning Support Unit (CSU) to secure services and through either alignment or recruitment starting to build a strong CCG team of staff.

Whilst we have made this progress we know we need to do much more. We know we need to address a new set of challenges, including greater collaboration and integration between providers, commissioners and social care and also including the potential for the development of mixed provider markets for NHS services, with public, private and voluntary sector suppliers. There are a new set of market-based levers for improving services, such as competitive tendering, introducing competition and harnessing patient choice, therefore we need the skills, knowledge and mindsets to use them effectively.

8.4.2 Our programme for development

The CCG is undertaking a structured programme to its development to address these challenges. The CCGs Organisational Development Plan (OD plan) provides this framework that includes how we will:

- develop an effective strategic and operational planning process that will enable us to deliver our vision
- ensure we have robust governance arrangements and that our decision making is open and transparent
- develop a distributive leadership model that is responsive to the different health needs and priorities across west Essex and that empowers staff, local clinicians and our patients in making and influencing commissioning decisions
- introduce more effective and efficient commissioning processes that are clinically led and have our patients at the centre
- build the capacity and capability of our CCG team and primary care
- build effective relationships with our partners, the public and our patients
- build a more dynamic, exciting organisation for our staff to work in and our practices to feel that the organisation embeds a membership and inclusive led culture.

We adopted a systematic approach to organisational development from diagnostic, identified capability gaps, route causes to action plan incorporating interventions and deliverables. Our plans are based around six key work streams these are:

- Leadership
- Governance
- Developing the organisation
- Processes, engagement and relationship building
- Talent and succession planning
- Strategic planning and delivery

8.4.3 Our interventions

The interventions we are taking fall into four broad categories:

- Actions to improve the CCG's organisational or decision-making structures, allowing for stronger strategic oversight, governance, delegation and accountability for delivery;
- Activities to establish new processes, including new frameworks for prioritising investments, developing commissioning strategies and harnessing human resources;
- Programmes to build the skills and behaviours needed in a clinically led commissioning organisation, ranging from leadership and team working to technical competencies; and
- Recruitment to bring new skills or capacity into the organization, in areas where existing resources are over-stretched or new technical competencies are required.

8.5 Our approach to Workforce Planning

We recognise that this is an area of development for the CCG and the local health system to develop a local workforce strategy that will cover the future health and care workforce requirements to support the transformational change required as outline in this plan and future plans. This will require a bolder approach to workforce planning involving a major shift in where care is delivered and how patients and service users relate to both health and social care professionals.

Our plans need to reflect the need for a more multi-skilled workforce that can deliver effective care with minimum interventions across health and social care; integrated providers and integrated commissioners. Workforce plans will also need to reflect, desired clinical outcomes and effectiveness, productivity, patient safety and quality, specific workforce criteria and professional bodies.

The CCG will work with its health and social care systems partners to develop these plans over 2013/14, working closely with the Essex Workforce Partnership.

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Section 9.0 Risks to Delivery

This chapter captures the potential risks against the deliverables contained within the Integrated Plan. This will form part of an on-going operational delivery plan. Progress will be monitored against this through the Clinical Commissioning Committee on a quarterly basis.

Table 18

Programme Board	Description of Risk	Probability	Impact	Mitigation
CCG Wide	Fail to build sufficient engagement from Primary Care	**Medium**	**High**	Incremental development programme in place
	Fail to build sufficient engagement from providers	**Medium**	**High**	System wide project structure
	Inability to develop lead provider model	**Medium**	**High**	System commitment to model
	Inability to develop integrated	**Medium**	**High**	Essex wide

	commissioning with social care			commitment secured
	Inability to dedicate sufficient clinical and executive leadership for QIPP delivery	**Medium**	**High**	Governance arrangements being refreshed and wider network of clinical stakeholders being developed.
	Inability to achieve all national and local performance standards	**Medium**	**High**	New performance management regime in place
	Inability to achieve all national and local quality standards	**Medium**	**High**	
	Inability to deliver capacity in the right place, workforce/infrastructure changes	**Medium**	**High**	Needs to be factored into to individual delivery plans
Older People	Delayed roll out of Integrated Frailty Programme	**High**	**High**	Spec in development in partnership with providers and incremental implementation plan being prepared
	Lack of Clinical Leadership for End of Life	**Medium**	**High**	Interim support secured. Discussions to widen to Palliative Care nurse rather than GP
Planned Care	Pathway review doesn't generate anticipated reductions in activity/cost	**Medium**	**High**	Review models from elsewhere that have been successful.
	Pathway review will generate growth in capacity/activity rather than reduction as unable to reduce activity in current providers.	**High**	**High**	Consider contractual levers.
	Lack of clinical availability to ensure service redesign is clinically led and signed up to	**Medium**	**High**	Establishment of Planned Care System Review Board, made up of Senior Executives from CCG and Provider to ensure engagement and delivery.
	Unable to work as a whole health economy with a common vision/aim, as organisations have their own agendas/pressure.	**Medium**	**High**	Establishment of Planned Care System Review Board, made up of Senior Executives from CCG and Provider to ensure engagement and delivery.
Urgent Care	Urgent care reconfiguration does not deliver desired outcomes	**Medium**	**High**	Daily management across system
	Patients do not change pattern of access	**Medium**	**High**	Meaningful and appropriate

				communication
	System capacity fails to match demand	**Medium**	**Medium**	Regular monitoring of whole system
Long Term Conditions	Pathway review does not generate reduction in cost/activity	**Medium**	**Medium**	Review successful models of care
	Engaging all stakeholders to regularly attend GP Practice level MDT's to	**Medium**	**Medium**	Effective facilitation by employing full time WTE Band 5 facilitator for this project
	Identifying more patients for LTC registers will impact on demand in primary, community and secondary care.	**High**	**High**	Ensure effective primary and community care management in place for extra cohort of identified patients
Medicines Management	Provider organisations not engaged in local decision making processes about medicines, resulting in inequity for our patients	**Medium**	**High**	Contractual levers
	Lack of buy in and engagement from partners in supporting changes to prescribing behaviours and processes	**Medium**	**High**	Contractual levers
	Other Programme Boards initiatives may increase pressures on prescribing as more services and medicines are provided in community care	**High**	**High**	take a holistic approach to budgets – i.e. bringing activity and prescribing budgets together
	Lack of resources for new drugs and new NICE approved therapies	**High**	**High**	Having good horizon scanning processes in place
	Lack of contract levers i.e medicines management schedule in contracts and variation on implementation and enforcement of standards particularly with providers where West Essex is an associate Commissioner	**High**	**High**	neighbouring CCGs and Contract managers to ensure processes are robust.
Children and Maternity	Increasing birth rate may put pressure on existing facilities (currently only 1 theatre) and may cause consequent increase in clinical risk/reduction in patient satisfaction	**Medium**	**High**	Increased capacity at PAH planned together with 2nd theatre, Essex plus capacity planning group working together
	Unable to recruit to Children's Community Nurses to enable Care Closer to Home agenda to be delivered as per planned timescales	**Medium**	**High**	Essex wide plans, joint recruitment, close monitoring, increased numbers of students being trained
Mental Health	No additional funding to increase IAPT capacity and failure to meet	**Medium**	**High**	Additional funding highlighted as cost

and Learning Disabilities	trajectory			pressure for 2013/14
	Resistance by provider to engage in activity which may reduce their income and dominant market position	**High**	**High**	Robust negotiation by the CCG to enable the work to move forward

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Appendix 1

<table>
<tr><td rowspan="3">QIPP BUS CASE PLANS FOR:
Programme Board
(E3)</td><td></td><td>Total Savings for 13/14</td><td>Total Productivity Impact by 2015
(G3)</td></tr>
<tr><td>Children & Maternity</td><td>£XXXX</td><td>Reduction of spend by ___%</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="2">Objectives (SMART)
(C6)</td><td colspan="2">Leadership</td></tr>
<tr><td colspan="2" rowspan="3">To continue to reduce Paeds attendance at A&E, to continue to develop care closer to home structures and to empower Paeds and parental LTC management.
Continuing work to establish robust transition to adult services to ensure efficient LTC management with minimal secondary care involvement</td><td>Clinical Lead</td><td>Dr Sue Humphries</td></tr>
<tr><td>Executive Lead</td><td>None Assigned</td></tr>
<tr><td rowspan="3">Delivery Leads</td><td rowspan="3">Jo Eley & Doug Tanner</td></tr>
<tr><td colspan="2">Key projects:
(D19)</td><td></td></tr>
<tr><td colspan="2" rowspan="11">Schemes that were implemented in 12/13:
Care closer to home/ reducing unnecessary acute care (reducing A&E attendances and LOS and WA)
Development of local ASD service (commencing January 2013)
Provision of local Bobath services (repatriation from London providers)
Provision of Paeds EOLC at home reducing hospice / acute spells
Move to AQP for Paeds continuing care
GP education around Paeds conditions to increase diagnostic confidence
Review of Neonatal community team working practices

Opportunities in 13/14 & 14/15 are to further develop some of the above schemes. In addition there is an intention to implement the following:

Possible de-commissioning of unproven Neo natal community team and expansion of existing team roles
Review of paeds urgent care with possible application of ambulatory care structures and tariffs
Review of cost and benefits of consultant led immunisation clinics
Repatriation of Tongue tie service
Pan Essex Paeds nurse led continence service to reduce OP activity
Maternity QIPP opportunities are required to await operational implementation of the Maternity Pathway Price (MPP)</td><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2">Clinical Engagement</td></tr>
<tr><td>Local acute consultants</td><td></td></tr>
<tr><td>Local GPs</td><td></td></tr>
<tr><td>Local GPs with specialist interest</td><td></td></tr>
<tr><td>Other clinical practitioners such as physiotherapists</td><td></td></tr>
<tr><td>Links with Other Projects:
(G19)</td><td>Public Health</td></tr>
<tr><td colspan="2">Workforce Implications
(C27)</td><td colspan="2">Activity Implications (detail baseline and anticipate reductions by HRG or relevant currency and profile)
(E27)</td></tr>
<tr><td colspan="2">Redesign of services will require providers to reassign existing staff
members to maximise benefits
Procurement programme will impact existing workforce structures</td><td colspan="2">1. Repatriation of Tongue tie service – 200 clinic repatriations @ unit cost of £100 : £20,000
2. Continence Service limited PYE - £20,000
3. MPP – Awaiting Q3 audit calculation W/c 28/1/13
4. Consultant led immunisation clinics – repatriation of MMR clinic activity re: Egg allergy severity - £10,000
5. Neo natal community team - TBC</td></tr>
</table>

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	6. Paeds urgent care – TBC W/c 28/1/13		
Finance (detail investment and savings and profile) (C33)	**Details of Patient Participation and Engagement (E33)**	**Equality Impact Assessment (F33)**	**How does this support delivery of CCG vision? (G33)**
			Through the active management of patients with or at risk of ambulatory care sensitive conditions we will prevent acute exacerbations and minimise the need for emergency hospital admissions or urgent health care provision **We will work in partnership with our patients living with long term conditions to support them in making healthy lifestyle choices and to self manage their conditions to avoid unplanned hospital admissions, to engage positively and effectively with care professionals and to maximise their health outcomes.**
Quality Indicators e.g…….. KPIs below must be aligned to quality indicators (C39)			
Monitoring:TBA			
Baseline: (D46)	**TBA**		
Milestones (D50)	31st Dec – Production of the business cases for the new schemes above.		
KPIs	KPIs will be scheme specific and integrated into contract negotiations		
Risks e.g……	**Severity**	**Likelihood**	**Action to mitigate**

Provider performance around delivery and re-design		High	likely	Effective use of KPIs and contract levers to enforce change
Key staff will not be in position within the commissioning / CSU / CCG structure leading to loss of corporate memory and delays in implementation		High	Highly likely	Robust handover plans once commissioning structures are confirmed
Primary Care Enablers				
● QP Indicators		● Four steps to Primary Care		● Practice Visits
● Locality Manager Support		● Use of MedAnalytics		
Financial Phasing	**2013/14**	**2014/15**		
	TBC	**TBC**	**Assumption that the savings are Recurrent**	
Productivity Opportunity	**2013/14**	**2014/15**		
	TBC	**TBC**		
Approved by the Programme Board		**Date:** _____		

West Essex Clinical Commissioning Group

<table>
<tr><td rowspan="3">QIPP Business Case Plans for Programme Board
(E3)</td><td></td><td>Total Savings for 13/14</td><td>Total Productivity Impact by 2015
(G3)</td></tr>
<tr><td>Medicines Management</td><td>£1.5m</td><td>Reduction of spend by __3.6_%</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="2">Objectives (SMART)
(C6)</td><td colspan="2">Leadership</td></tr>
<tr><td colspan="2" rowspan="2">To deliver £1.5million in13/14 & by £1million in 14/15 QIPP productivity from the prescribing budget . The budget will be set to include the QIPP savings target. Therefore if the Medicines management costs come in on or under budget the CCG will have made their QIPP target.</td><td>Clinical Lead</td><td>Dr Sanjeev Rana</td></tr>
<tr><td>Executive Lead</td><td>Melanie Crass</td></tr>
<tr><td colspan="2" rowspan="2">Key projects:
(D19)</td><td rowspan="3">Delivery Lead</td><td>Anurita Rohilla</td></tr>
<tr><td rowspan="2">Clare Romain</td></tr>
<tr><td colspan="2" rowspan="2">The Medicines management team will continue to have a proactive approach to medicines management. Visiting GP practices that are outliers in prescribing / spend and creating tailored plans for them to address the overspend /issue.

In addition to the above the following major programmes will be initiated:
• GP’s don’t initiate (Sip feeds / stoma/ dressings / specialist drugs)
• Improve clinical outcomes by reducing polypharmacy and the stopping of unnecessary medication. – Produce guide for GPs to use in practice
• Waste Management through patient empowerment – reporting to the GP if they are receiving more medication than they need. Developing a system for DNs and community nursing teams to report excessive medication they see in homes and improving repeat prescribing systems in practices.
• Ensure all Antipsychotic prescribing in patients with dementia is clinically appropriate.
Continue to monitor specials and ensure cost effective prescribing practice
Improve communication at transfer of care from secondary to primary care
Disease or therapeutic specific area:
Ensure insulin analogues and diabetes medicines are prescribed in accordance with NICE guidelines
Ensure appropriate prescribing of LAMAs and asthma patients that are not using their combination inhaler properly are stepped down to a steroid only inhaler
Use scriptswitch to implement formularies and guidelines
Ensure safer prescribing of warfarin, hypnotics and antibiotics
Working with social care and healthcare providers in the delivery of medicines safely to vulnerable adults</td><td>Gaynor Harrington</td></tr>
<tr><td></td></tr>
<tr><td colspan="2"></td><td colspan="2">Clinical Engagement</td></tr>
<tr><td colspan="2"></td><td>Local acute consultants</td><td>Dr Ambe (SEPT) Dr Stevens (NEPFT)</td></tr>
<tr><td colspan="2"></td><td>Local GPs</td><td>Sanjeev Rana, Iain Gilchrist, Karin Ashar</td></tr>
<tr><td colspan="2"></td><td>Local GPs with specialist interest</td><td>Dr Julian Brown (Eclipse)</td></tr>
<tr><td colspan="2"></td><td>Other clinical practitioners such as physiotherapists</td><td>Acute trusts staff
Louise Crowley (SEPT) and community staff
John Biddulph (PAH), Val Shaw (Addenbrookes) K Patel (BLT)
LPC</td></tr>
<tr><td colspan="2"></td><td>Links with Other Projects:
(G19)</td><td>As prescribing is often the first initiative in healthcare for patients – Meds management will be involved in all the other programmes.</td></tr>
<tr><td>Disease specific area:</td><td colspan="3">Activity Implications (detail baseline and anticipate reductions by HRG or relevant currency and profile)
(E27)</td></tr>
<tr><td>Safe cost effective prescribing for patients with diabetes.
Safe cost effective prescribing of inhalers for respiratory disease.</td><td colspan="3">Impact on prescribing budget</td></tr>
</table>

Safe prescribing of warfarin in the community. Safe prescribing for patients with dementia				
Finance (detail investment and savings and profile) (C33)		**Details of Patient Participation and Engagement (E33)**	**Equality Impact Assessment (F33)**	**How does this support delivery of CCG vision? (G33)**
Budget for 12/13 including QIPP target	£_____	There is a patient representative on the Medicines Management Board and we have wide patient engagement at stakeholder events	NHS West Essex believes that people have equal rights of access to treatments on the basis of need and health care should be allocated justly and fairly on the basis of need and capacity to benefit, so as to maximise the welfare of patients within the budget available. So by identifying a group of patients that can best benefit from new treatments with local specialists we are making the best use of the budget and treating everyone equitably.	The Medicines management programme fully supports the CCG Vision in delivering healthcare. In particular, i) keeping patients out of hospital where appropriate and ii) supporting patients to self manage their conditions. Approx. 10% of all hospital admissions are medicines related – therefore polypharmacy and the stopping of unnecessary medication is crucial.
Forecast outturn for 12/13	£_____			
	£_____			
Budget for 13/14:	£_____			
NOTES:				
How will CRES impact on the above ?				
Quality Indicators eg…….. KPIs below must be aligned to quality indicators (C39)				
National NICE Prescribing Quality Indicators				
Monitoring:				
Baseline: (D46)	The monitoring will be against the Medicines management budget. This is the same process that has been used in 12/13 QIPP. The PPA will detail the CCG's spend and will forecast the total in year expenditure.			

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Milestones (D50)	**Dec 13th 2012** – Medicines Management Board away day. Further discussion / planning for the delivery of QIPP in 13/14. **April 2013** – All the schemes have been sufficiently worked up so that they can be implemented at the start of the financial year. **July 2013*** - Medicines Management review after Q1 – Using the PPA data asses the effectiveness of their delivery against plan. Ensure that actions are in place to address any potential slippage against plan.*Or as soon as there is meaningful PPA data.
KPIs	Sitrep produced monthly and presented to the programme board for discussion.

Risks eg……	**Severity**	**Likelihood**	**Action to mitigate**
Dependencies on key resources being available	Showstopper	unlikely	AR: Recruitment in progress
Nice Guidance and new drugs on the horizon causing cost pressures	High	likely	AR: Continuous horizon scanning and monitoring of prescribing v spend
Impact of other QIPP schemes impacting on prescribing	High	Highly likely	SR: Close working with other Boards

Primary Care Enablers				
● QP Indicators		● Four steps to Primary Care		● Practice Visits
● Locality Manager Support		● Use of MedAnalytics		
Adhere to CCG drug restrictions and recommendations				
Adherence to scriptswitch recommendations				
Financial Phasing	**2013/14**	**2014/15**		
	£1.5m	£1m	**Assumption that the savings are Recurrent**	
Productivity Opportunity	**2013/14**	**2014/15**		
	N/A	N/A		
Approved by the Programme Board		**Date:** _____		

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<table>
<tr><td rowspan="3">QIPP Business Case Plans for Programme Board
(E3)</td><td></td><td>Total Savings for 13/14</td><td>Total Productivity Impact by 2015
(G3)</td></tr>
<tr><td>Planned Care</td><td>£3.8m TBC</td><td>TBC</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="2">Objectives (SMART)
(C6)</td><td colspan="2">Leadership</td></tr>
<tr><td colspan="2" rowspan="2">To reduce elective spend by:
- ensuring elective care services commissioned are clinically effective, cost effective and provided in the right setting
- supporting general practice with referral support
- contractual controls and validation.</td><td>Clinical Lead</td><td>Dr Amik Aneja</td></tr>
<tr><td>Executive Lead</td><td>Dean Westcott</td></tr>
<tr><td colspan="2">Key projects:
(D19)</td><td>Delivery Lead</td><td>Paula Halfhide & Josephine Smit</td></tr>
<tr><td colspan="2" rowspan="15">Schemes that were commenced in 12/13:
1. Reduction in diagnostics
2. Central referral service (CRS)
3. Optimising local access
4. Treatments of limited clinical effectiveness (TOLCE)

Opportunities in 13/14 & 14/15:
1. Reduction in DA Diagnostics
- working closely with Primary Care and providers to reduce duplication of tests and use all opportunities to improve computer based requesting and reporting along with education / best practice advice and guidance opportunities.
2. TOLCE
- Increase thresholds/policies through review of Beds/Herts, Cambs/Peterborough and Better Care Better Value (BCBV) 5 thresholds. The BCBV thresholds were identified by Tricordant as areas of opportunities for West Essex CCG as activity levels are above our peers. Tricordant estimated savings of up to £1m.
3.Contractual levers and increased validation
- In patient activity to Day Case and day case shifting to outpatient across the 4 main providers.
- Expand validation eg. Additional searches (at present only short stay high cost & Excess bed days) C2C referrals, practice input. Medianalytics to support.
4. Increased Referral support for GP practices
- includes C&B advice and guidance, telephone triage, virtual clinics, use of Medianalytics to demonstrate variation and support analysis at patient level, education (with support from Deanery), referral templates, peer review of referrals. Tricordant estimated savings of £1m-£2.5m to reducing first OP rates to upper quartile.
5. Optimising Local Access / Service redesign
- Procurement of community based services for Ophthalmology , Urology , ENT (Tricordant estimated savings of £400k), carpal tunnel.
- Other service redesign Cardiac Devices , DA Cardiology , Renal Stones, Pain Management (linked to being an outlier in BCBV low back pain surgery)</td><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2">Clinical Engagement</td></tr>
<tr><td>Local acute consultants</td><td>Support from Acute Trusts needed to effectively engage</td></tr>
<tr><td>Local GPs</td><td>CCG Clinical leads and other co-opted leads as appropriate. Sufficient support is essential.</td></tr>
<tr><td>Local GPs with specialist interest</td><td>CRS GpwSIs</td></tr>
<tr><td>Other clinical practitioners such as physiotherapists</td><td>SEPT</td></tr>
<tr><td>Links with Other Projects:
(G19)</td><td>• Links with the LTC programmes especially around the Cancer programme and long term conditions. Need to ensure double counting doesn't occur.
• Links with Meds Management programme board to ensure that there is no adverse prescribing impacts.
See primary care enablers below</td></tr>
<tr><td colspan="2">Workforce Implications
(C27)</td><td colspan="2">Activity Implications (detail baseline and anticipate reductions by HRG or relevant currency and profile)
(E27)</td></tr>
</table>

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Coding Manager Support for TOLCE policies to allow to accurate assessment of impact coding and recruitment risk. Limited hours and cost required. Primary care Secondary care Community services	**Forecasted 12/13 activity**☹In Brackets planned activity) I/P – DC = 26,600 - (24,849) I/P – Elect = 6938 - (6,097) O/P – FA = 87,802 - (84,303) O/P – FU = 166,944 - (171,651) O/P – Proc = 49,850 - (39,068)

Finance (detail investment and savings and profile) (C33)		**Details of Patient Participation and Engagement (E33)**	**Primary care enablers**	**How does this support delivery of CCG vision? (G33)**
Investments:		Patient input into service redesign	QOF QP indicators Locality Manager Support Support to deliver referral support 4 steps to primary care Continue work to reduce the number of diagnostic requests Active participation in service redesign process Use of medianalytics system for validation purposes	Improves productivity Care closer to home Improved patient satisfaction
Service Redesign – reprovision of services in community				
TOLCE coding support				
Clinical support				
Potential Saving opportunities: (see separate sheets for details)				
Increased Referral Support	Target Saving £450k in 13/14 with a further £250 in 14/15.			
Increased validation & contractual levers	Target Saving £1.646million			
TOLCE	Target Saving £784k			
Service Redesign	Target Saving £280K			
Diagnostics	Target Saving £650K By overcoming the roadblocks that delayed delivery in 12/13			

Quality Indicators eg…….. KPIs below must be aligned to quality indicators (C39)	
DOMAIN 3: helping people to recover from episodes of ill health or following injury – Improving outcomes from planned treatments **DOMAIN 4: ensuring that people have a positive experience of care – Patient experience of hospital care , Friends and Family Test** **DOMAIN 5: Treating and caring for people in a safe environment and protecting them from harm**	
Monitoring:	
Baseline: (D46)	12/13 forecast outturn at mth 7. No predictions for growth have been included.
Milestones	**See separate sheet**

(D50)	
KPIs	Will be determined through the individual schemes.

Risks eg……	**Impact**	**Likelihood**	**Action to mitigate**
Provider overperformance against contract plan	High	unlikely	Contracts Team:Tight contract control and review on a monthly basis – Planned care monthly contract review meeting to be held/ FOT / PCSRC
QOF QP indicators for planned care and diagnostics don't achieve sufficient impact	Medium	unlikely	JS/PH: Regular distribution of data, development of a reporting pack highlighting aspects of activity and spend (dashboard)
Validation / enforcement of contract terms by CCG doesn't achieve any financial savings because data quality is accurate	Low	unlikely	PH/Contracts Team: Close control by contract managers – review at monthly meeting – PCSRC, FOT and planned care contract meeting
GPs feel referrals are necessary or the care needs to be reprovided in a different setting so suggested reductions are not achieved via referral support approach	Medium	unlikely	JS/PH: Approach present contract providers to see if they are willing to allow for use of coding managers to assist in this process.
Aims for procurement do not materialise in line with expectations	Medium	unlikely	JS/PH: Ensure service specifications and financial modelling are accurate
Diagnostics unbundling affects OPFA activity and charging across the pathway ie changes baseline so impacts on reporting success of schemes	High	likely	PH/Contracts Team: Clearly understand PBR guidance and impact on assumptions made to date
The EoE DA Pathology Procurement impacts on the financial and activity assumptions above regarding DA Diagnostics		likely	DW: Clearly understand the procurement and funding that will need to be handed over to the preferred supplier to come out of DA funded to present providers
Tricordant predicted savings for TOLCE require service redesign/reprovision as well as tighter restriction policies so take longer than planned and more resources to achieve savings.	High	likely	JS: Ensure sufficient resources are available to support – predominately clinical support required
Primary Care Enablers			
● QP Indicators	● Four steps to Primary Care		● Practice Visits
● Locality Manager Support	● Use of MedAnalytics		
Referral Support Approach			

Continue work to reduce the number of diagnostic requests				
Active participation in service redesign				
Financial Phasing	**2013/14**	**2014/15**		
	£3.8m	TBC	**Assumption that the savings are Recurrent**	
Productivity Opportunity	**2013/14**	**2014/15**		
	TBC	TBC		
Approved by the Programme Board		**Date:** _____		

QIPP Business Case Plans for Programme Board (E3)		**Total Savings for 13/14**	**Total Productivity Impact by 2014 (G3)**
	Long Term Conditions	**£1,261,875**	**Reduction of activity by:** **Diabetes:** 164 1st OPA 425 FUA 148 NEL Admissions (primary and/or secondary diagnosis) **COPD:** 150 NEL Admissions (primary diagnosis) 453 FUP **DA to Ca Diagnostics/Colorectal FU:** 100tilisa 700 OPA **Heart Failure Service Development:** 140 NEL Admissions (primary diagnosis)

Objectives (SMART) (C6)	**Leadership**	
Reduction in activity within an acute setting with a primary diagnosis of Diabetes, COPD, Heart Failure, Atrial Fibrillation and Cardiovascular Disease. Reduction in 1st OPA due to DA to cancer diagnostics and early discharge of colorectal cancer patients with good prognosis.	Clinical Lead	Siobhan Jordan
	Executive Lead	Siobhan Jordan
	Delivery Lead	Chloe Atkinson
Key projects: (D19)		
- Diabetes Service Development – Consultant Led Community Service - COPD Improvement Plan which includes improved Telehealth service, early support discharge pathway for COPD patients and introduction of patient education programmes. - Direct Access to Cancer Diagnostics (Flexi Sigmoidoscopy, Chest XR, Brain MRI and Non Obs US) - Early Discharge for Colorectal Cancer Pts with good prognosis - HF, AF & CVD Service Development	**Clinical Engagement**	
	Local acute consultants	Sri Redla, Douglas Newberry
	Local GPs	
	Local GPs with specialist interest	Miranda Roberts, Christine Moss, Sanjeev Rana, David Tideswell

		Other clinical practitioners such as physiotherapists	Ram Gulrajani, Jane Tadman, Gail Walker
		Links with Other Projects: (G19)	Integrated Bid (GP Led MDT) Direct Access workstream – Planned Care Urgent care delivery Medicines Management Primary care Mental Health and LD.

Workforce Implications (C27)	**Activity Implications (detail baseline and anticipate reductions by HRG or relevant currency and profile) (E27)**
- Diabetic Consultant required to provide care within a community setting. - Band 4 clinicians, both community and acute, required to deliver early supported discharge pathway for COPD patients	**Reductions in activity for Diabetes and COPD were calculated by LTC Programme Board Clinicians or Tricordant.** - Diabetes lead provider model has been agreed. Initial proposals stated that 40% of 1st OPA and OP FU will be taken out of secondary care over the first 1 year of service implementation, followed by a further 40% in the second year of service. Based on 11/12 acute data, over 13/14 this equals: **- 40% of 410 1st OPA (164 x £244) =£40,016** **- 40% of 1062 FU appointments (425 x £99) = £42,075** - Reduction of 20% of NEL admissions with a primary and/or secondary diagnosis of diabetes within the first year of implementation. 11/12 acute data shows there were 740 NEL admissions with a primary and/or secondary diagnosis of diabetes which equals: **- 148 NEL admissions = £328,856** - COPD improvement plan will propose a reduction in NEL admissions for patients with a primary diagnosis of COPD and respiratory FU appointments within the 1st year. 11/12 (Ref – CowderySB) data shows 415 NEL admissions with primary diagnosis of COPD (J440-J449) while M7 SLAM data projects 1812 Respiratory FU taking place within 12/13. Using this activity data the projected savings are: - **NEL admissions (150 x £2,222) = £333,300** - **25% of FU Appointments (453 x £105) = £47,565** - Tricordant have calculated that DA to Cancer Diagnostics and Early discharge for colorectal pts with good prognosis will save 700 OPA per year but will take 6 months to implement. This equals **£125,000.** **-** Tricordant have looked at cardiology redesign**.** This work will include a Heart Failure Community Service review which will aim to avoid 120 NEL admissions in line with the agreed NEL admission avoidance targets set for Heart Failure patients. **There is further potential for stretch within the Respiratory service over 2013/2014**

Finance (detail investment and savings and profile) (C33)		**Details of Patient Participation and Engagement (E33)**	**Equality Impact Assessment (F33)**	**How does this support delivery of CCG vision? (G33)**
Diabetes – Investment will be required for Diabetes Service Development – a cost envelope will be agreed to allow expressions of interest from	Proposed gross savings - £410,947	- West Essex Diabetes Stakeholder Meeting - West Essex Respiratory Network - West Essex LTC Programme Board	Completed	

local Trusts.				
COPD Improvement Plan	Proposed gross savings - £380,865			
Cardiology Service Development may require investment for service development	Proposed gross savings - £345,063			
DA to Cancer Diagnostics and Colorectal FU	Proposed gross saving - £125,000			
TOTAL:	**£1,261,875**			
Quality Indicators egg…….. KPIs below must be aligned to quality indicators (C39)				**How does this support delivery of CCG vision? (G33)**
Diabetes: Domain 1: - Potential years of life lost from causes considered amenable to healthcare: adults [over 20 yrs]	**COPD:** - Under 75 mortality rate from respiratory disease - Potential years of life lost from causes considered	**Cardiology/Heart Failure:** - Under 75 mortality rate from cardiovascular disease - Potential years of life lost from causes considered	**DA to Cancer Diagnostics/Colorectal FU:** - Under 75 mortality rate from cancer Domain 2: - Health related quality of life for people with long-term conditions	

Domain 2: - Health related quality of life for people with long-term conditions - Proportion of people feeling supported to manage their condition - Unplanned hospitalisations for chronic ambulatory care sensitive conditions Domain 3: - Emergency admissions for acute conditions that should not usually require hospital admission - Emergency re-admissions within 30 days of discharge from hospital Domain 4: - Patient experience of GP out-of-hours services - Patient experience of hospital care Domain 5: - Incidence of healthcare associated MRSA infection - Incidence of Clostridium difficile infection	amenable to healthcare: adults [over 20 yrs] Domain 2: - Health related quality of life for people with long-term conditions - Proportion of people feeling supported to manage their condition - Unplanned hospitalisations for chronic ambulatory care sensitive conditions Domain 3: - Emergency admissions for acute conditions that should not usually require hospital admission - Emergency re-admissions within 30 days of discharge from hospital Domain 4: - Patient experience of GP out-of-hours services - Patient experience of hospital care Domain 5: - Incidence of healthcare associated MRSA infection - Incidence of Clostridium difficile infection	amenable to healthcare: adults [over 20 yrs] Domain 2: - Health related quality of life for people with long-term conditions - Proportion of people feeling supported to manage their condition - Unplanned hospitalisations for chronic ambulatory care sensitive conditions Domain 3: - Emergency admissions for acute conditions that should not usually require hospital admission - Emergency re-admissions within 30 days of discharge from hospital Domain 4: - Patient experience of GP out-of-hours services - Patient experience of hospital care Domain 5: - Incidence of healthcare associated MRSA infection - Incidence of Clostridium difficile infection	- Proportion of people feeling supported to manage their condition Domain 3: - Emergency admissions for acute conditions that should not usually require hospital admission - Emergency re-admissions within 30 days of discharge from hospital Domain 4: - Patient experience of GP out-of-hours services - Patient experience of hospital care Domain 5: - Incidence of healthcare associated MRSA infection - Incidence of Clostridium difficile infection	
Monitoring:				
Baseline: **(D46)**	The baseline activity, unless otherwise stated, is the 12/13 forecasted outturn position. COPD – 20% reduction in NEL activity & 25% FU appointments associated with COPD. GP MDT's working with Primary Care and monitoring the performance of practices against their peers in the locality.			
Milestones	**Diabetes**			

(D50)	- Sign up required by PAH and SEPT on Lead Provider Model by 22.2.13 – CA/SJ - Calculate total cost of diabetes service across West Essex and amount we will want to pass over to Lead Provider 22.2.13 – Chloe Atkinson - Contract written with clear KPI's and outcomes for all sections of pathway – 26.4.13 – CA/CSU/MR/SJ - Sub contracts with providers agreed – 30.4.13 – CA/CSU/MR/SJ **COPD** - PAH to recruit to Resp CNS to implement COPD Discharge Bundle and Early Supported Discharge Pathway – 30.4.13 – CA/SJ - Agree with SEPT and PAH ESD Pathway and process – 29.3.13 – CA/SJ/SEPT/PAH **DA to Cancer Diagnostics** - Calculate the potential rise/fall in activity which this will cause – 1.3.13 – Chloe Atkinson/Patrick Ruddy - Agree DA pathway with PAH based on DoH Guidance – 29.3.13 – Chloe Atkinson/Christine Moss - Promotion of pathway to GP's – 29.3.13 – Chloe Atkinson/Christine Moss **Colorectal FU** - Design Primary Care FU pathway based on DoH best practice – 1.3.13 – Chloe Atkinson/PAH - Ensure engagement with PAH and GP's – 30.4.13 – Chloe Atkinson/Christine Moss - Get agreement with Cancer Network – 30.4.13 – Chloe Atkinson/Christine Moss **Cardiology** - Re-instate Cardiology Network – 28.2.13 – Chloe Atkinson - Calculate current Heart Failure activity through 2nd Care and SEPT HF Team – 30.4.13 – Chloe Atkinson - Design pathway to aid Early Supported Discharge for Heart Failure patients – 31.5.13 – Chloe Atkinson/SJ/Cardiology Network - Implement changes to pathway – 30.9.13 – Chloe Atkinson/SJ/Cardiology Network			
KPI's	Improvements in patient care and experience – these need to be agreed by the LTC Programme Board in February 2013.			
	KPI's identified above for COPD and Diabetes in terms of reductions in NEL admission			
	1st outpatients apt and F/U apt			
Primary Care Enablers				
● QP Indicators		● Four steps to Primary Care		● Practice Visits
● Locality Manager Support		● Use of MedAnalytics		
Emergency admissions vs risk registers				
Identification of at risk patients by Eclipse Live				
Lead the MDT meetings for complex patients				
Use DA Diagnostics for Cancer Patients				
Engage in the Colorectal FU pathway				
Risks e.g……		**Severity**	**Likelihood**	**Action to mitigate**

- Services unable to be provided within the cost envelope stated		High	unlikely	CSU: Realistic cost envelope calculated
- Over estimation of savings which can be achieved		Medium	likely	
- DA to cancer diagnostics could increase demand		High	likely	CCG: Close monitoring of GP referral trend
Financial Phasing	**2013/14**	**2014/15**		
			Assumption that the savings are Recurrent	
Productivity Opportunity	**2013/14**	**2014/15**		
Approved by the Programme Board		**Date:** _____		


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QIPP Business Case Plans for Programme Board (E3)		Total Savings for 13/14	Total Productivity Impact by 2015 (G3)
	LD&Mental Health	£1.0m (£800k investment in IAPT)	5.4%

Objectives (SMART) (C6)	Leadership	
Decrease numbers of people on clusters 1 to 5 receiving a service in specialist care Improve contract management	Clinical Lead	Dr Miranda Roberts
	Executive Lead	None Assigned
	Delivery Lead	Cathi Emery
Key projects: (D19)		Nicola Colston
MENTAL HEALTH: 3 Major streams of work being worked on in 13/14 and 14/15: 1) Full Scoping of low complexity patients (clusters 1-5) that can be moved into being supported through Primary Care. Scoping required to ID this cohort …the activity and the numbers to identify the financial savings that can be made by reducing the block contract by the according amount. 2) Scoping of opportunity through improved 107tilisati 2) LEARNING DISABILITIES: 1) Further efficiencies being sought from the HPFT contract		
	Clinical Engagement	
	Local acute consultants	
	Local GPs	
	Local GPs with specialist interest	
	Other clinical practitioners such as physiotherapists	
	Links with Other Projects: (G19)	Frail elderly project Support to nursing homes project Older adult CMHT review (ECC) Integrated development plan with ECC

Workforce Implications (C27)	Activity Implications (detail baseline and anticipate reductions by HRG or relevant currency and profile) (E27)
Staff would be required to work more efficiently Any procurement activity in rehabilitation services might require TUPE arrangements Streamlining support services at PAH would require re structure of management systems and cooperation across commissioning partners	(1)Further scoping to be achieved hypothesis that activity will be reduced in specialist care but activity overall may increase (2) Activity may not decrease in acute care as demographic pressures but resources used more efficiently (3)Unknown at present as KPI's still under discussion (4) Potential reduction of share of 22 beds at Severalls House Learning disability - dependent on contract negotiations

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Finance (detail investment and savings and profile) (C33)		Details of Patient Participation and Engagement (E33)	Equality Impact Assessment (F33)	How does this support delivery of CCG vision? (G33)
Rehabilitation service – reduction in bed numbers will reduce block with NEPFT	Reduction in bed numbers will reduce block contract with NEPFT potential share of 900,000/I million for cash savings and reinvestment (balance to be discussed). This is across the cluster – savings for West Essex will be 1/3)	**Mental Health**: All decisions are made at the programme Board which includes a patient representative **LD**: All relevant parties are included in the decision making process Partnership Board The Big Health Day	Each project will have an equality impact assessment completed	parity of esteem between mental and physical health

Quality Indicators e.g…….. KPIs below must be aligned to quality indicators (C39)	
Use of outcome tools in primary and specialist care : Further work to be done	
Monitoring:	
Baseline: (D46)	(1) Honos information now available – validity to be confirmed : referral rates across in specialist care currently being scoped (2) scoping report completed : detailed work on data in accident and emergency underway (3) contract negotiations underway with discussion begun on what the KPI's could be (4) review completed : action underway to move clients from specialist inpatient care :procurement begins in the Spring
Milestones (D50)	(1) project plan to be agreed by April. Meeting to be held early March to agree plan and to scope clusters for inclusion (2) scale of resource available to be discussed and agreed by April (3) by end of January clarity on KPI's

	(4) agreement on any financial support to ECC procurement and what health services the procurement might include to be agreed by end of Feb 2013 (4) number 3 applies and decision on recovery college hub and spoke pilot by mid January 2013
KPIs	(1) Full scoping: KPIs for the Talking Therapies contract would apply
	(2) Keeping MH patients out of acute care: KPIs to be developed
	(3) Contract management: KPIs need to be developed
	(4) Recovery indicators under development

Risks e.g……	**Severity**	**Likelihood**	**Action to mitigate**
Alcohol Liaison Nurses not in post	High	Highly likely	Ben Hughes(PH): Work with County Council to recommission services
KPIs not put in place for the contract	High	Highly likely	NC: People being put in place to robustly manage the contract
LD: Further savings may not be available	Low	unlikely	ST: Active contract management
Not enough capacity to project manage	High	likely	CCG: discuss use of transformation funds
Inability to move clients from Severalls House to free resource	High	unlikely	it is the timing that will be affected and other ways of moving clients are currently being discussed

Primary Care Enablers				
● QP Indicators		● Four steps to Primary Care		● Practice Visits
● Locality Manager Support		● Use of MedAnalytics		
Financial Phasing	**2013/14**	**2014/15**		
			Assumption that the savings are Recurrent	
Productivity Opportunity	**2013/14**	**2014/15**		
Approved by the Programme Board		**Date:** _____		

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<table>
<tr><td rowspan="3">QIPP Business Case Plans for Programme Board
(E3)</td><td></td><td>Total Savings for 13/14
£1.58m</td><td>Total Productivity Impact by 2015
(G3)</td></tr>
<tr><td>Urgent Care</td><td></td><td>Reduction of : Minor attendances in A&E
Reduction in 0-72 hr LOS</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="2">Objectives (SMART)
(C6)</td><td colspan="2">Leadership</td></tr>
<tr><td colspan="2" rowspan="2">To Reduce A&E Attendances in 13/14.
To reduce the number of non elective stays with a 0-1 day length of stay (LOS).
To reduce the number of non elective stays with 0-72 hr LOS
Better 110tilisation of RAC and community bed base
Integration of CARS with acute teams (ongoing)</td><td>Clinical Lead</td><td>Dr Rory Mcrea</td></tr>
<tr><td>Executive Lead</td><td>Mel Crass</td></tr>
<tr><td colspan="2" rowspan="4">Key projects:
(D19)</td><td>Delivery Lead</td><td>Sandra Herbert</td></tr>
<tr><td rowspan="3"></td><td>Michelle Bassett</td></tr>
<tr><td></td></tr>
<tr><td></td></tr>
<tr><td colspan="2" rowspan="8"><u>Contractual</u>
Regular contract Validation on A&E attendances to ensure WECCG has contracting responsibility for those being charged. Review of trends to understand if there has been coding drift and to prevent coding anomalies. Bi-monthly audits to look at conversion rates from attendance to admission and referencing this to staffing levels at the trusts and other notable factors e.g. periods of extreme cold/heat. Audit and tracking of admissions made between 3;50 and 4hrs that have a 0-1 day LOS; patients who tracking through CDU to 72 hours in EAU and opportunities in ambulatory pathways and handover to community.

Explore the options within contracting at PAH to provide targets around streaming inappropriate A&E attendances away from the Emergency Dept. – either back to Primary Care or other appropriate services. Agreement reached with PAH that front door of ED works within the principle of cost neutrality and two options of costing to be explored (1) risk sharing or (2) variable local tariff for assessment with caps in order to reflect the cost neutrality. Model to be developed by end Q4 for inclusion in contracting round and options assessed and risk assessed once acitivty for Q3 to date has been validated. Explore options at other three trusts with lead commissioners.

Complete scoping exercise to understand the costs (coding) / activity and the patient flows during Q$ and using data up to Q3 to date for:
- The clinical decision unit (CDU)
- The ambulatory Care unit (ACU)
-The Emergency Assessment unit (EAU)</td><td colspan="2">Clinical Engagement</td></tr>
<tr><td>Local acute consultants</td><td>ED – Dr Joud Abduljawad – PAH
ACU -
SEPT -</td></tr>
<tr><td>Local GPs</td><td></td></tr>
<tr><td>Local GPs with specialist interest</td><td></td></tr>
<tr><td>Other clinical practitioners such as physiotherapists</td><td>SEPT Senior Team</td></tr>
<tr><td>Links with Other Projects:
(G19)</td><td>Children & Maternity – to link with the Paediatric front door being developed

Older People generally but specifically around</td></tr>
</table>

Consider service specification for self presenting stream and develop it further once the pathways for CDU, ACU and EAU defined and agreed. Contractual levers including local terms to be drawn up to mitigate risk in the interim. **Programme of quarterly audit to be devised to check assumptions and whether there are cost pressures building (actual or potential) and devise mechanisms to mitigate.** **<u>Minors in Primary Care</u>** **Working with primary care to increase access/capacity, led by Primary Care Delivery Managers and focussing on practices where they are outliers, developing action plans and supporting and sharing new ways of working so patients turn to primary care not ED in the first instance. Targets for individual practices for monitoring to be developed based on best practice not FOT. Communication strategy to public about use of ED, put out in several languages to reflect local communities. Work with voluntary sector to ensure messages are displayed in community halls etc reflecting ethnic diversity of West Essex.** **Develop a performance framework including access/capacity model for primary care out of hours that ensures patients use the service rather than ED. Again communication via media and in practices to advise patients of the service and how to access. Ensure all practices have a similar message on answerphones about accessing out of hours provision.** **Communication to all practices regarding the changes at PAH highlighting the alternatives available, including costs of patients using the above pathways (practices have requested this).** **<u>Opportunities for shared care – SEPT</u>** **Explore the options for shared care with community and acute for patients on ambulatory care pathways to avoid a percentage of the followup outpatient attendances (% to be agreed once scoping exercise has been completed)** **PAH proposing all heralded medical GP referrals are admitted to EAU for specialty assessment, rather than via ED. Explore the options of developing shared care arrangement to avoid full admission cost to EAU through joint assessment with CARS.** **In conjunction with SEPT develop a robust model for the RAC (at SMH and SWCH) so that all practices use this for all but emergency medical admissions) including exploring further he reconfiguration of beds so there is a greater emphasis and availability for admission prevention so the model can be tested, flexed and developed over Q1 and Q2 of 2013-14 ready for winter 2013-14. Preliminary evidence has shown that locally there should be a split minimum 50:50 for admission avoidance availability.** **<u>Ambulance and alternatives</u>** **Work with the ambulance service and Older Peoples Programme leads to reduce the number of patients conveyed**		**admission avoidance car** **Long Term Conditions generally but also in relation to CARS and shared protocols between acute and community in relation to ambulatory care** **Locality Delivery Managers to support developments and hold practices to account** **Communications**

to acute hospitals, including how the role CARS could be incorporated to reduce conveyances. (Older Peoples programme leads developing model for admissions prevention car as the first response to category C calls.) Within Tricordant report stated that 62% of all calls are conveyed to acute hospital. 20% of all Ambulance journeys are Health care professional initiated. Explore the options of alternatives pathway for transport, particularly to RAC (Ollies) **<u>2014-15 schemes</u>** **from Q2 develop and scope the potential of the hospital in the home model for implementation in 2014-15**		

Workforce Implications (C27)	**Activity Implications (detail baseline and anticipate reductions by HRG or relevant currency and profile) (E27)**
TUPE staff from UCC (SEPT) integrated front door of Princess Alexandra hospital **Staff who have indicated they do not wish to TUPE and with diagnostic skills,**	**Total spend in A&E forecasted to be £9.538million (including UCC spend). This is broken into Minors - £2.324m / STD's -£5.084m / Majors - £1.478m and UCC £688k** **The integration of the front door – currently being scoped**

incorporated into community teams **Diagnostic skills for community teams**		**full identification of patient flows between the ED / Ambulatory Care / The CDU / The EAU – currently being scoped** **VB11Z – "No investigation with No significant treatment". Total spend on VB11z = £720K. Spend at 4 providers £615K & 10,276 attendances. Coding drift from vB11Z to VB09Z has already been noted as trusts improve coding. Contractual levers to be used where the drift is seen in year or not agreed as part of contract discussions.** **Challenge for primary care to provide capacity in hours and out of hours that currently matches demand made on acute for patients presenting with primary care conditions.** **Additionally there is a £0.5m savings against the ambulance contract in the category – See Treat & Convey (12/13 contract was for 20,861 @ £250. Ths equates to a reduction of 9.5%. This to be achieved through (1) establishment of admissions avoidance CAR (2) better use of RAC in the first instance for non emergency medical patients and (3) role of CARS.** **Reduction in followup attendances for patients on ambulatory care pathways (% to be defined) through shared cared working/protocols between acute and community** **Reduction in standard LOS patients to 0-72 hr LOS by integrating community more into acute (% to be defined)** **reduction in 0-1 day LOS with CARS teams integrating and working with front doors at all four main trusts more effectively (% to be defined)**		
Diagnostic skills for community staff		**Details of Patient Participation and Engagement (E33)**	**Equality Impact Assessment (F33)**	**How does this support delivery of CCG vision? (G33)**
Reduction in Ambulance convayancesby 2000 (out 20,861 / 9.5%)	**Saving of £500K**			**Active management of patients with or at risk of ambulatory care sensitive conditions we will prevent acute exacerbations and minimise the need for emergency hospital admissions or urgent health care provision. Right care, right place with people accessing services most appropriate to need Care closer to home**
Access/capacity in primary care (in hours and out of hours) Current overperformance at M8 on FOT is £160K – estimate 50% in 13-14 and 50% in 14-15	**Saving of £150K**			
Better use community bed base – OP attendances only as admissions being counted within Older People and LTC	**Saving tbc**			
CARS team at front door (under 65's)	**Saving of £150K**			

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Quality Indicators eg…….. KPIs below must be aligned to quality indicators (C39)				
Helping people to recover from ill health or following injury by ensuring that the appropriate patients are in A&E. **By de-cluttering the A&E dept by ensuring that only the appropriate patients are seen – allows patients quicker access to treatment and therefore ensuring patients have a positive experience of care** **By providing a range of services to support people to better manage their care**				
Monitoring:				
Baseline: (D46)	**12/13 outrun for the A&E activity - Care must be taken as the integration of the front door has resulted in the removal of the Urgent Care Centre (UCC). Therefore activity in 13/14 must be monitored against the total of the 12/13 activity in the ED and the UCC** **12-13 outturn position for patients assessed RAC** **12-13 community bed utilisation excluding stroke – only count A & E attendance reduction as NEL admission data counted with Older People/LTC** **12-13 CARS at front door** **12-13 outturn position for patients on ambulatory care pathways and numbers of followups on each pathway** **12-13 breakdown of 0-1 day LOS, 0-24, 0-48 0-72 hours in EAU**			
Milestones (D50)	**Q4 – full understanding of the spend / coding and patient flows in the ED / ACU and the CDU/EAU** **Q4 – contractual leverage and local terms within contracts (acute and community that enables/ensures delivery)** **Q4 and Q1 modelling regarding use of community beds** **Q4 – primary care (in hours and out of hours) opportunities and targets.** **Q4 – Communication to public about how to access services** **Q4 – communication to primary care regarding changes**			
KPIs	**The number of minor attednances streamed to more appropriate care setting on a weekly basis to meet the plan (TBC)** **% GP heralded medical cpatients not admitted to EAU following assessment** **% use of RAC through improved community bed utilisation** **% of DA and admissions via RAC over 12-13 baseline** **% reduction of category C conveyances through service model being developed by Older People's Programme**			
Risks eg……		**Severity**	**Likelihood**	**Action to mitigate**
Acute engagement in adapting to changes around integrating the front door		**High**	**possible**	**Agreement of cost neutral position as minimum. Opportunities for different models of costing (1) variable local tariff, (2) risk share** **Owner SH with contracting team**
Acutes's ability to stream inappropriate patients away to appropriate place of care.		**High**	**possible**	**Contractual** **Owner Contracting team and SH**
Coding – both better coding at acute, coding drift and changes in coding				
Primary care (in hours and out of hours) increasing capacity to meet demand		**High**	**possible**	**Targets and performance managed by Locality Managers**

				Owner Locality Managers
Resistence to change in RAC/community bed position		**High**	**possible**	**Flexibility and testing over Q1 and Q2 to gain confidence of acute trusts for Q3 and beyond in 2013-14** **Owner – SH with contracting team**
Collaboration between SEPT and acute to deliver CARS integration		**Medium**	**possible**	**Develop protocols and pathways that support the transfer of patients safely to community** **Owner SH**
Financial Phasing	**2013/14**	**2014/15**		
	CARS £150K **Better use community beds tbc** **Ambulance £500K** **Primary Care £150K**	**Primary Care tbc** **Hospital in the home**	**Assumption that the savings are Recurrent**	
Productivity Opportunity	**2013/14**	**2014/15**		

Appendix 2

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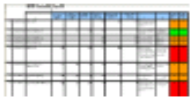
REPORTING FRAMEWORK FOR QIPP 2013/2014

	WORKSTREAM TEAM MEETINGS WEEKLY: MONDAY	WORKSTREAM ACCOUNTABILITY MEETINGS FORTNIGHTLY	PROGRAMME BOARD MONTHLY: WEEK 1/2	FORMAL EXECUTIVE COMMITTEE MONTHLY: WEEK 2	CLINICAL COMMISSIONING COMMITTEE MONTHLY: WEEK 3	FINANCE & PERFORMANCE COMMITTEE BI-MONTHLY: WEEK 3	WEST ESSEX CCG BOARD MONTHLY: WEEK 4
REPORTS	Weekly Milestone Tracker	Monthly Summary Work stream report and Milestone Tracker	Monthly Summary Work stream report	2 Part QIPP report	2 Part QIPP report	→	.....
DETAILS	**Attendees:** Delivery leads & PMO **Owner:** PMO **Purpose:** To holds the Delivery team to account on their actions and ensure that milestones are met.	**Attendees:** Delivery leads / PMO/ Exec Lead **Owner:** Executive lead **Purpose:** Review Programme plans – and progress against these plans Identification of areas of slippage & to address them. Identify additional actions required Assurance - Escalation	**Attendees:** Delivery leads / PMO/ Stakeholderc / Exec Lead / Clinical lead / Providers / Voluntary Services / Social Care /Patient Reps **Owner:** Designated Chairman of the Programme Board **Purpose:** Responsible for the delivery of QIPP programmes, developing initiatives, overseeing projects and monitoring progress.	**Attendees:** Executive Board Members **Owner:** PMO **Purpose:** Copy what we have put in Clinical Commissioning Committee + Overall – Assurance + ESCALATION OF RISK.	**Attendees:** CCG Chair / CCG Vice-chairs / Assos Medical Director/ Clinical leads / Exec team /Social Services/ **Owner:** PMO **Purpose:** Part 1:Provide detailed financial performance of the QIPP schemes with the financial forecast for the year end. Part 2: Provide written document that details the current position highlighting where there has been significant change. Details of any actions that will impact the QIPP delivery.	→	.....
OUTCOMES	**ACTION REQUIRED:** PMO to maintain log of weekly actions to be delivered and their status. Escalation to Senior management around slippage and roadblocks. Ensure the Risk Log is updated.	**ACTION REQUIRED:** SITREP Review Programme plans – and progress against these plans Identification of areas of slippage Give direction to manage risk and close potential shortfall of the programme	**ACTION REQUIRED** Programme boards to take stock on project performance, risks and issues and be clear on deliverables for next period.	**ACTION REQUIRED** Confirm assurance and give directions where risks to programme delivery.	**ACTION REQUIRED** Assurances for the board around the QIPP programme.	→	.....
Example	**Risk Log / Action Log** Risk Severity Mitigating Actions / Owners. Action – Owner Status Impact			 + 			

Sheet.32