NHS
West Essex
Clinical Commissioning Group

Operational Plan

2014/15 - 2015/16

DRAFT Subject to CCG Board Approval

Contents

1.0	Our Vision
2.0	Working with our Citizens
3.0	Quality and Patient safety • Quality on a Page • Response to Francis • Compassion in Practice • HCAI • Patient Experience • Quality Premium • Local Quality Measure • 7 Measurable Ambitions • Constitutional rights and pledges • Further Quality Standards • Continuing Health Care
4.0	Changing How we work • Integrated Commissioning (inc BCF) • Integrated Provision (inc BCF) • Primary Care at Scale • Commissioning for Prevention
5.0	Improvement Interventions • Governance and Approach • Access to High Quality Urgent and Emergency Care • Frailty • Working Age Adults • Children and Maternity • Mental Health and Vulnerable Adults • Stroke • Productivity of Elective Care • Specialised Services Concentrated in Centres of Excellence
	Sustainability (Financial Plans)
7.0	Enablers
8.0	Governance Overview

This Operational Plan brings together the priorities for the West Essex Health and social care system over the next two years and in some cases beyond. At the core of this plan are our Transformation Programmes that we have developed with our partner commissioners Essex County Council and our local health and social care providers. In particular we have worked closely with ECC , in the development of our proposals for application of the Better Care Fund (BCF) and our broader integrated Commissioning agenda. ECC and providers South Essex Partnership Foundation Trust, Princess Alexandra Hospital Trust , Essex Cares and North Essex Partnership Foundation Trust have contributed significantly to the unplanned care programmes of work encompassing Frailty and Urgent Care.

Any enquiries about the plan should be directed to West Essex CCG, Spencer Close, St Margaret's Hospital, The Plain, Epping, CM16 5TN

Claire Morris, Chief Officer clare.morris4@nhs.net
Toni Coles, Director of Transformation toni.coles@nhs.net
Dean Westcott, Director of Finance, Contracting & Performance dean.westcott@nhs.net
Jane Kinneburgh, Director of Nursing and Quality jane.kinneburgh@nhs.net

Version	Reviewed by	Date
Draft 0	CCG Workshop on Planning Guidance and Requirements	6 /1/14
Draft 0 and BCF Proposals	CCG Executive Clinical Commissioning Committee	16/1/14
Draft 0	West Essex Systems Briefing Session	17/1/14
Draft 0	Patient Reference Group	28/1/14
Draft 0	CCG Board	30/1/14
Draft 1	CCG Executive Committee	13/2/14

Executive Summary

This plan sets out the work plan for West Essex CCG over the next two years April 2014 to 31 March 2016.

During the last year we undertook a major engagement exercise with our patients, residents and wider stakeholders in partnership with Essex County Council and our providers. The outcome of this engagement has informed our short, medium and longer term vision for transforming our services , *"My health, My future, My say – A vision for the west Essex health and care system 2014-2014"* The discussions that took place through this programme have contributed directly to how we plan to design and shape our services for the next 3, 5 and 10 years. Seven principles have guided the development of our vision:

1) Quality first - Patient safety, clinical effectiveness, better outcomes and care for people as people
2) Significantly shifting the point of care - the right care is provided at the right time and in the right place
3) Integration between health and social care
4) Connected transition of care and support between professionals and organisations
5) Provision built around and **responsive to the different needs** of our communities and localities
6) Maximise **productivity and efficiency** where appropriate
7) Allow individuals to **take responsibility for their own health and retain independence** where appropriate.

These principles underpin the aspirations that we have set out in this plan. Having established our vision we are now setting out on a major "transformation Journey" It is through our **transformation programmes** that we have set our trajectories to for improvement against the **CCG Outcome Indicators** and the **7 measurable ambitions**. In most case we have set our ambitions against the highest performers.

The CCGs transformation programmes include:

- Transforming **urgent and emergency care** services to ensure that timely care is available when required but also reduce unnecessary use of emergency hospital services.
- Improving care for **frail and older people** to avoid unnecessary admission to hospital
- Making care more accessible and local for people with **ambulatory care sensitive conditions,** including support to prevent worsening of condition and improvement in self management
- Implementing new high impact pathways for **Children** to support avoidance of unnecessary time in hospital, Ensuring early intervention and prevention through integrated approaches to care
- Ensuring high quality care for people with **mental health** conditions ensuring parity of esteem across all health and social care services including physical health. Shifting point of care for lower acuity conditions into primary care setting.
- A step change in **elective care:,** improving how we contract with our providers to ensure the most effective and efficient pathways for our citizens

We have high ambition for these programmes of work. They will form the basis of how we will drive forward an improvement in quality but also offer opportunity to improve productivity and as such have financial savings attached to them. **Section 5 Improvement Interventions** summarises these opportunities 14/15:

Frailty	£1.2m
Ambulatory Care	£0.2m
Children	£0.5m
Mental Health	£1.3m
Elective Care	£5.6m

Our ambitious work programme relies on a number of key enablers that will support the improvement in care that we want to achieve.

These include:

- Development of a model of **integrated commissioning (Better Care Fund supports)**
- Commissioning for **integrated provision of care** and delivery of improved outcomes for patients.
- Improving how we **contract** including alignment of CQUINS to improving patient outcomes , ambitions and quality premium and introduction of new contracting arrangements such as **Accountable Lead Provider**
- Supporting the development of our providers including primary care to respond to our ambitious plans, supported by a **contestability plan**
- **Community Mobilisation** working with our communities to increase the role that they play in their own community to support personal empowerment and responsibiliy.
- Ensuring that the right infrastructure is in place , developing **estates and IT strategies**
- Ensuring appropriately trained, developed and availably **workforce**
- Developing our organisations supported by an **Organisational Development Plan**

Patient Engagement

Most importantly we outline how we will engage and work with our patients and communities. We are developing our patient groups (that feed to board) to ensure a broader demographic is represented and will work with us, together, to test ideas, gather information and influence commissioning decisions and in doing so aligning patient engagement to be at the heart of service transformation and delivery.

Quality and Patient Safety

The CCG is responsible for ensuring that health care services are of a high quality and continuously improving. To improve the quality of care we will promote a culture of quality and ensure that it is central to everything that we do.

To achieve this we require strong and measurable mechanisms for reporting quality issues, such as early warning indicators including patient feedback, staff surveys and clinical outcome data. The quality section of this plan demonstrates how we will ensure that the recommendations of the Francis review will be assured and how we routinely work with our providers to ensure that quality of care is continually improving.

Changing how we work

For the CCG to transform the health and social care system we must work with patients, professionals, service providers and local partners such as the County Council and the District Councils but we need to do this in a different way than we have in the past. This means that we will need to commission differently moving to joint commissioning with the County Council. This will support the commissioning of care that is integrated across providers both in the health system and social care. To support this we are proposing different models of contracting, including Accountable Lead Provider whereby we contract with one provider who in turn will manage the wider supply. We also see a new and expanded role for primary care that is a key component of our plans. The CCG and its partner practice have over the last 12 months been exploring a different approach to provider care to our population. From July 2014 our two locality business units, Epping Forest and Harlow as one and Uttlesford will start providing what will be the beginning of a range of ambulatory care services within a primary care environment.

Sustainability (financial plans)

The CCGs Financial Plan demonstrates achievment a 1% surplus in all financial years of the planning cycle. In 2014/15 the CCG transformation and efficiency target is set at £12.9m . The plans are transformational and are limited to just 8 core schemes (under the 4 transformation work streams. Additionally there are benchmarked efficiencies which are to be delivered via contract management.

1.0 Our Vision for High Quality Sustainable Care

This section summarises the CCG Vision resulting from an extensive series of engagement events that took place over the summer in 2013 and forms the basis of out Operational Plan together with the local context from the West Essex JSNA

1.1 Local Context

1.2 Our Vision

1.0 Our Vision for High Quality Sustainable Care

1.1 Local Context

In setting out our Vision, transformation priorities and ultimately this plan the CCG has been guided by health and well being and social care needs, changing demographics and economic challenges within the system as follows:

- Higher than average premature mortality rates in Harlow with Harlow having the highest rate of deaths as a result of smoking in Essex
- Worsening premature mortality rates for circulatory disease, cancer and respiratory disease relative to our peers
- Survival from cancer is lower than the national average
- Higher than average prevalence of depression
- Under ascertainment of diagnosed COPD
- Increase in alcohol related admissions to hospital
- Increasing life expectancy yet variation of life expectancy across our communities
- Proportionately more people aged over 65 in west Essex than the rest of the country
- Total population of west Essex is expected to grow by 12.1% in next 10 years as compared to a national average of 8.7%

If people carry on using health care services in the way that they currently use health services, this would put enormous pressure on our local health system. For example, there would be a 14 per cent increase in the number of hospital admissions per year from 62,000, to 71,000, and an increase in the number of attendances at A&E from 83,000 to 92,000. Along with the pressure on health services the aging population in particular puts increasing demands on social care including residential home places and re-ablement packages. This plan sets out how we plan to manage this challenge over the next two years.

1.2 Our Vision

"My Health, My Future, My Say" sets a vision for the west Essex health and care system over the next 10 years. The development of our vision was informed by two major engagement programmes undertook by the CCG with patients, clinicians and service providers in west Essex during 2013. Listening to our patients and stakeholders we have identified the following key interventions as the basics that we need to right

- Identifying high users of health and care services through **risk stratification**
- Planned and coordinated management of individuals health and care needs by **multi disciplinary teams**
- When care is needed it is **coordinated** by an individual best placed to know the patient's needs
- **Personal health plans** are in place
- **Shared patient records/information available** across providers
- Patients are empowered to **manage their own care**
- Supported **independent living**
- Managing **mental and physical health** together
- **Proactive disease management** including early intervention

1.3 Our Providers

Our hospitals have an important and unique role to play in supporting people when they are seriously ill, but many people use hospitals in other circumstances. We will be working with our hospitals to establish a clear definition of their role. We see The Princess Alexandra Hospital in particular supporting delivery of a whole system model of integrated care pathways in partnership with our primary care , community and mental health providers to reduce the fragmentation of care that currently exist within our system.

2.0 Working with our Citizens

This section describes how we will be working with our citizens in the planning and delivery of care, ensuring that they are at the heart of everything that we do

2.1 Ensuring our Citizens are fully involved

2.2 Ensuring Patient Voices are heard

2.3 Mobilising our Communities

2.0 Working with our Citizens
2.1 Ensuring our Citizens are involved

Enhanced routes for patients' and citizens to:

- influence decision making at all levels
- ensure their voices to be heard at board level

Despite having an established PPE model, WECCG wanted to explore how we could engage with more people in more innovative ways. After months of research, discussion, extensive channel testing and consultation with a wide range of internal and external partners, the WECCG board approved enhancements to its PPE model. The enhancements to the model mean there is a **fivefold increase** in opportunities for **local peoples' voices to be heard at board level.** Citizens will personally and collectively, have a richer range of ways to be involved with the CCG's decision making and ways to connect with our clinical and non-clinical senior decision makers. This increase in the opportunities for people to influence our work and decision making will allow us to connect with people in a more targeted way. We will work with a wider range of people - giving voice to people that might not normally engage. Our plans have been endorsed by **HealthWatch a**nd will see the CCG co-producing work with local people representing, for example: carers, children and young people, older people, people with long term conditions, people with disabilities, colleagues from the voluntary sector, migrant and ethnic minorities.

Working with our Citizens Timelines……

.

Joint approach to citizen engagement, District Councils and ECC by **July 2014**

Systematic approach to citizen involvement in commissioning in place by **April 2014**

2.0 Working with our Citizens
2.2 Ensuring Patient Voices are Heard

Opportunities will include:

Patient Reference Group (PRG): Our PRG has been with us since the CCG inception and its member's views, support and feedback has been invaluable in our journey to becoming a fully-fledged CCG. The PRG had itself, identified the need to, in time, create a membership that was more representative of the broader demographics in our communities and the new approach for this group will allow many more people to be involved in the CCG's decision making. We will be increasing the size of this group and opening membership of it up to anyone in our community who has experience or insight to share. In order to ensure we give as many different voices the opportunity to get involved, we will shortly be inviting people to express an interest in joining, by filling out an application form. We will offer assistance in completing the form to people who need it and the point of the form is to help us identify the different strengths people might bring to make the group as broad as possible. We hope to achieve a membership that will include representation of;

Carers , Children and young people, Older people People with long term conditions People with disabilities People with mental health need, Voluntary sector , Migrant and ethnic minorities

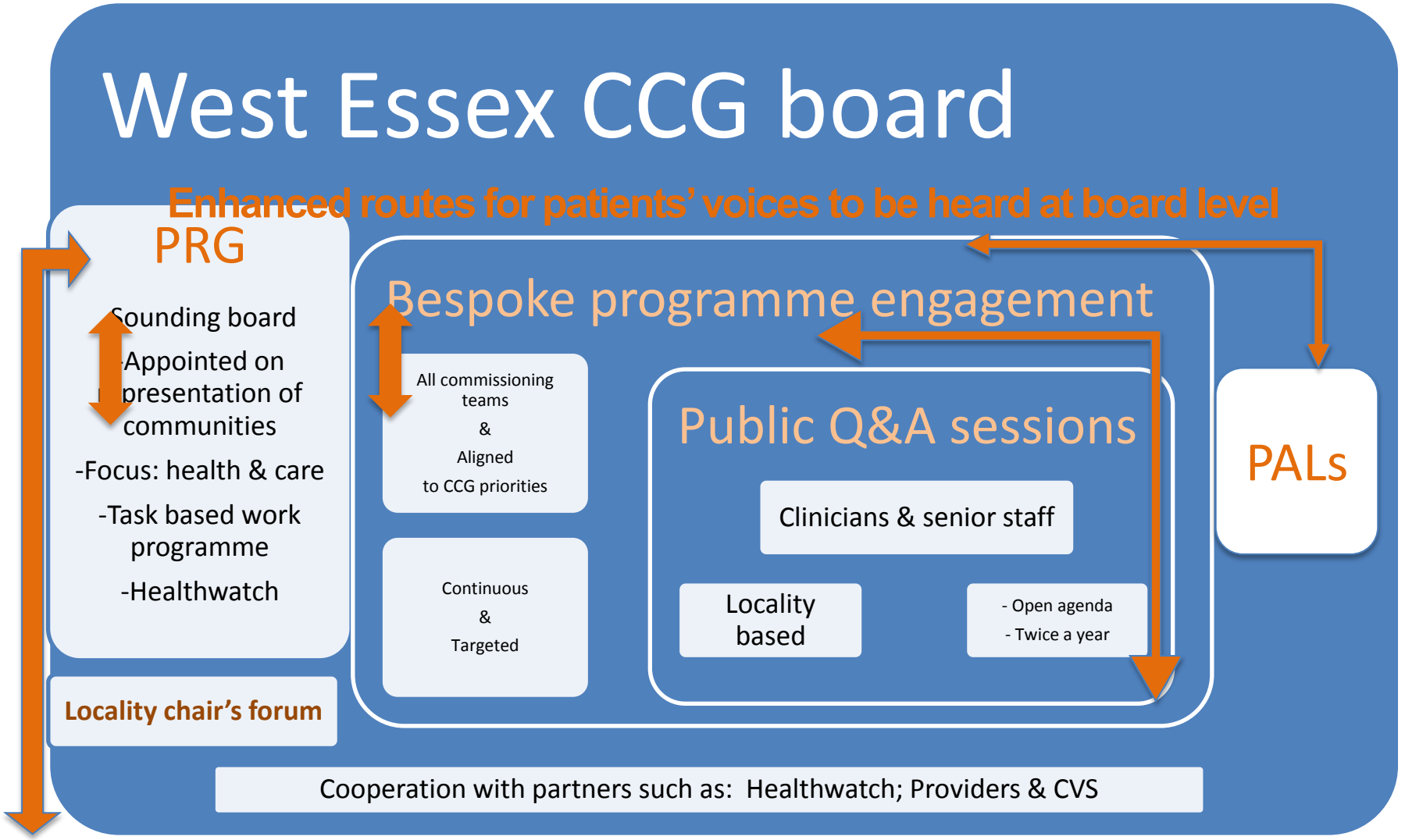
This will be a democratic group that will respect all voices and points of view, so the hope is also that those who feel a formal 'committee' style of meeting isn't for them, will also be enticed to get involved. The PRG will also have a working aspect, which will see it undertake projects that report back to our board and therefore members should expect to get lots of satisfaction from seeing their input come to life in the CCG's future work.

Public Question & Answer sessions: When statutory organisations engage, it is normally within the constraints of a set topic. We identified an appetite for a space where citizens could engage with us without the constraints of a specific agenda. Twice a year, in each of our three localities we will hold open Q&A sessions. The sessions won't have a set agenda, so members of the public will be able to quiz, comment and make suggestions to our GPs and senior managers on any subject they wish.

Engaging with individual commissioning teams on specific topics: We are working with individual clinicians, commissioners and their teams to support them to develop their own tools to involve local people who are relevant to their service areas. Each team will connect with their relevant stakeholders in different ways (for example, be it: long terms conditions, mental health or women's and children's), but we will be encouraging them to develop their own, bespoke ways to involve local people with experience or insight in to their areas. Local people might want to input via formal meetings, or more informal routes, such as focus groups and workshops. They might even want to input remotely (by telephone, correspondence – or even via the internet). The idea is that we tailor the engagement style to suit the relevant audience and make it easier for people to access the CCG.

2.0 Working with our Citizens

2.2 Ensuring Patient Voices are Heard



2.0 Working with our Citizens

2.3 Mobilising our Communities

Along with the "*Who will Care ?* Commission" the CCG sees our communities having a powerful contribution in complementing health and care services to deliver improved outcomes for individuals and communities as a whole. We see the voluntary sector having an increased role in implementing our vision and being part of an integrated system working more closely with general practices. In addition to this we want to work with our partners in ECC and District Councils to promote and develop the role of volunteers, building on the existing concepts such as health champions, neighbourhood watch and village agents.

The CCG has a strong ambition to develop and mobilise the voluntary sector to:

- gather data and intelligence from our communities on what is important in health and care provision;
- deliver services as part of an integrated system that will empower individuals to either prevent ill health and support people to maintain good; and
- help local people navigate the system supporting individuals to access the right care in the right place.

Empowering communities – Key Milestones	By When	Key Outcomes
Mobilising communities event	**April 2014**	Establish the scope of opportunity and programme of work
Increasing investment in the third sector	**2014/15 - 15/16**	Unique services offered by organisations that have a real understanding often through own experience will enrich the range of services that we commission in a cost effective manner.
Care navigators/ community agents	**2014/15**	Support citizens to make informed choices about their health and well being and support citizen empowerment
Pooled budgets commencing	**April 2014**	Health and social care joint commissioning of voluntary sector

West Essex Clinical Commissioning Group

3.0 Quality and Patient Safety

This section demonstrates how the CCG are ensuring a relentless focus on the provision of high quality care, that is safe, clinically effective and provides as good an experience for the patient as is possible. In this section we outline trajectories that the CCG has set against the 7 deliverable ambitions . We will achieve these ambitions through delivery of our Quality and Transformation agenda

3.1 Improving Quality
- Response to Francis, Berwick and Winterbourne
- Compassion in Practice
- Systems and Processes

3.2 Governance and Reporting to support Quality
3.3 Healthcare Associated Infection
3.4 Patient Experience in our Services
3.5 Quality Contractual Standards
3.6 Quality Premium
3.7 7 Measurable Ambitions
3.8 Constitutional Rights and Pledges

3.1 Improving Quality

Improving quality

Francis, Berwick and Winterbourne

The CCG has prepared a response to the Francis Review. Many of the recommendations in the review focus on strengthening relationships with the CCG, the action plan identifies specific actions and timescales for implementing this. There are 5 themes to the review:

- High quality, patient-focused and compassionate care must be the central value
- Consistent culture of Openness and Candour:
- Values and Standards – patient at the centre
- Leadership in staff at all levels of the healthcare system must be encouraged
- Use of information to improve patient and staff experience


Microsoft Excel Worksheet

Along with our action plan for Francis we will be agreeing actions from Berwick and Winterbourne reviews by end of March.

Compassion in Practice
Compassion
Communication
Commitment
Courage
Competence
Care

The CCG is contracting with providers to deliver the six Cs initiative which ensures delivery of compassionate care. We expect our providers to present action plans to us that will be agreed and monitored throughout the year. We are also working with Health Education East of England and the Essex Workforce Partnership Steering Group to support development of this initiative.

We are in the process of recruiting a senior nurse whose specific role will be to work with providers to ensure that this is delivered.

The actions identified in the Francis review also contribute to the delivery of this initiative.

Systems, Process and Standards

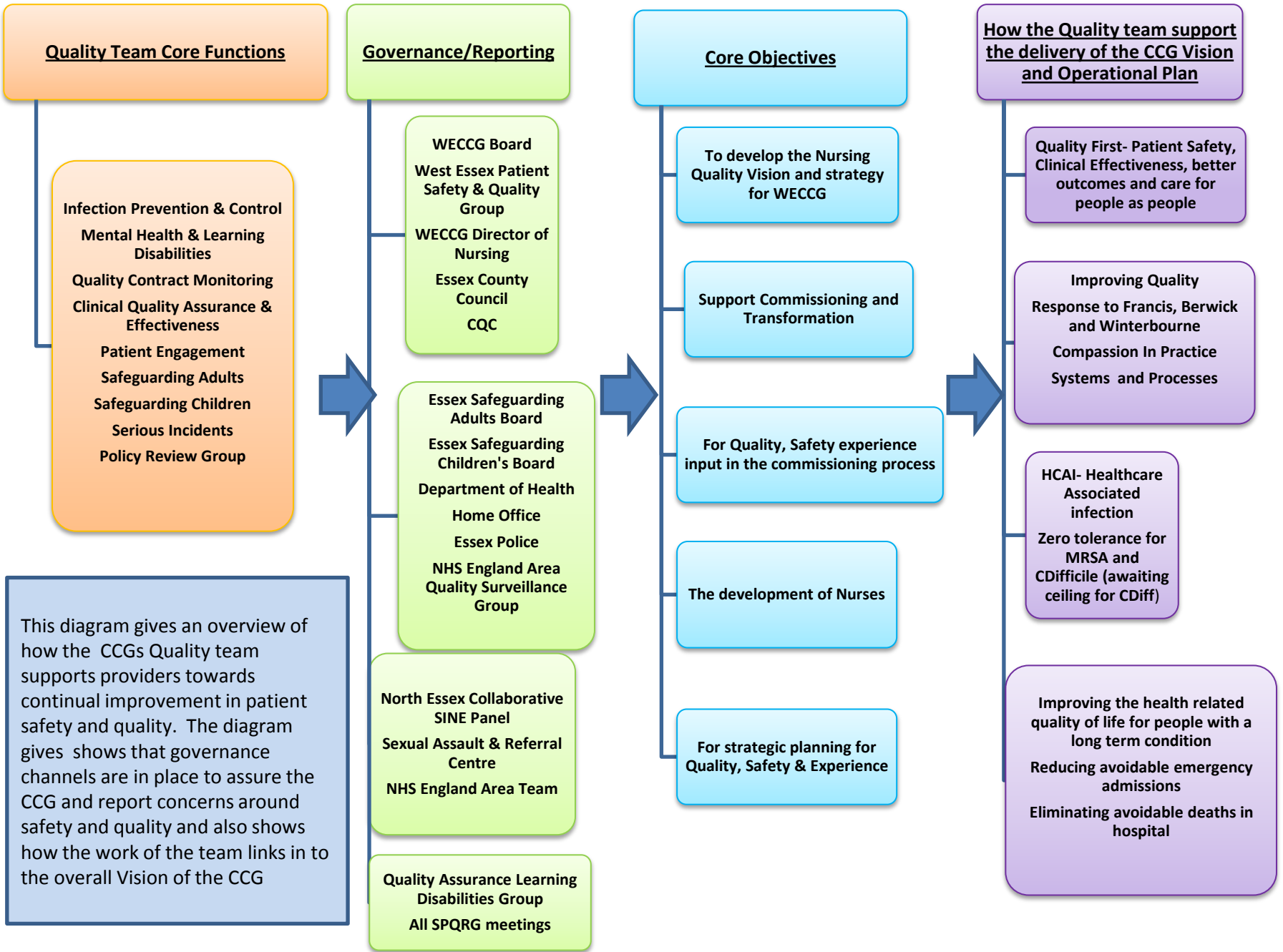
The CCG operates a rigorous assurance framework (imbedded document describes). This supports performance management across all performance standards and is overseen by Service Performance & Quality Review Group (SPQRG) and Patient Safety and Quality Committee ((PS&Q) covering:


Microsoft Word Document

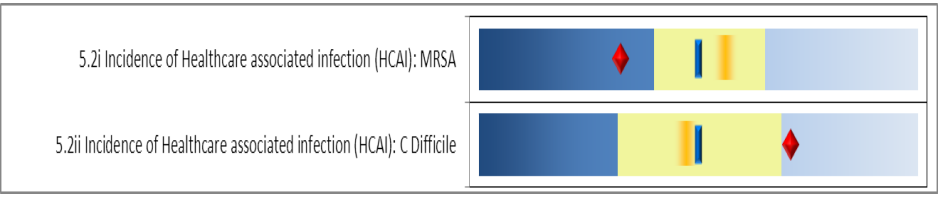
- Quality
- NHS Constitution. Essentially this is National Standards
- Outcomes and Supplementary Indicators including local priorities, Quality Premium, Potential Years of Life Lost (PYLL) and the Friends & Family Test.
- Finance

The SPQRG meetings take place with each provider on a monthly basis . The PS&Q meeting takes place monthly and is chaired by a lay member of the CCG Board with representatives including, Director of Nursing, Medical Director, and Vice Chair of the CCG. This committee will oversee the CCGs responsibilities to ensure that the recommendations of the Francis, Berwick and Winterbourne Reviews are implemented.

3.2 Governance and Reporting to Support Quality



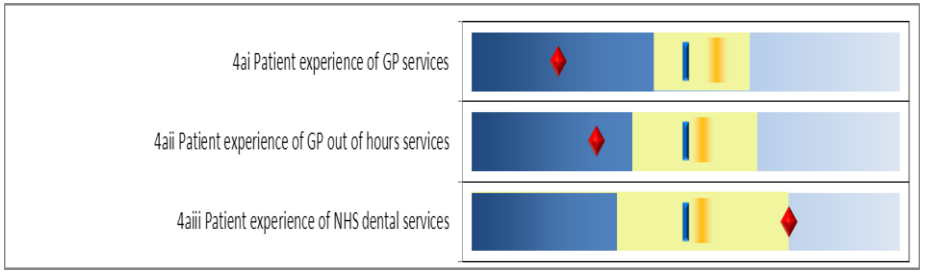
3.3 Healthcare Associated Infection



The CCG will contract for zero tolerance for MRSA and Cdifficile (awaiting ceiling for Cdiff) in 14/15 and 15/16 contracts. These targets are performance managed through the Service Performance and Quality Review Group on a monthly basis.

Through contracting negotiations we will be reviewing the latest performance against outcome indicators and will be sharing this with providers. Our monthly performance for 13/14 indicates an improved position for MRSA. We will be seeking to maintain this during 14/15 and beyond.

3.4a Patient Experience (Primary care)



Working in partnership with NHS England……

- Further work to be undertaken with individual practices, building on the work undertaken by Primary care foundation and NHS England in 2013/14.
- Improvement plans to be developed for each practice in the bottom 10%.
- Implementation of 7 day working in each locality.
- Improvement in GP access in Stansted from Autumn 2015 as a result of the new practice premises development.

3.4b Patient Experience – Acute and Community Care

The CCG receives monthly assurance from main providers, PAH (acute provider), SEPT (community Provider) and the CCG Patient Experience Team as below.

PAH

A monthly dashboard showing : Type, Item, trend, month

Complaints: (Number per month)

Combined Friends & Family Test numbers

Friends & Family individual numbers from :

Emergency Dept., Inpatient Ward & Maternity

All PALS

PALS- which are compliments

Web – Choices/Ratings

An Executive Summary which covers:

Complaints

Friends & Family Test

PALS

Complaints

NHS Choices

National Patient Survey

Elimination of Mixed Sex Accommodation

CQUINS

A&E Service Experience

PLACE

PROMS

SEPT

Patient Experience:

Complaints (broken down by directorate & Location)

Compliments

PALS broken down by source rec'd :

Survey,Email,Letter & Telephone

Resolution Time

Outcome

Friends & Family Test via the Patient Experience Indicator(which has been implemented as part of a CQUIN target)

How did we do surveys – trust wide patient satisfaction survey

Elimination of Mixed Sex Accommodation

CQUINS

PROMS

DIGNITY

WECCG

Tabular data for the previous month which includes:

PALS Contacts

Complaints

Compliments

Table and Graphs showing PALS by subject and organisation

Subject/Service Area trend analysis for all of the above

Learning/Actions for all of the above

3.5 Quality Contractual Standards – Patient Safety

In addition to the specific performance indicators that are referred to in other parts of this chapter, the CCG works closely with providers via SPQRG meetings to ensure that standards are being met and where improvements are required that action plans are put in place .

Indicator	Assurances
VTE	Contract with providers to identify all patients at risk and number of patients requiring prophylaxis. Good identification and prescribing. Monitored through SPQRG meetings on a monthly basis. In the event of an avoidable VTE occurring RCA is requested with lessons learnt and action plans
Pressure Ulcers	Contract with providers monitor occurrence of avoidable pressure ulcers and treatment of unavoidable. Good performance but when an avoidable incident occurs RCA is requested with lessons learnt and action plans. Monitored through SPQRG meetings on a monthly basis..
Mortality	HSMR and SHMI monitored through PS&Q and SPQRG on a monthly basis and attendance at hospital mortality group. West Essex providers not an outlier.
Serious Incidents	Monitored through PS&Q and SPQRG on a monthly basis. Reporting levels good. Occurrence always followed with RCA, lessons learnt and action plans
Provider Staffing levels	Contract with providers to provide workforce plans and methodology for staffing levels, monitor on a monthly basis through SPQRG with providers
Staff Satisfaction	Providers expected to undertake NHS Staff Survey, results reviewed on an annual basis through SPQRG
Patient Safety Alerts	NHSE provide service from 1 April 2013 and cascade to all providers
Continual learning on patient safety improvement within providers including serious incidents	As seen above continual improvement is sought. Where poor performance and/or serious incidents occur RCA takes place with lessons learnt followed with action plans to improve. We are also members of the North Essex Collaborative Group that reviews serious incidents to ensure continual improvement in safety
NHS Safety thermometers MH, medicines safety, maternity	Contract with providers to measure safety of services through safety thermometers. Also forms part of a national CQUIN. Good performance

3.5 Quality Contractual Standards – Patient Safety cont……

In addition to the specific performance indicators that are referred to in other parts of this chapter, the CCG works closely with providers via SPQRG meetings to ensure that standards are being met and where improvements are required that action plans are put in place .

Indicator	Assurances
Safeguarding Vulnerable People in the Reformed NHS  Microsoft Word 97 - 2003 Document	Contracts reflect standards outlined in the Safeguarding Vulnerable People in the Reformed NHS; Accountability and Assurance Framework (2012) Providers submit annual ESAB/ESCB audit to the CCG with action plans. Monitoring of the action plans takes place via SPQRG meetings. Named GPs are funded by the CCG to continue supporting GPs and practices in their safeguarding work. Partner agencies work and engagement with Essex Safeguarding Adults Board/Essex Safeguarding Children Board is evidenced at both operational and strategic level through specialist Doctor and nurse roles in provider and designated leads for safeguarding in CCG- these roles allow for internal oversight of safeguarding within the organisation and offer expertise and safeguarding prioritises to be taken forward in organisations i.e. Child Sexual Exploitation, MHA. The SCCN provides a collegiate approach to deliver the safeguarding agenda across Essex as identified within NHS England document (4.1) The CCG has a Strategy for Safeguarding Children and Adults (2013-15). The priorities outlined in the Strategy are reflected in contracts with our providers.
Safeguarding to address key priorities of child sexual exploitation, female genital mutilation, sexual violence and domestic abuse	children's contract sets out an expectation on provider to develop these areas of work. An initial scoping exercise has been undertaken and workshop has been set with safeguarding specialist in provider for discussion on FGM and meeting intercollegiate guidance. Outcomes will be taken back to CQRG. The CCG continues to commission a community domestic abuse nurse specialist, an aligned KPI requires a practitioner to review all domestic incidents. Practitioners work with clients and children to empower them to recognise the dynamics of domestic abuse supporting them to protect themselves and their children. Providers and CCG are engaged with the ESCB CSE strategy with CSE champions nominated in all organisations Training on Domestic Abuse and CSE is planned for GP shutdowns during 2014. The CCG works closely with local Domestic Abuse organisations to facilitate engagement in Primary Care.
s**afeguarding** duties d to be reflected in all local plans and NHS England will seek continuous assurance on this important issue	Governance arrangements with reporting schedules are in place within CCG and provider organisations. The CCG Vision 2014/16 document and the adult and children's safeguarding strategy outlines the organisations commitment to safeguarding.
provision for improvement and sustainability of domestic abuse services	CCG works closely with local Domestic Abuse organisations currently providing domestic abuse specialist workers in Maternity Department, A&E and Primary Care to help facilitate partnership working with our providers and local GPs.

3.6 Quality Premium

The CCG has set improvement trajectories for each mandatory quality indicator to support achievement of the quality premium in 14/15 below.

Measure	13/14 Baseline	14/15 Target	Aligned to Transformation Programme	Interventions to support improvement
Potential years of life lost (PYLL) from causes considered amenable to healthcare: adults, children and Young People	1905 YLL per 100,000 in 2012	Reduction by at least 3.2% on 13/14	Working Age Adults, Frailty, Children,	
Improving access to psychological therapies (IAPT)	10%	15%	Mental Health	Additional investment in IAPT services
Avoiding emergency admissions, composite measure of: a) Unplanned hospitalisation for chronic ACSC (adults) b) Unplanned hospitalisation for asthma, diabetes and epilepsy in children c) Emergency admissions for acute conditions that should not usually require hospital admission (adults) d) Emergency admissions for children with lower respiratory tract infection	1,669 per 1000,000 population	Reduction or 0% change	Working Age Adults, Frailty, Children,	Frailty, ACS and children's transformation programmes with targets for reduced avoidable admissions

3.6 Quality Premium cont…….

Measure	13/14 Baseline	14/15 Target	Aligned to Transformation Programme	Interventions to support improvement
Addressing issues in 2013/14 FFT, supporting roll out of FFT in local economy in 2014/15, support local providers to roll out, evidence to be provided Patient Experience Survey Indicator	Patient Experience Survey results available in February	Improved average score between 13/14 and 14/15, agree target	Quality Team	Action plans to reduce negative responses monitored by quality team at SPQRGs
Improved reporting of medication-related safety incidents - Increased level of reporting of medication errors	No reporting by PAH, SEPT report numbers but not nature	PAH contracted to report numbers and nature of incidents and SEPT to report nature of incidents and see an increase in reporting	Quality Team	Improved reporting in place from 1 April 2014
Local measure - Improved identification of people with undiagnosed COPD – supports longer term outcome of preventing people from dying prematurely and enhancing quality of life for people with long term conditions	1.6%	1.8%	Working Age Adults and Frailty	Increase in patients diagnosed and placed on register (next slide)

3.6 Local Quality Measure – Improved Identification of People with Undiagnosed COPD

Links with CCG Outcome Indicators	***Preventing people from dying prematurely*** **Reducing premature mortality from the major causes of death:** **Under 75 mortality from respiratory disease (NHS OF 1.2).** ***Enhancing quality of life for people with long term conditions*** **Reducing time spent in hospital by people with long term conditions:** **Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) (NHS OF 2.3.i)**
Rationale	Evidence suggests that between 10 to 34 percent of the NELs for an acute exacerbation of COPD are in patients with previously undiagnosed COPD. Proactive early diagnosis and treatment could reduce need for emergency admission. The NICE Quality Standard for COPD (QS 10: Statement 1 – diagnosis) and the Outcomes Strategy for COPD and Asthma recommend targeted case finding in those at higher risk of COPD. The JSNA identifies that COPD mortality is significantly worse in the Harlow locality as shown overleaf. This figure is significantly worse that the England average.
Improvement Target and Investment	The CCG proposes that the number of patients registered on West Essex GP COPD registers will increase by a minimum of 700 between 31st March 2014 and 31st March 2015, across West Essex. This has been calculated using the current percentage registered of 1.6%, with the aim of reaching 1.8%. In order to identify 700 confirmed cases of COPD, NICE Guidance states that approximately 2800 at risk patients need to be screened in the first instance. NICE guidance also proposes a specific definition of patients to be screened; however, local proposals include the testing of FEV1 levels, in-conjunction with a COPD Assessment Tool (CAT) which measures the impact of the condition on a person's life. GP Practices will need to be funded to undertake this extra work load and prevalence targets will be set for each practice to ensure this premium is met. Additional investment may also be required to ensure Primary Care

3.7 7 Measurable Ambitions

Our transformation programmes and improvement interventions outlined in Section 5.0 are underpinned by opportunities to improve against local outcome indicators. The transformation programmes and part of the quality work programme detailed in this plan highlights our position against the outcome indicators where they relate to that particular programme. The table on slide 3.5 shows the ambition that we have set for these outcomes over the next 5 years. The transformation programmes will be the main contributor to achieving this improvement. The summary below shows how the ambitions align to each programme

Ambition 1 Securing Additional years life from conditions amenable to healthcare	All programmes
Ambition 2 Improving the health related quality of life for people with a LTC	Frailty, Adult and Mental Health programmes
Ambition 3 Reducing avoidable emergency admissions	Frailty, Adult and Mental Health programmes
Ambition 4 Increasing proportion of older people living independently following discharge	Frailty programme
Ambition 5 Increasing positive experience of hospital care	All programmes
Ambition 6 Increasing positive experience of general practice and care in the community	All programmes
Ambition 7 Eliminating avoidable deaths in hospital	Quality work programme

3.7 7 Measurable Ambitions

Per 100,000	Domain 1 Securing Additional years life from conditions amenable to healthcare	Domain2 Improving the health related quality of life for people with a LTC	Domain3 Reducing avoidable emergency admissions	Domain3 Increasing proportion of older people living independently following discharge	Domain4 Increasing positive experience of hospital care	Domain 4 Increasing positive experience of general practice and care in the community	Domain 5 Eliminating avoidable deaths in hospital
Baseline	1905 YLL per 100,000 in 2012	74.2 (12/13)	1,669 per 100,000 pop (12/13)	Awaiting indicator	165.9 (2012)	7.2 (2012)	Awaiting indicator
2014/15	1785	75	1208	Awaiting indicator	155.8	7.1	Awaiting indicator
2015/16	1728	76	808	Awaiting indicator	150.7	6.9	Awaiting indicator
2016/17	1673	77	803	Awaiting indicator	145.7	6.7	Awaiting indicator
2017/18	1619	78	788	Awaiting indicator	140.6	6.4	Awaiting indicator
2018/19	1517	79	773	Awaiting indicator	135.6	6.0	Awaiting indicator

3.7 Measurable Ambitions

Indicator	Methodology	Supporting interventions
Securing Additional years life from conditions amenable to healthcare (where intervention can impact on mortality lung cancer excluded from measure).	Baseline 1844/100,000 (middle of 2nd best quintile, Continuing at 3.2% decrease per annum would take us to 1517 per 100,000 by 2018. This is slightly higher than the best CCG in 2012	The CCG is an outlier for premature mortality for CVD, breast cancer and respiratory disease . Work programmes to Improve local cancer standards and diagnosis and treatment of respiratory disease (ACS programme) will support this trajectory.
Improving the health related quality of life for people with a LTC	Baseline 74.2% (bottom of the second best quintile) to 79% in 18/19, Our expectation is to reverse the decline seen between 11/12 and 12/13, consolidate over 14/15 and make progress from 15.16 as our primary care initiatives start having impact. 1% improvement year on year, steady rise, discussion around this being survey based and inherent risks	**Frailty , ACS and children's programmes** early diagnosis of conditions, increasing ability to manage and reduce exacerbations, self management tools, management of more conditions at home and in primary care, better follow up care, social care and care support all delivered through improved integration of care.
Reducing avoidable emergency admissions	Baseline is 1,669 per 100,000 population in 12/13. WECCG is near the top of the 2nd best quintile. WECCG has only just returned to its 09/10 position. Through the ACS and frailty programmes the CCG has ambitions to reduce avoidable admissions significantly with a 54% reduction against the 4 composite measures over a 5 year period.	**Frailty, ACS and Children's programmes** more prevention and reablement in the community, improved management of exacerbations, management of more conditions at home and in primary care, better follow up care, social care and care support all delivered through improved integration of care.
Increasing positive experience of hospital care	165.9 per 100,000 in 2012, (based on a large number of survey questions) in worst performing quintile. Aim to move to top quintile by 2018 to 135.6	Quality team developing action plans for improvement with providers
Increasing positive experience of general practice and care in the community	7.2 per 100 patients in 2012; this is in the second worst performing quintile. Aim to get to a position equal to the current middle quintile. We have modelled more improvement towards the end of the period 14/15 – 18/19.	Working in partnership with NHS England to implement improvement plans with worst performing practices.

3.8 Constitutional Rights and Pledges

The CCG is contracting to hit all targets in 14/15 where failing in 13/14 we will work with providers to ensure clear action plans are in place to achieve this. The standards detailed below are those for which performance is variable. Action plans are either in place or in developments and will be closely monitored through monthly SPQRG meetings with providers

Standard	Key Actions and Interventions
18 Weeks • Achievement of 95% / 90% standards at a speciality level – focus on T&O and Urology • 52 week breaches – aim for achievement of 10 case "lower threshold" as a minimum	Princess Alexandra are consistently achieving the national RTT standards at an aggregate level. We have established weekly RTT meetings and are working closely with the Trust to ensure delivery at a specialty level in 2014/15. PAH aim to be specialty level compliant in April 2014 and we are currently working with the Trust to agree trajectories. Currently 24 completed cases Year to Date at month 8. The CCG has implemented processes to routinely monitor +40 week waits and to proactively seek assurance from Trusts that these will not breach 52 weeks. With PAH we are reviewing all pathways that exceed 35 weeks at the weekly RTT meeting.
A&E • Achievement of 95% 4 hour standard on a daily basis	Resilience against the 4hr standard will follow on from lessons learnt during the 2013/14 winter planning and surge management process. 2014/15 will be based around fully integrated and sustainable working across all system providers and partners. This will be underpinned by a revised and strengthened Urgent and Emergency Care Governance framework . Daily performance monitoring, shared organisational operational standards and effective escalation processes will be introduced to deliver sustainable service delivery.
Cancer • Consistently achieve all monthly cancer standards Microsoft Excel Worksheet	PAH are currently failing against the Breast Cancer 14 Day Standard and are producing an urgent recovery plan. Month 9 data shows issues in a number of other standards and this is being escalated via the West Essex Cancer Board and PAH SPQRG. All breaches are analysed on a case by case basis. Detailed contractual standards, KPIs and SDIPs (as attached) are being negotiated for inclusion in 14/15 contracts:

Standard	Key Actions and Interventions
Ambulance • Move to a position of compliance against all Category A Call standards • Regional solution	The CCG is actively engaged in the East of England Ambulance regional management process. The regional Risk Summit took place on 28 January 2014 where the following key actions were agreed: • The Trust will develop a new recovery plan by the end of March 2014 • This recovery plan will require transitional funding which all CCGs will be asked to support • The Trust is looking to appoint Locality Directors for Essex, HBL and Suffolk/Norfolk • The Trust is beginning to recruit 400 paramedic trainees • 2013/14 financial penalties identified will not be applied by CCGs
Stroke • Consistently achieve all monthly stroke standards	PAH have breached a number of standards throughout 2013/14 and the CCG has agreed recovery trajectories in respect of: 1. % of high risk TIA patients scanned and treated < 24 hours 2. % of stroke patients admitted to a ward < 4 hours 3. % of patients receiving thrombolysis < 3 hours Trajectories are being delivered with the exception of number 2. Current achievement is 70% against the 95% standard. Recovery plans are monitored through the West Essex Stroke Board and SPQRG meetings and will continue to be driven in 2014/15.
IAPT % of people that have entered psychological therapies Achieve 15% by end of 2014/15	We are working closely with the West Essex IAPT Provider, MIND, to ensure delivery of the 2013/14 intermediate target of 10%. Meetings are scheduled with MIND in February 2014 to review and agree budgets and detailed plans to ensure delivery of the 2014/15 standard. Additional funding has been set aside by the CCG to underpin delivery.
Dementia Achieve the 90% “Find / Assess / Refer” standards	Princess Alexandra Hospital are currently non-compliant in respect of the “Find” and “Refer” standards. The CCG’s Director of Quality has agreed a detailed action plan and trajectory with the Trust to deliver compliance by May 2014. Delivery of the plan and on-going compliance through 2014/15 will be monitored through the monthly SPQRG meetings with the Trust.

4.0 Changing How We Work

In this section we outline how we plan to work differently to support our transformation agenda.

4.1 Integrated Commissioning
4.2 Integrated Provision (inc BCF)
4.3 Primary Care at Scale
4.4 7 Day Working
4.5 Commissioning for Prevention
4.6 Commissioning Continuing Health Care

4.0 Changing How We Work

4.1 A Modern Model of Integrated Care – Integrated Commissioning

Providing integrated services is dependant on integrated commissioning between health and social care. We are therefore committed to integrated commissioning with Essex County Council. We aim to operate in a shadow form from April 2014 whereby we commission through pooled budgets, shared commissioning resources and joint governance between ECC and WECCG, achieving shared outcomes through the joint commissioning of health and social care services. Plans are progressing for integrated commissioning for our frail elderly population and also for Learning Disabilities. **The Better Care Fund will act as an enabler for integrated commissioning for frailty.** Beyond this we will be exploring integration opportunities for children and mental health.

Outline governance arrangements

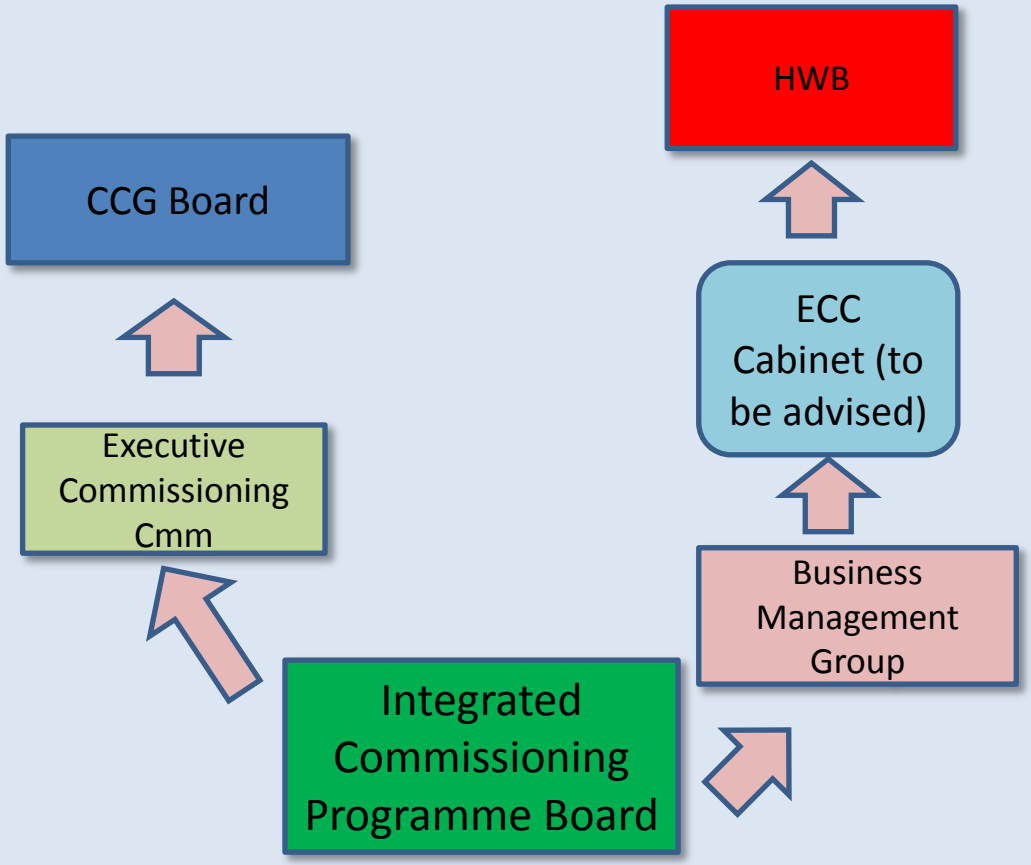
During 14/15 we will explore further what our preferred organisational form will be to work as a Accountable Care organisation with the aim of a clear conclusion on a preferred option by September 2014 for implementation by April 2015.

- **From April 2014** working under the principles of an Accountable Care Organisation for Older People, shadowing shared outcomes, budgets, governance, resources
- **From April 2015/16** working closely with ECC as **an** Accountable Care Organisation for commissioning of Older People , Children, Learning Disabilities, Mental Health

4.0 Changing How We Work

4.1 A Modern Model of Integrated Care – Integrated Commissioning

The governance structure through which the CCG and ECC are working to take forward our plans to develop integrated commissioning are shown below:



4.0 Changing How We Work

4.2 A Modern Model of Integration – Learning Disabilities

The Michael Report: *Healthcare for All* (2008) and the Mencap report: *74 Lives and Counting* (2012) provide clear evidence that people with a learning disability have unequal access to health services and are often at risk through failures to make reasonable adjustments to meet their needs.

The impact of these greater health needs and unequal access to general health services is that people with a learning disability are likely to die prematurely. The recently published *Confidential Inquiry into Premature Deaths of People with a Learning Disability*: 2013 (University of Bristol; Improving Health and Lives Learning Disability Public Health Observatory) identifies from the cohort they studied that men with learning disabilities died on average 13 years sooner than men in the general population; and women with learning disabilities died 20 years sooner than women in the general population. Overall, 22% were under the age of 50 when they died; 43% of the deaths investigated were identified as 'unexpected' and 42% 'premature' whilst fewer deaths of people with learning disabilities (38%) were reported to the coroner compared with the general population (46%).

The view is that an integrated health and social care team is best placed to take responsibility for the end-to-end health and social care experiences of people with LD. This will support an improvement in safeguarding and access to services, enhancing the experiences and outcomes from both health and social care.

Key Patient Benefits

- **Experience will improve and better outcomes will be achieved for people with learning disabilities.**
- **People will no longer become "stuck" in hospital assessment and treatment services (this happens currently because the current pathway between health and social care services is disjointed and managed separately);**
- **Funding disputes between CCGs and ECC (which can cause delays to people receiving the services they need) will no longer occur;**
- **Social care services will be enabled to work with health services to ensure that people's health needs are being met effectively and that people are being supported to live healthy lifestyles;**
- **The same health interventions and services will be accessible to people with learning disabilities that are available to any other citizen within Essex.**

- The same health interventions and services will be accessible to people with learning disabilities that are available to any other citizen within Essex. - **April 2014**
- Formal Pan Essex integration of commissioning resource (North and South Essex). **- April 2015**
- Service design - Integrated pathways for all cohorts – **throughout 2015**
- Joined-up care management and assessment **– April 2016**

4.0 Changing How we Work

4.2 A Modern Model of Integration – Learning Disabilities

Improving quality

Principles	Increasing pressure on the health and social care system is potentially best mitigated through integration. There is a pressing requirement to respond to the national Winterbourne View action plan, which requires us to demonstrate that we are delivering joined-up services for people with learning disabilities. Integrating LD will act as a key "early adopter" project to test and evidence the impact that can be delivered. The lessons can be translated across other areas Integrating LD commissioning will safeguard the benefits defined in the WAA Increasing Independence programme, through ensuring contractual buy-in to solutions that are best for the total combined expenditure There is some evidence that demand is a factor not only of demography, but also of the design of the system; an integrated approach to management and design of the system will mitigate the potential negative impacts The market continues to innovate and develop solutions for the separate budget and procurement processes. The market will only provide the innovative joined-up community-based solutions when the integrated budget puts those out to tender. Similarly the stand-alone nature of current performance and contract management makes it more difficult to hold suppliers to account for performance across the whole system;
Outcomes	**To improve customer experience and outcomes for people with learning disabilities through integrated pathways** **To create organisational capacity to address the impact of the projected demographic pressures** **To deliver the requirements of the Government response to Winterbourne View** **To bring the commissioning budgets together to drive greater value from the market with an increased focus on avoiding the poor experiences and outcomes which the cohort can suffer** **To drive value as well as managing increasing demand by developing integrated specifications** **To reduce the potential risk of systemic failure by creating integrated care pathways that improve experiences** **The development of integrated care and support pathways, to deliver the integrated specifications to deliver the *"Behaviours that Challenge"* work stream within the "*Increasing Independence for Working Age Adults"* programme*** **To address the issue that people with learning disabilities continue to have lower life expectancy and experience poorer health outcomes than the general population, despite increasing levels of funding over recent years.**
Priorities	The approach to commissioning will have changed to enable people with learning disabilities to have improved customer experience and outcomes. Commissioning teams for Health and Social Care will be co-located, with commissioners working as a single team to define integrated specifications Commissioning of services will be carried out as a joint activity between Health and Social Care, with budgets jointly managed There will be an approach to governance in place which enables and operationally manages joint commissioning and provides delegated authority to make commissioning decisions Commissioners will commission services which are delivered via integrated pathways between Health and Social Care, with seamless service and minimal hand offs People with learning disabilities will be supported to live healthy and fulfilling lives, with health and social care services working together to enable this to happen.

4.0 Changing How We Work

4.2 A Modern Model of Integrated Care – Integrated Provision

We strongly believe that integration is the answer to ensuring people get the best possible care and outcomes for their individual conditions. It is one of the underlying principles to our vision. We will be supporting integration where we can use it as a key enabler to:

- Bring together the organisations involved in patient care to deliver consistent and coordinated care
- Offer patients higher quality and more efficient care that better meets their individual needs
- Improved efficiency in how patient's conditions are managed and supported

The CCG is leading the way in developing an "Accountable Lead Provider"(ALP) approach to contracting and commissioning for a targeted population. We are working towards a role out of this approach for our frail elderly population in the first instance. Rather than commission separately for all the different health and social care services that this population needs, we will contract with one lead provider, who will be accountable for ensuring that the population achieve the outcomes that we have jointly commissioned with ECC. The plan is have an ALP operational in 2015/16, and to 'shadow' this arrangement in 2014/15

In this approach the ALP will manage and be responsible for a supply chain of care providers including themselves to deliver these outcomes. By commissioning these services in this way we want to free providers to innovate and work together to deliver improved care for frail people. The specific approach to frail elderly is explored further within the Transformation section of this plan.

The Better Care Fund is an enabler to facilitate phase one of the frailty programme. The CCG will contribute a sum of circa £18m into a pooled budget with ECC via a S75 Agreement from 2015/16. Further detail can be seen on slide 5.2 – Transformation of Frailty Services

4.0 Changing How We Work

4.2 A Modern Model of Integrated Care – Integrated Provision for Frailty

Our timeline for rolling out this out is shown as follows:

Year 1 2014/15	Year 2 2015/16	Year 3 2016/17
Shadow form	Single contract	Review and improve Transform services
Transform services	Transform services	Expand chain
Some incentives	Some incentives	

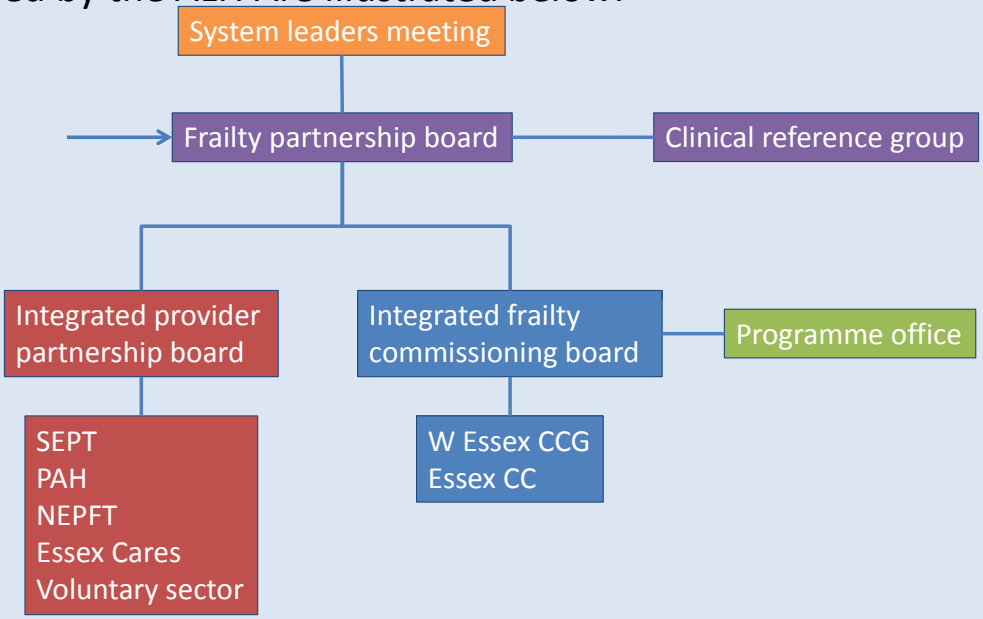
We are currently working with our providers to develop the year 1 and year two ambitions and will shortly be specifying within contract what will be expected. Typically for year two this is likely to include the following:

- the total budget available to meet the health and social care need
- the required health and social care combined, outcomes for the population group and the basis on which these outcomes will be measured;
- the incentivisation model by which benefits and risks will be shared between the CCG, ECC and the ALP for over or under-achievement of health gains for the population;
- details of the governance structures and reporting mechanisms through which the ALP will enable the CCG and ECC commissioners to have confidence in, and be publicly accountable for the integrity of all aspects of the care services provided by the ALP.
- Year 1 will see significant reductions in non-elective settings, with more effective community alternatives.

4.0 Changing How We Work

4.2 A Modern Model of Integrated Care – Integrated Provision for Frailty

Proposed governance structures and reporting mechanisms through which the ALP will enable the CCG to have confidence in, and be publicly accountable for the integrity of all aspects of the care services provided by the ALP. Are illustrated below:



4.3 Providing Primary Care at Scale

The CCG and its partner practices have over the last 12 months been exploring how a programme of transformation within primary care can support a different approach to providing care to our population. Our primary care localities, Harlow, Uttlesford and Epping are proposing to establish themselves business entities to facilitate their ability to act as lead coordinators for the management of care for a number of conditions over and above core services. Uttlesford will form one entity and Harlow and Epping will join to create a second. This will involve practices taking responsibility for a total budget for a group of patients. Plans are being developed as follows:

- Localities to form business entities by 1 April 2014 including the managed transfer of a range of services into primary care.
- Extended range of provision of ACSC (Plus) commencing **July 2014** including use of technology including TeleDiagnosis, TeleFundus Screening, TeleOphthalmology and initially focussing on diabetes, respiratory and cardiology to aid diagnosis and treatment.
- Extended provision- 7 day working **June 2014** including use of technology offering more flexible ways for patients to access general practice
- Locally Enhanced Services to be commissioned through localities rather than individual practices, reducing variation in care, sharing skills and improving efficiency
- Commence co-location of services /community based hubs from **Sept 2014** providing an extended range of wider out of hospital services including consultant led and specialist nurse led services tailored to locality needs. This will ensure people get the best possible care and will bring together multidisciplinary teams in a meaningful and directed way.

NB Expansion of Primary Care is a key enabler to the Adult Transformation Programme refer 5.3.

Benefits
• Reducing variation in GP referrals through rolling out good practice for managing demand and reprovision
• Practices working together to provide efficient services through services being shared across a wider base including sharing responsibility for patient care more efficiently and effectively across the week.
• shift to prevention and early intervention through person-centred care
• Caring for people as individuals with closer professional-patient relationships
• Practices providing a front door to a wider range of services
• A more integrated approach to providing general practice and wider out of hospital services
• Driving up quality in primary care generally
• More care delivered at home, in primary care and in the community
• Services delivered via a single point of contact with primary care as the coordinator

4.4 7 Day Working

Improving quality and access

10 Clinical Standards

Urgent Care | **Frailty** | **Children** | **Adults**

- Health and Social care commissioners in west Essex will expect providers to ensure the same standards of services are provided across seven days. We will be commissioning for outcomes with the expectations of the same level of interventions being in place at weekends as during the week to prevent unnecessary admissions and support discharge.
- In the meantime the CCG is developing an Urgent Care Strategy, in response to associated 'winter pressures' in the acute hospital setting . There is a clear expectation that 7 day support for hospital discharge on a WECCG 'whole system' basis. Priorities including 7 day discharge from PAH, health and social care in-hospital capacity and activity and Health and social care support and reablememt services for community discharge are being piloted this winter., supported by rapid assessment, and CARS,
- The accountable lead provider for frailty will be commissioned to develop a set of services that 'wrap around' patients and operate flexibly across a 7 day service arrangement.
- Early diagnosis of ACS conditions is highly dependent on improved and direct access to diagnostics, with urgent reports being provided to GP's within 24 hours. The CCG therefore expects the ACS service model to be available 7 days per week where appropriate. We will be commissioning for outcomes and these outcomes will be the same regardless of day of the week and expect primary care providers to be provider extended 7 day a week services from July of 2014
- We are working with all of our providers to develop action plans to support their response to the 10 clinical standards for 7 day working. This will be a key component of SDIPS over the next two years.

4.5 Commissioning for Prevention

There is a clear understanding that Public Health is everybody's business and working in partnership with all commissioners, wider stakeholders and the communities of Essex is seen as the most effective way of delivering against the outcomes nationally and locally. Essex County Council is responsible for the public health of Essex residents and has been given a grant of £50 million - that was historically National Health Service money – to improve the population's health. Of this approximately £7½ million is spent in the West Essex CCG area. The strategic context around agreeing optimal use of public health resources includes the Essex Health and Wellbeing Strategy, the Essex County Council Corporate Plan, the National Public Health Outcomes Framework, centrally mandated areas for public health action and locally assessed needs.

PH area	Spend	Transformation area
Falls prevention	£450,000*	Frailty
Senior Health Checks	£40,000	Frailty
Health Checks	£367,000	Adults
Health Trainers	£110,000	Adults
Stop Smoking services and interventions	£395,000	Adults
Sexual Health - GUM	£1,093,950	Adults
Sexual Health - Young People Service	£368,359	Adults
Sexual Health - CASH service	£524,570	Adults
Obesity	£300,000*	Adults, Children
Drugs and alcohol	£2,612,586	Mental Health
Depression and OP	£48,498*	Mental Health
Healthy Schools	£15,000	Children
5-19 Health Child Programme	£1,179,462	Children
VCS grants	£58,220	any
* New or proposed for 14/15		
N.B Some figures are approximate as not all contracts have a geographical basis		

We will use the resource to commission a comprehensive range of public health services. Key strands of commissioning next year will include

- Mandated must do's: healthchecks, national child measurement programme, sexual health services, & health protection
- System productivity eg falls prevention, alcohol,
- Priority areas from JSNA etc: depression in older people, obesity and physical activity, domestic abuse

4.5 Commissioning for Prevention
Examples of working together to achieve shared outcomes

Integrated Public Health Commissioning Programme
Aimed at: Reducing harm caused by alcohol misuse, reducing falls in older people, improving recovery from stroke and improving continence care
Delivery start date: April 2014.
Resourced through: ECC and CCG
Description: Our JSNA Lifestyles Deep dive identified significant harm being caused to our population through alcohol misuse, and in the over 65s by falls. The programme, jointly commissioned between ECC and the CCG and forming part of our integrated commissioning programme, provides a substantial increase in investment of alcohol brief screening and intervention and treatment programmes, and in integrated falls clinics locally by ECC in return for the CCG increasing investment in stroke early supported discharge and continence services

Reducing Health Inequalities through stop smoking services
Aimed at: Smokers in deprivation quintiles 4 and 5
Delivery start date: April 2014.
Resourced through: ECC
Description: A health equity audit on smoking has identified that differences in access to stop smoking services and quit rates between affluent and deprived communities across the CCG are resulting in a failure of smoking cessation to address health inequalities. The project aims to increase referral rates of smokers from GP practices serving our 40% most deprived communities to levels that address this.
This fits with WECCG Local Quality Premium intervention to improve COPD case finding and management

Improving the mental health of vulnerable people and groups
Aimed at: Older people, people accessing IAPT and secondary mental health services
Delivery date: July 2014
Resourced through: ECC
Description: Research shows that there is a high prevalence of undiagnosed depression in older people and that patients of all ages who access mental health services have poorer physical health outcomes. This scheme will commission a suite of initiatives aimed at improving the mental health of older people and vulnerable groups, including screening and treating older people for depression, social prescribing to address loneliness and isolation in older people, floating support to assist patients with mental health problems to deal with housing problems and debt, and providing health trainers to people accessing secondary care mental health services to assist them to address health damaging behaviour such as smoking and alcohol misuse.

4.6 Continuing Health Care

CHC Governance

- SLA and service specification in place with Central Eastern CSU to deliver against the National Framework for CHC (2012 Revised), Responsible Commissioner Guidance and key quality markers. The CSU deliver on behalf of the CCG both the core CHC service and the retrospective claims. The CSU employs specialist practitioners who are subject matter experts in this field of practice.

    - The performance of the service is reported to the CCG and monitored by the CCG in a number of ways including:
    - Reporting of Monthly KPI's
    - Monthly reporting of activity, cost and performance via a dashboard, and narrative identifying key areas
    - Bi Monthly reports to the CCG Quality Committee presented by key CHC leads
    - Monthly finance report and forecast of CHC spend
    - Quarterly National benchmarking reports
    - Weekly reporting on the clearing of backlog reviews
    - Monthly reporting of performance of the retrospective reviews against trajectory
    - Fortnightly Essex wide meetings with the AT across Essex
    - Meetings with CCG DON and Finance Director
    - Provision of ad hoc requests for information
    - Close links with the CCG quality team and CHC staff in the CSU

Personal Health Budgets

- On schedule to be in place by September 2014 as per national programme.
- In our own engagement programme there was keen interest from citizens to the concept of personal budgets.
- We intend to maximise opportunities presented by the national rollout of the programme . With evidence of the greatest benefit attributable to areas of spend that impact on the amount of control that people have over their lives we see the management of LTCs as a key area for development in the use of personal budgets going forward.

NHS
West Essex
Clinical Commissioning Group

5.0 Transformation Programme and QIPP

In this section we describe the transformation interventions that we see as the key to delivery of our ambitions to improve quality and productivity of health and care services.

5.1 Introduction
5.2 Governance Arrangements
5.3 Access to Highest Quality Urgent and Emergency Care
5.4 Frailty and Older People
5.5 Working Age Adults
5.6 Children and Maternity
5.7 Mental Health and Vulnerable Adults
5.8 Stroke
5.9 A Step Change in Productivity of Elective Care
5.10 Specialised Services Concentrated in Centres of Excellence
5.11 Enablers

5.1 Transformation Programme and QIPP - Introduction

Transformation Programme (QIPP)

The CCG has developed a transformation programme with ambition to deliver real change and improvement in how health and social care services are delivered to the population of west Essex. The aims of the programme are to:

- **Improve quality.** *Patient safety, clinical effectiveness, better outcomes and care for people as people.*
- **Significantly shift the point of care**, *the right care is provided at the right time and in the right place*
- **Integration between health and social care**, *for both commissioning and providing of care*
- **Connected transition of care**, *and support between professionals and organisations*
- **Maximise productivity and efficiency**.

My Health, My Future, My Say – A vision for the west Essex health and care system 2014-2014 was the result of a major engagement exercise that the CCG undertook in partnership with ECC and providers during Summer 2013. This process has informed the transformation programmes that we are taking forward. These are:

- Frailty and Older people
- Adults (ambulatory care sensitive conditions
- Children and Maternity
- Mental Health and Vulnerable Adults

Our transformation programme incorporates our wider business as usual reform programme which includes the following:

- Urgent and emergency care
- Stroke
- Productivity in elective care
- Concentrated centres for specialist care

This chapter of our plan describes each of the programmes. In particular how they each contribute to improvements in patient care, how they contribute to the 7 ambitions and how they support a step change in productivity.

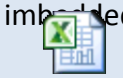
The programme will be overseen through the governance arrangements shown at 5.2. The programme itself is unpinned by the following gateway principles:

1) Outline project mandate

2) Business case to demonstrate
    - Innovation, CCG using tools such as The Advisory Board Company, The Kings Fund, Better Care.
    - A thorough review of best practice sought through evidence based research
    - Clinical engagement
    - Patient engagement
    - Improvement in quality and positive impact against CCG outcomes and 7 ambitions
    - Opportunity for productivity

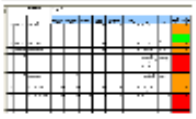
3) Project Implementation
    - Detail project planning
    - Risk management
    - Progress reporting
    - Reporting against project milestones
    - Reporting against planned savings

The CCG operates a PMO function that will oversee the transformation programme. QIPP Assurance checklist imbedded.



5.2 Transformation Programme and QIPP - Governance

MONITORING ARRANGEMENTS FOR TRANSFORMATION/QIPP 2014/2015

MEETINGS	WORKSTREAM TEAM MEETINGS WEEKLY: MONDAY	WORKSTREAM / TASK & FINISH	PROGRAMME BOARD MONTHLY / QUARTERLY	FORMAL EXECUTIVE COMMITTEE MONTHLY: WEEK 2	→	• CLINICAL COMMISSIONING COMMITTEE • FINANCE & PERFORMANCE COMMITTEE MONTHLY: WEEK 3	WEST ESSEX CCG BOARD MONTHLY: WEEK 4
REPORTS	Weekly Milestone Tracker Risk logs	PROGRAMME SUITE (produced monthly)	PROGRAMME SUITE (produced monthly)	2 Part QIPP report ((produced monthly)	→	2 Part QIPP report (produced monthly	ACCOUNTABLE OFFICERS 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				+		

5.0 Improvement Interventions – Transformation Programme

5.3 Access to Highest Quality Urgent and Emergency Care

5.3.1 Urgent and Emergency Care – Plan on a Page
5.3.2 Governance Overview
5.3.3 Winter/Operational Approach
5.3.4 Strategic Development

5.3.1Urgent and Emergency Care – Plan on a Page

Governance Overview

Urgent Care Strategy Board (monthly) - Development of longer term U & E Strategy and service integration agenda from 2015 to 2018 – stakeholder and increased clinical involvement linked to national plans (Keogh review) - ***ongoing with overall strategy agreed by end of Q1 of 2014/15***

Urgent Care Working Group (weekly/bi-weekly dependent on requirements) - senior operational membership from all providers and development of 14/15 action plans for delivery of system capacity and resilience – ***plans agreed by end of March 2014***

Operational system network (daily via on site meetings and teleconferences) – day to day operational interface between providers – ***continuous process building on successes of winter initiatives13/14***

Three Phase approach to Urgent Care Provision

Pre Hospital phase (attendance avoidance)

- GP in car to support EEAST ambulance reduction in conveyances
- Increased GP urgent appointment slots
- Focus on minor injury and ailment treated in Primary Care environment
- SPA alternatives to hospital
- NHS 111 patient navigation to Pharmacy & self-care options
- Care homes initiatives

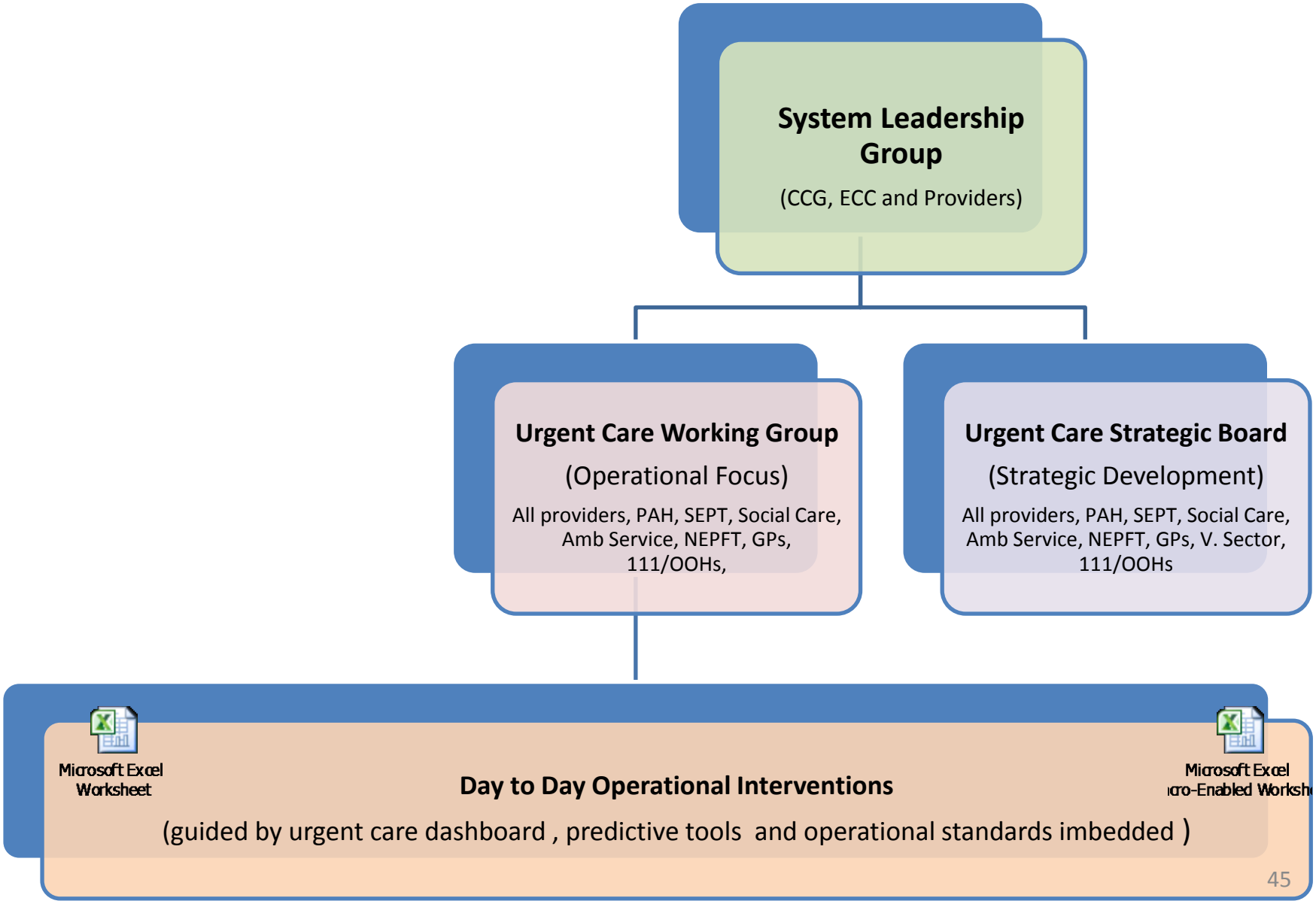
Hospital arrivals phase (admission avoidance)

- Enhanced streaming to OOH service
- CARS nurse initiative
- Co-location of agencies
- Frailty Pathway development
- C&YP initiatives
- Mental Health support
- Reablement initiatives
- Joint Health and Social care ownership and approach

Discharge phase (post hospital recovery & readmission avoidance)

- Enhanced streaming to OOH service
- CARS nurse initiative
- Co-location of agencies
- Frailty Pathway development
- C&YP initiatives
- Mental Health support
- Reablement initiatives
- Joint Health and Social care ownership and approach

5.3.2 Providing High Quality Urgent and Emergency Care Pan System Governance



5.3.3 Providing High Quality Urgent and Emergency Care

5.3 Winter /Operational Approach

Improving quality

Overview of Approach

•CCG has the role of system manager with oversight of performance and delivery of all providers and system partners
•Governance of winter pressures management is via the Winter System Programme Board chaired by the CCG accountable officer
•The system wide performance dashboard has been used to monitor and develop system KPIs . This will continue to developed with local predictive decision support tools and increased use of CAMS system.
•Increased scrutiny from both NHS England and Trust Development Authority with focus on A&E 4 hour target and Ambulance handover times
•Health economy received £5m to support winter pressures in the community and at Princess Alexandra Hospital
•Sustainable plans for use of 70% marginal rate have been agreed and will be monitored going forward by the UCWG
•Significant underperformance during November and December with PAH failure against 4 hour target in Q3
•McKinsey intervention commissioned to give external view of system challenges and opportunities to improve

Recovery Measures

•Increased focus and pace in system led by Winter Programme Board meeting weekly
•Additional interim executive level CCG support to ensure high level engagement across urgent and emergency care
•McKinsey inputs added to overall system recovery plan and increased monitoring of performance against agreed actions
•Adoption of 7 day working arrangements across all system partners
•Co-location of providers at PAH to ensure effective escalation and communication
•Decision support framework strengthened to include:
    •System wide urgent care dashboard
    •More effective and frequent teleconference arrangements
    •Increased engagement from Ambulance and OOH providers
•Urgent care Working Group review of existing plans, escalation processes and triggers for improved system responsiveness at times of increased activity
•CCG leading the advanced development and implementation of cross system operational standards and joint working to reinforce the escalation process.

Recovery, Resilience and sustainability

•20 bed modular ward (SSEAU) opened at PAH on 20th Jan
•Additional Community and Social Care capacity now online
•Developing relationships across all partners remains key to delivery of quality patient care
•Winter Programme Board focus on remaining weeks of 13/14 period and ensuring ongoing sustainability throughout 2014/15
•Planned revision of Urgent and Emergency Care governance arrangements to support future 5 year strategy
•Awareness of national Urgent Care guidance and clinical models from Keogh review
•UC mobilisation event planned for March to begin strategy process
•The CCG through the CSU commissioning mechanism is fully engaged in the process of ensuring ambulance services are at the heart of sustainable delivery of urgent and emergency care. Building on improving relationships and joint schemes developed during this winter period the CCG and its partners are focussed on delivery of the enhanced role of the ambulance service as defined by the Keogh review.

5.3.4 Providing High Quality Urgent and Emergency Care

Strategic Development

What are we trying to achieve through the Urgent Care Strategy ? …*Following the Urgent and Emergency Care Review we will create an integrated urgent care system, that will improve value for money & reduce spend to reinvest in proactive care and to ensure people with urgent or emergency care needs get to the right person / service as quickly as possible aligned to the recommendations and clinical models as follows:*

To ensure minor injury and minor illness are treated outside of the acute hospital setting

To ensure patients with mental health issues are treated outside of the acute hospital where appropriate when their clinical needs have been met

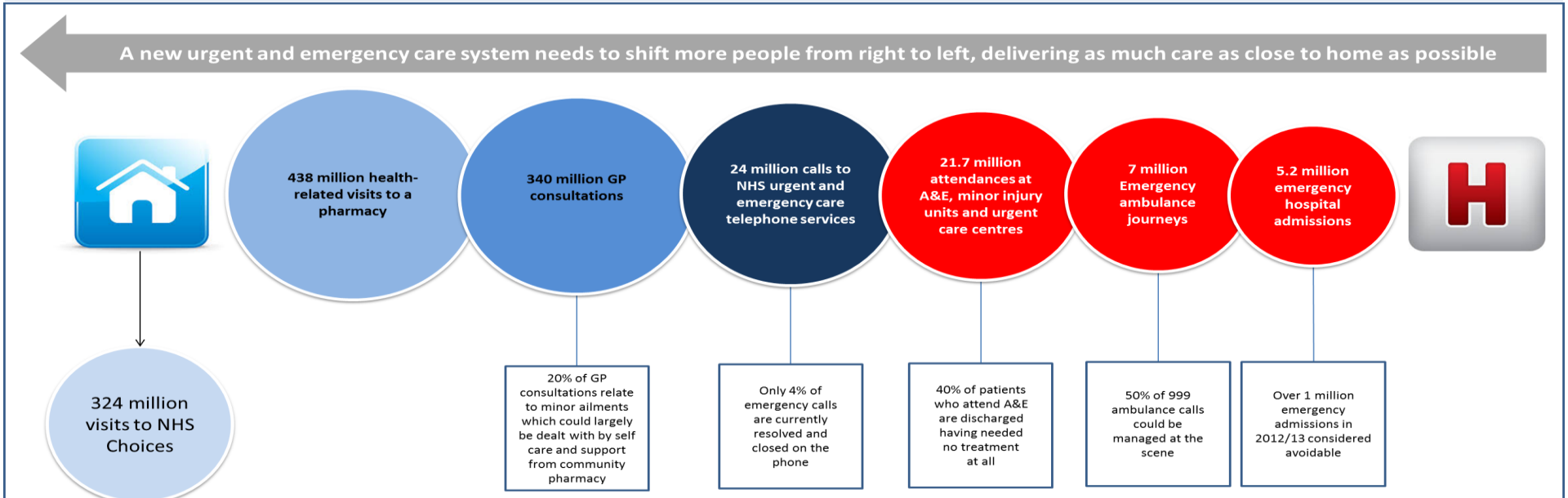
To ensure patients with ambulatory care conditions are treated as quickly as possible and not admitted into hospital unnecessarily

To ensure patients with multiple chronic health needs have access to timely assessment by appropriately skilled clinicians and have an appropriate care plan delivered

To improve access to and responsiveness of urgent community support services

To ensure that patients do not stay in hospital longer than they need to

To ensure people with specialist emergency needs are fast-tracked to the appropriate specialist service, e.g. stroke



5.3 High Quality Urgent and Emergency Care Strategic Development cont……

Key Milestones	14/15	15/16	16/17	17/18
"Phone First" (inc 111, OOH, SPA) service spec development	√			
Integrated UCC &OOH service planning	√			
Review crisis services	√			
Self care and pharmacy strategy	√			
Workforce strategy development	√			
"Phone First" (inc 111, OOH, SPA) procurement		√		
Integrated UCC &OOH service specification development		√		
Continued development of mobile assessment services		√		
"Phone First" (inc 111, OOH, SPA) hub launched			√	
Integrated UCC &OOH service procurement			√	
Mobile services implementation			√	
Integrated UCC & OOH service launched				√
Workforce Strategy	√	√	√	√
Engagement and Communications	√	√	√	√

14/15 & 15/16 – Building resilience

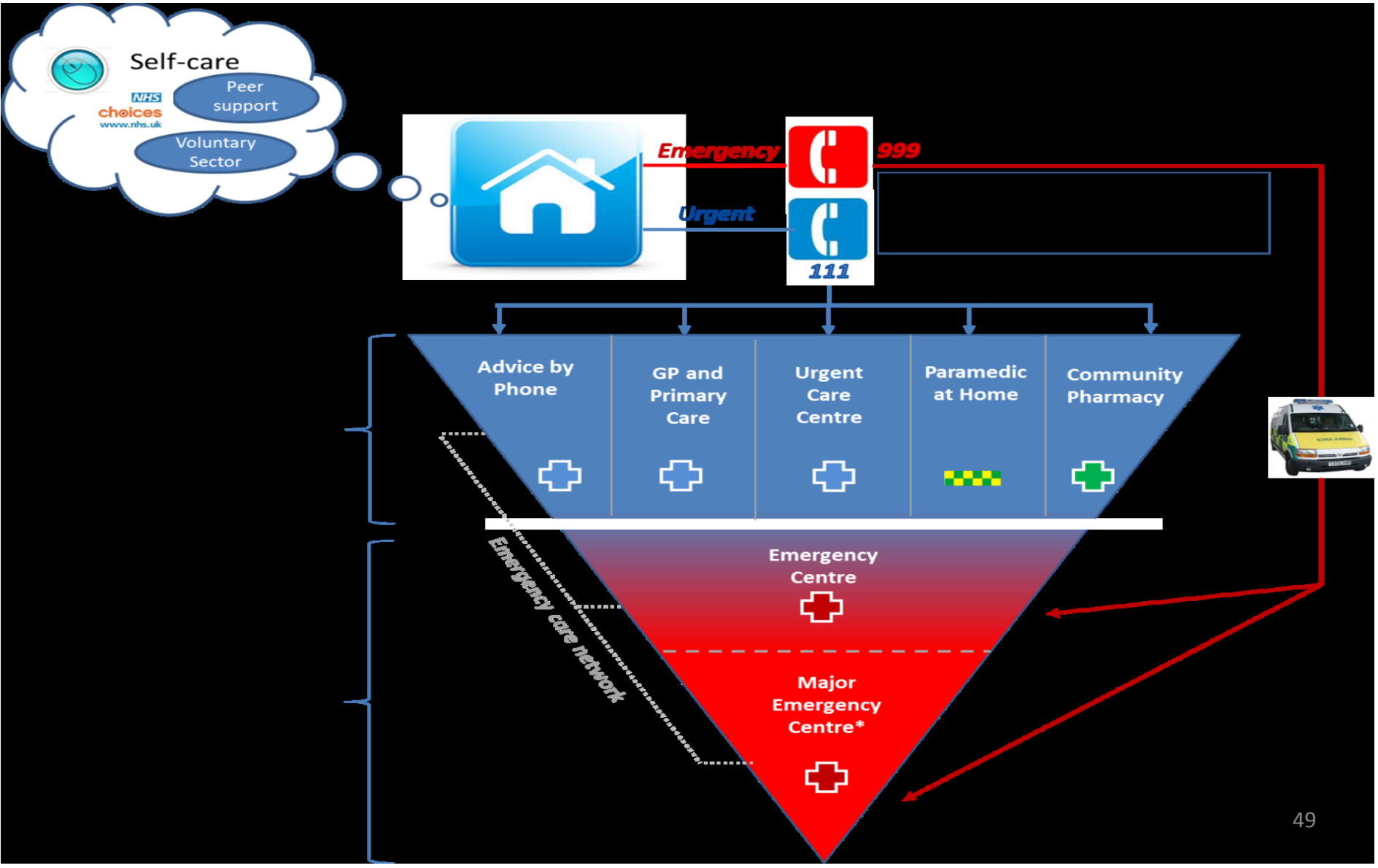
16/17 & 17/18 – Implementing Strategy

Key Opportunities 2014/15

- tender OOH & 111 service
- align with single point of access (SPA)
- Influence ambulance service contract to improve emergency response and improve integration with GPs and providers – imbedded diagram illustrates

5.3.4 High Quality Urgent and Emergency Care Strategic Development cont……..

The diagram below illustrates the vision for urgent care in the west Essex system over the next two years. This shows a reduction in reliance on hospital care except in the case of a major emergency. Access will be improved in community and primary care settings supported by self care and advice from 111 services



5.0 Improvement Interventions – Transformation Programme

5.4 Frailty Programme

5.4 Improvement Interventions – Transformation Programme Frailty

Summary of Programme

- The West Essex system is proposing a fundamentally different approach to the provision of care for the frail population in West Essex. This approach will facilitate improved co-ordination of care involving all agencies, including third sector, across health and social care working more closely together, to ensure that they combine efforts to achieve the very best outcome for those who use services. The overarching benefits will be:
    - potential to share resources,
    - improving efficiencies by eliminating unnecessary duplication.
    - improve quality of care by reducing the barriers between different parts of the care pathway
- The Integrated Frailty Programme will be commissioned jointly by CCG and Social Care and provided by SEPT as accountable lead provider with an integrated supply chain including Essex County Council, Princess Alexandra Hospital, Essex Cares, Primary Care, Ambulance Service, North Essex Mental Health Trust and voluntary sector, with aspirations to develop the supply chain further and expand the role of the social care sector.

Aims and Objectives	Goals for Patients
Demonstrate a marked improvement in patient experience and quality of care, which is centred on the needs of the individual Share risk and gain appropriately through the West Essex care system	Increasing the length of time known conditions are maintained in a stable condition, and therefore reducing the frequency of acute exacerbations
Work through organisational boundaries and promote inter-organisational working	Decreasing the severity of acute exacerbations when they cannot be prevented, by early detection and rapid response
Develop a commissioning landscape that supports prevention of crisis	Reducing the impact of acute exacerbations by shortening the duration of the episode through rapid response and effective re-ablement
Develop a commissioning landscape that supports prevention of crisis	Reducing the levels of vulnerability/ frailty by managing the risk of developing/ worsening additional co-morbidities
Invest in infrastructure that will improve sharing of patient information across organisations involved in care; and also support performance management	Fewer ‘crises’ requiring acute admission
Improve productivity and make better use of resources.	A slower transition to frailty for those at risk of becoming frail

5.4 Improvement Interventions – Frailty Transformation Programme

Improving quality

Principles

- designed around the needs of the frail and those likely to become frail;
- reductions in acute admissions and readmissions, A&E attendances and outpatient follow-ups; replaced by preventive and re-ablement services in community setting.
- joint commissioning of health and social care; and will develop an integrated supply chain
- localised models of care
- Self-care and carer support are integral to the programme;

Outcomes

- to improve independence and reduce crisis by ensuring individuals have access to reactive support, and multidisciplinary advanced care planning, to empower patients to feel confident in managing their condition(s) and prevent causes for health decline.
- through education, advanced care planning, better access to support services and family and carer support and education services to improve the quality of life for people over the age of 75, or with dementia or living in a care home.
- prevent avoidable admissions will use information shared between the acute providers and community providers to ensure follow up care for those discharged from hospital have the social and health support which mean the risk of readmissions is significantly reduced. Integrated intervention following discharge includes; reablement, therapy, social support, and carer support and education.

Priorities

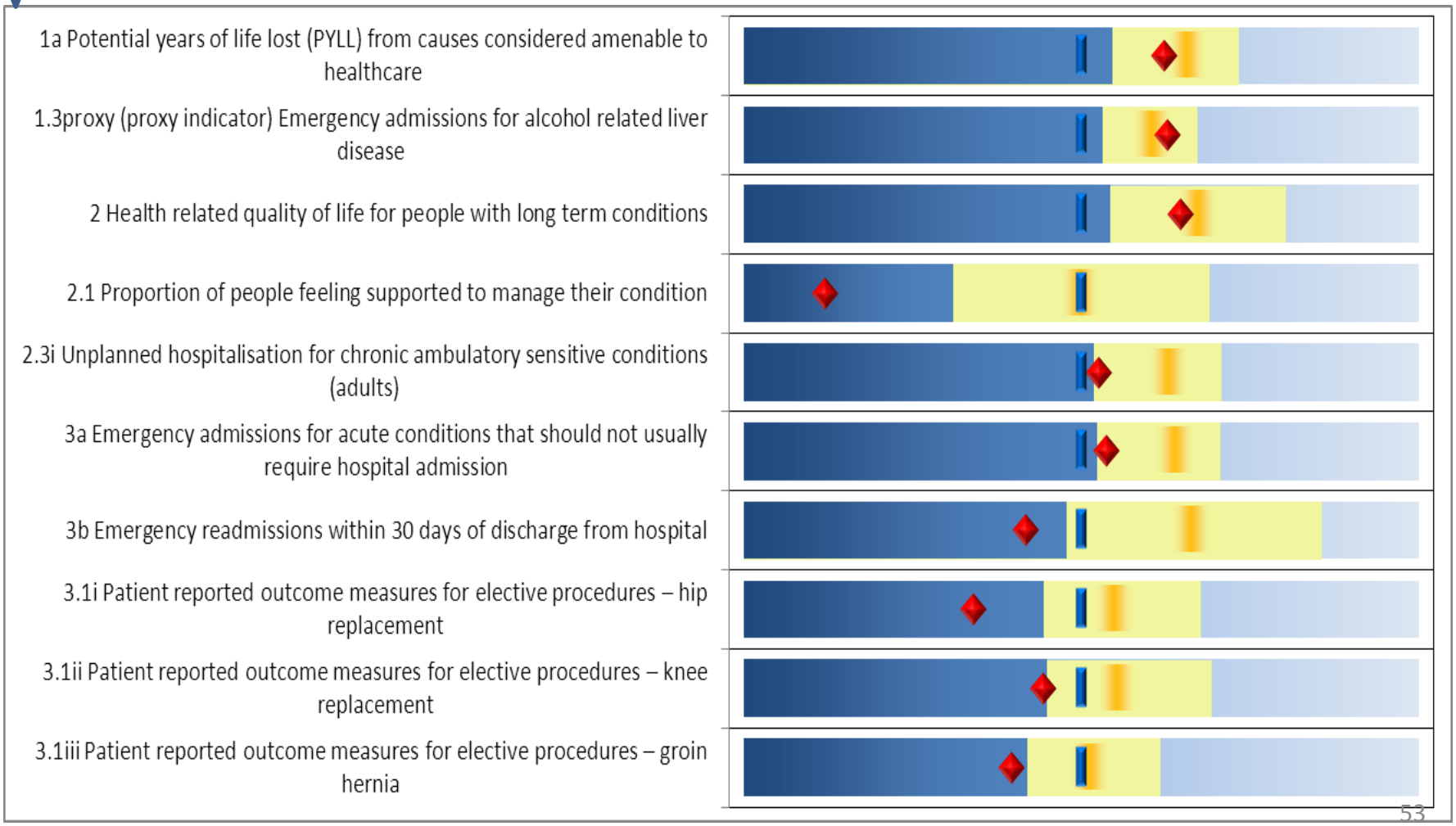
- Designing integrated care around the needs of the frail and those likely to become frail means designing services ‘around’ the needs of the patient; the programme will include activities focused on changing professional ‘culture’ .
- Preventative care will necessarily include a focus on more minor problems.
- A single point of contact for services is included in the integrated care model
- Integrated care is the main plank of the programme

5.4 Improvement Interventions – Frailty Transformation Programme

The frailty programme is a key intervention that will contribute to an improvement in the outcome indicators below:

National Average Peer Group Average

CCG Position



5.4 Improvement Interventions – Frailty Transformation Programme

Key outputs that will support improvement in outcomes

Year 1 2014/15	Year 2 2015/16	Year 3 2016/17
integrate health and social care: access to social care information & access to rapid response social care via SPA for A & E & RAC	Fully integrated health and social care access via a Care Co-ordination centre to all piloted services	Establish full capability of care co-ordination centre
Improve access to reablement for hospital discharge	Extend access to rapid response to community	Embedding and roll – out of all successful pilot schemes
Front end of PAH changes to support admission avoidance activity	Improve rates of community based rehab at home	Re-design and re-pilot unsuccessful schemes
Improve access to RAC	Set up specialist MDT's	Establish full MDT working
Working towards dedicated step up beds in focussed units.	Increase capacity for step up intermediate care	
Focus on admission avoidance from care homes	Ambulance trust changes to support admission avoidance	
Extension to mental health crisis support for AA	Revised focus on community dementia support and liaison	
Pilot MDT's in willing and able GP practices, developing risk stratification tool	Delivery of supportive end of life pathways, revise integrated community team working including falls pathway	

5.4 Improvement Interventions – Frailty Transformation Programme

					2014/15	2014/15		
					Activity	Financial Gross Savings £	Investment / reprovision £	Financial Net Savings £
Frailty (Older People)	**Frailty**	13/14 start	1		1,608	2,390,000	(1,224,000)	1,166,000
	Hospice at Home	13/14 start	1			432,000	(310,000)	122,000

5.0 Improvement Interventions – Transformation Programme

5.5 Adult Programme

5.5 Improvement interventions – Transformation Programme - Adults

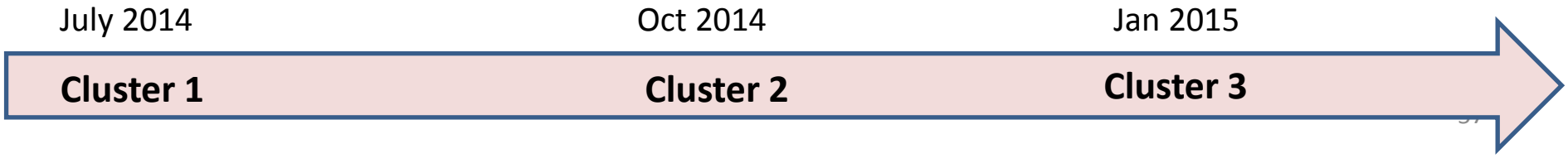
The CCG currently provides care for patients with an ACS Condition through a number of pathways, across primary, community and secondary care settings. The business case imbedded outlines West Essex CCG's commissioning intentions to improve the care provided for adults living with an ACS condition.

It is evident that current ACS care is provided across numerous complex pathways and with limited formal integration, resulting therefore in the absence of shared management of patients in west Essex and delays in diagnosing chronic health conditions. There is currently a gap of specialist support within primary and community care settings, which results in patients not being treated within the correct environments.

West Essex CCG aim to commission a model of care, which can be tailored based on individual need. This model of care will result in integrated, co-ordinated services along with specialist level management of complex patients within a Primary/Community based setting. The majority of patients will be diagnosed earlier, receive on-going management in Primary Care and be given the tools to self-manage their condition. In commissioning this pathway of care West Essex CCG aim to improve the experience and outcomes for patients within the west Essex health economy, living with an ACS Condition.

Aims and Objectives	Goals for Patients
Improved quality and equality of care across West Essex through earlier diagnosis and holistic support for patients through multi-disciplinary clinics.	Quicker response to early signs of ill health.
Ensuring improved provision and quality of care for patients in a primary care setting where clinically appropriate.	Allow people with ACS conditions to live (with support) independently for longer at home or in the community.
Promote self-management to enable patients to self-care more effectively and maintain independence.	Improved responses to crisis and acute episodes of ill-health.
Avoid unplanned hospital admissions by proactive identification of patients at risk, creating efficiencies.	Improved support for families and carers

Implementation Timeline



5.5 Improvement Interventions – Adults Transformation Programme

Improving quality

Principles

- Improved quality and equality of care across West Essex through earlier diagnosis and holistic support for patients through multi-disciplinary clinics.
- Ensuring improved provision and quality of care for patients in primary care where clinically appropriate.
- Promote healthy lifestyles and self management to enable patients to self care more effectively and maintain independence and/or increased years of life through promotion of healthy lifestyles and earlier diagnosis across all ACS conditions.
- Promote self-management to enable patients to self-care more effectively and maintain independence.
- Avoid unplanned hospital admissions by proactive identification of patients at risk, creating efficiencies.

Outcomes

- Increased years of life through earlier diagnosis across all ACS conditions.
- Holistic support for patients with co-morbidities through multi-disciplinary clinics.
- Improved health related quality of life through the provision of innovative self-management tools, primary care based specialist clinicians and enhanced rehabilitation programmes.
- Proactive identification of patients at risk of crisis to avoid emergency admissions.
- Preventing patients suffering exacerbations through enhanced education programmes, thus avoiding emergency hospital admissions.

Priorities

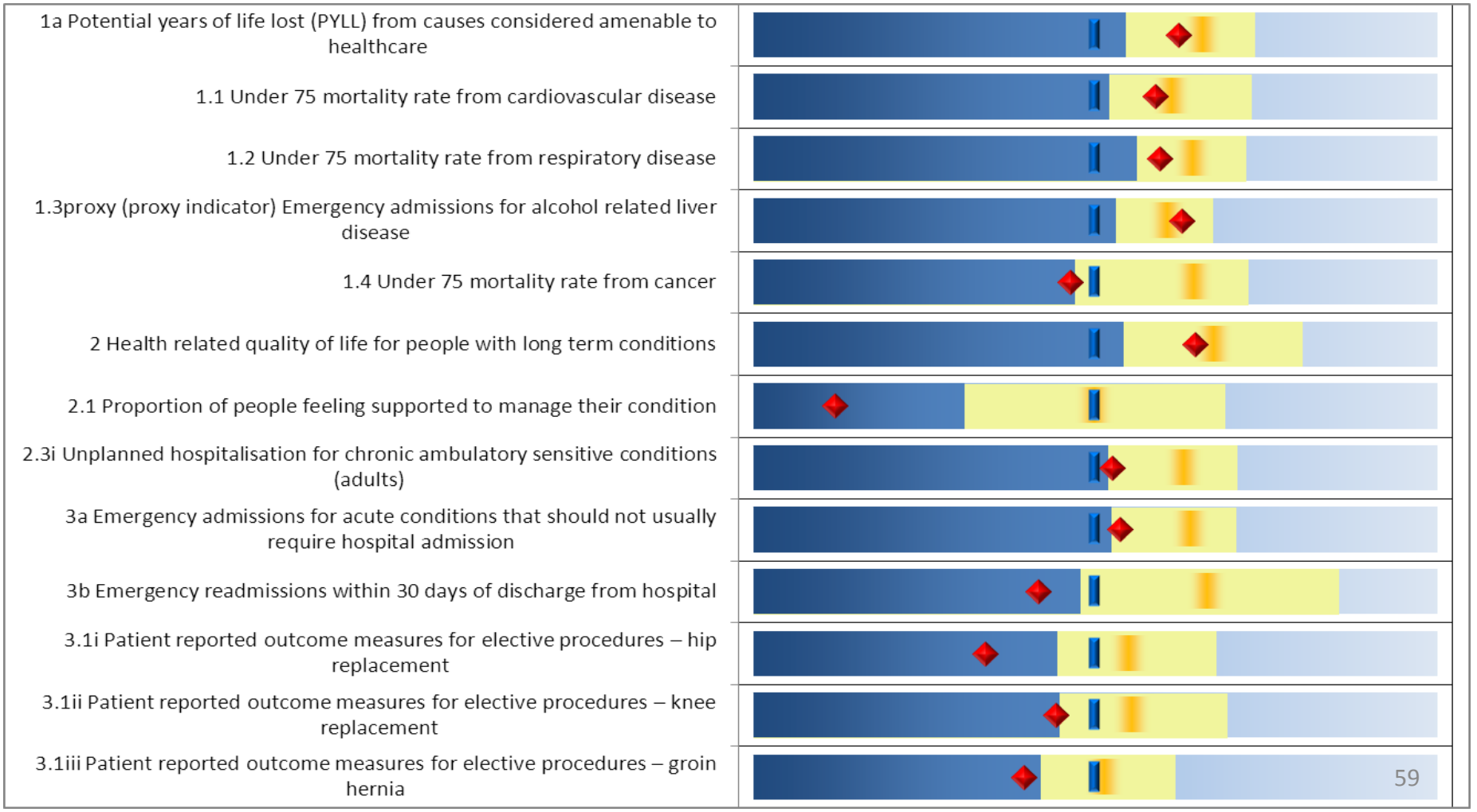
- Quicker response to early signs of ill health.
- Allow people with ACS conditions to live (with support) independently for longer at home or in the community.
- Improved responses to crisis and acute episodes of ill-health.
- Improved support for families and carers.

5.5 Improvement Interventions – Adults Transformation Programme

The adult programme is a key intervention that will contribute to an improvement in the outcome indicators below:

National Average Peer Group Average

CCG Position



5.5 Improvement Interventions – Adult Transformation Programme – Productivity Opportunities

					2014/15	2014/15		
					Activity	**Financial Gross Savings £**	**Investment / reprovision £**	**Financial Net Savings £**
Working Age Adults	**ACS priorities (Under 75 only)**	Staggered implementation	2		585	401,000	(201,000)	200,000

NHS
West Essex
Clinical Commissioning Group

5.0 Improvement Interventions – Transformation Programme

5.6 Children and Maternity Programme

5.6 Children's Health and Social Care Transformation framework

Principles

- Significant shift away from a hospital setting to home.
- Reviewing primary care to deliver consistent high quality care
- Connected transition of care between primary & community care
- Collaborative commissioning across the 0-19 pathway. Integrated pathways, shared outcomes.
- Ensuring early intervention and prevention through integrated approaches to pathway re-design and commissioning
- Ensuring safe and effective practice across all services
- Parent education materials and community care in the home to promote independence

Outcomes

- Children with LTCs such as asthma, diabetes & epilepsy will benefit from better management of care via community nursing & clearer clinical pathways.
- Reducing unplanned hospital stays, through provision of care closer to home where clinically appropriate.
- Preventing unplanned admissions from lower respiratory tract infections, which become serious.
- Improving the experience within maternity services and the patient experience in healthcare settings.
- Delivering safe care to children in acute settings.
- Children and young people are safe from harm and abuse

Priorities

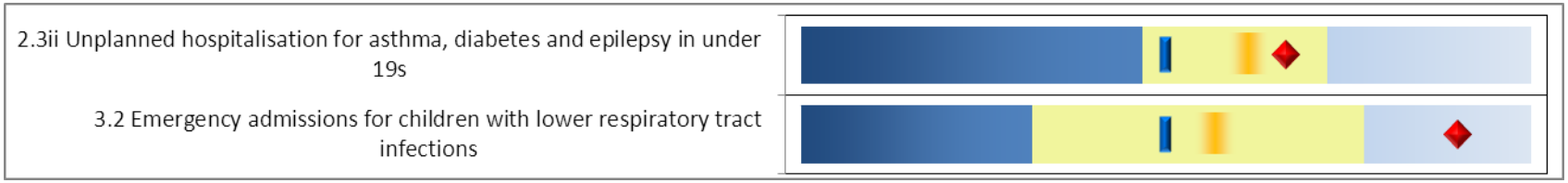
Provision of quicker responses to early indicators of risk through better provision of primary care.

- Better management of low level illness & LTCs in non-hospital settings.
- Better responses to crisis & acute episodes through more proactive primary & community care.
- Community safety - high rates of domestic abuse and social behaviour and the effects of crime on health.
- CAMHS – improving experience for young people and their families and thresholds for decision making
- Transitional care from children to adult services – forward planning with specialist skill from an early stage to support
- Strengthening Integrated Working, coordination of services and information sharing

5.6 Children's Services (Health and Social Care) Priorities

Priority	Key work-streams	Key dates
Paediatrics	Sustainable services incorporating Quality Review (Paediatric plan as part of Acute Strategy) Paediatric re-design (reducing down hospital admissions) – High impact pathways Reconfiguring services closer to home (integrated pathways of care)	June 2014
SEND reforms	To develop a Local Offer that is holistic and covers 0-25 education (provide clarity around how school based local offers will link to over-arching local offer for the area), training, transport, social care, health and support for employment and independent living. EHC Plans, joint assessment and provision Short Breaks/ Aiming High / provision of range of activities Short Breaks overnight residential review	September 2014 September 2014 Review 2014-15 re-commissioned 2016-17
Early Years Health visiting and FNP 5-19 Child Health	Review of Childrens Centres leading to re-commissioning 2016 Contract review for 2014/16. West Essex Early Years redesign. Transition plan agreed for HV & FNP to ECC Agreed approach to shared health and social care dashboard Agreed 5-19 plan and inter-dependencies	Re-commissioned April 2016 April 2015 September 2014 September 2014
Maternity	3 year sustainable maternity strategy Maternity review (incorporating quality and capacity review)	
CAMHS	Re-design of CAMHS Tier 2-3 services as part of Essex Wide re-procurement Define work – streams as per the project plan Integrate new design into local area services	To March 2014 March 2014-May April 2015
Safeguarding and domestic abuse	Identified joint priorities across safeguarding and domestic abuse	September 2014
Early Help offer	Focus on early intervention activities and approaches to prevent escalation of issues. Promotion of Essex Support for Children and Families in Essex Document and Shared Family Assessment	On going during 2014-15

5.6 Improvement Interventions – paediatric high impact pathways (indicators and measures)



WECCG are above national average and good within peer group for the < 19 unplanned hospitalisation for asthma, diabetes and epilepsy and for emergency admissions for children with lower respiratory tract infections, so there is limited improvement to be gained here.

Significant numbers of children access urgent care services within West Essex Hospitals when alternatives are available. Ensuring appropriate pathways for care are in place will facilitate timely and appropriate access to services.

Microsoft werPoint Presentati

- The paediatric high impact pathways (HIP) workstream will focus on a small number of common conditions (including asthma and respiratory tract infections) which can be appropriately managed within the community and at home thus avoiding admission to hospital. Their use will embed a consistent approach throughout the clinical community, reducing inequalities within West Essex and promoting evidence-based practice.
- GP practices will be provided with p02 saturation monitors. This is following advice from consultation paediatricians stressing the importance of an accurate p02 reading when diagnosing respiratory conditions.
- A GP launch event and attendance at GP stakeholder meetings will build confidence and strengthen engagement to the HIP
- Parent education materials for HIP will be revised and circulated and a wider parental engagement programme, working with ECC Citizenship Programme, will be developed and form a winter 14/15 communication plan
- A workshop will take place between acute and community providers and commissioners to strengthen the pathways and clinical decision making at the front door and at discharge.
- Community nursing staff have attended Children's Assessment Knowledge Examination Skills (CAKES) training to enhanced quality of service delivery and ensure the child is seen in the appropriate place of care.

The diabetes best practice tariff will be reviewed to be included in the paediatric specification for 14/15 acute contract.

5.6 Improvement Interventions – cost opportunities

					2014/15	2014/15		
					Activity	**Financial Gross Savings £**	**Investment / reprovision £**	**Financial Net Savings £**
Childrens and Mat	High Impact Pathways	13/14 start	1		39	13,628	0	13,628
	Other childrens pathways	14/15 start	2		2,041	520,405	8	520,397

5.0 Improvement Interventions – Transformation Programme

5.7 Mental Health and Vulnerable Adults Programme

5.7 Improvement Interventions – Transformation Mental Health and Vulnerable Adults – Productivity Opportunity

Improving quality

Principles

- Improved outcomes through high quality evidence & practise based interventions.
- Build primary & community care resilience to prevent ill health.
- Ensure parity of esteem with physical health via public health & care services.
- Free up block contract payments to reinvest in primary care MH education & pathway development.
- Improved understanding of primary care referral patterns to support any further local commissioning decisions
- Ensuring patients treated in the right place at the right time in the most cost effective provision
- Develop integrated approach to addiction services in line with identified needs
- Agree practices that ensure "Parity of Esteem" for all services for citizens with mental health conditions

Outcomes

- Improved early intervention, with better patient experience.
- Reducing unnecessary bed use in acute & secure psychiatric wards.
- Maximising the potential of primary care MH services to maintain independence & quality of life.
- Strengthening the interface between mental & physical healthcare.
-

Priorities

- Better prevention of mental health through early intervention.
- More responsive to early signs of mental health through early intervention.
- Lower acuity mental health conditions to be treated in primary care setting
- Reduction in bed use wherever possible allowing more people to live independently.
- Better co-ordination of social & MH needs through strengthened interfaces between health & care providers.
- Better physical health for those with MH through strengthened interfaces between health & care providers.

5.7 Improvement Interventions – Transformation -Transformation Mental Health and Vulnerable Adults

Year 1 2014/15	Years 2 & 3 2015 - 17
Explore opportunities of joint commissioning with public health colleagues to support early intervention and community well being including families and carers.	Further development of primary care mental health including establishment of "hub" model. Roll out based on early implementers across North Essex. Need to incorporate second level education programme to support new function (required in-practice presence from secondary care & assignment of care workers).
Suicide prevention – commencing with pathfinder application led by Mid Essex – learning to be shared across North.	Development and implementation of GPwSI role – suggestion is to start with dementia. Proposal to work through Strategic Network to understand national practice and build on existing service models.
Establish North Essex Mental Health Clinical Network (likely locality forums) input into service and pathway redesign.	Implement Mental Health Redesign Programme - based on the findings of the 2014/15 review programme to enable the delivery of the strategy and local plans focussing on early intervention, community well-being, integration of physical and mental health services, rehabilitation pathways/recovery models and the provision of high quality specialist in patient services.
Development of a series of "Think Tanks" to explore across all providers opportunities for improvement. Suggestions to date: Urgent Care, Management of Long Term Conditions & Pain.	
Further development of IAPT, primary and community mental health services. National Funding/project management support sourced	
Development and roll out of Primary Care (General Practice) Mental Health Education Programme. Link to EQUIP and establishment of North Essex Mental Health Clinical Network.	
Commence Development of single point of access (primary care based). Business case to be produced for individual CCG/North Essex Pilot (6 months).	
Development of Personality Disorder Strategy for North Essex	
Preparation for joint procurement of new CAMHS tier 2 and 3 service.	
Repatriation programme for out of area placements	
Collaborative working with specialised commissioning for Personality Disorders and Locked Rehabilitation Services.	
Section 12 Procurement	
Contract discussions with NEP to support: ▪ Development of proposals to integrate service provision for patients with mental health and long term conditions. ▪ Improve access to consultant psychiatrists ▪ Establishing effective KPIs to improve quality, provision of data and clinical effectiveness	
Development of a comprehensive service review programme to explore and fully understand the provision of NEP services (community, CRHT/inpatient and dementia services), exploring opportunities for integration and to make recommendation for future delivery of the North Essex Mental Health Strategy and CCG locality plans via collaboration and contestability.	
Review of Mid Essex Recovery Pilot with potential roll out to other North Essex CCGs	

5.7 Improvement Interventions – Transformation Mental Health and Vulnerable Adults – Productivity Opportunity

					2014/15	2014/15		
					Activity	Financial Gross Savings £	Investment / reprovision £	Financial Net Savings £
MH & Vulnerable Adults	**Clusters 1-4**		2			1,696,919	(443,317)	1,253,602
	SPoA		2			99,000	(22,000)	77,000

5.0 Improvement Interventions – Transformation Programme

5.8 A Step Change in Elective Care

5.8 Improvement Interventions – A Step Change in Elective Care

We have recently undertaken a benchmarking exercise to review how productive we are across a number of areas of acute activity in comparison with better performing CCGs. Opportunities to improve productivity in elective care have been identified as follows:

Activity	14/15	15/16
Elective inpatient conversions from 1st outpatient attendances	√	
Follow up to first outpatient attendance	√	
First outpatient attendances referred by GP	√	
Day case procedure to outpatient procedure	√	
Reduction in MFF by shifting activity from London providers		√

The first phase of the working age adults work programme (ACS) has identified a number of procedures that can be carried out in a more accessible and lower cost setting than currently available in secondary care. A phased shift of this activity into a primary care setting will start in July of this year. The second phase will involve a review of ENT urology and MSK procedures.

A significant amount of west Essex elective activity currently goes into London Hospitals. The CCG will support PAH to repatriate some of this work over the coming years

	14/15	15/16 and beyond
ACS procedures, shifts to primary care	√	
ENT, Urology, MSK		√

5.8 Improvement Interventions – A Step Change in Elective Care

					2014/15	2014/15		
					Activity	Financial Gross Savings £	Investment / reprovision £	Financial Net Savings £
Primary Care	**Referral Management**	13/14 start	1		2,792	411,984	(24,000)	387,984
Contract Management	**Invoice Validation**		3		na	1,594,664	0	1,594,664
	Elective IP conversions from 1st outpatient led attendances		3			1,174,902	0	1,174,902
	Follow Up to First OP		3		18,303	1,435,431	0	1,435,431

5.0 Improvement Interventions – Transformation Programme

5.9 Review of Stroke Services

5.9 Improvement Interventions - Stroke

Current Position

The National Stroke Strategy 2007 outlines what is needed to create the most effective stroke services in England. The strategy identifies major stages in the stroke patient's pathway and stresses a need to reorganise the way in which stroke services are delivered. A whole pathway approach to the provision of stroke services is essential to maximising clinical outcomes, resultant quality of life and experience of stroke services. The first 72 hours of care is vital to ensure the optimum clinical outcome for stroke survivors, underpinned by an effective whole system pathway for assessment, discharge and repatriation to local stroke services, subsequent rehabilitation and longer term support.

The CCG is committed to delivering high quality stroke services to all of our population. Citizens in the south of our patch currently access high quality acute care within London Hyper Acute Stroke Units (HASU). Patients in the centre of our patch access care from Princess Alexandra Hospital and in the North of our patch from Addenbrookes. Although performance at PAH is improving, sustainable high quality care is always going to be challenging to provide from a relatively small DGH. Consistent good performance at Addenbrookes also seems challenging although with a larger footfall of patients it is likely that Addenbrookes will be able to achieve high standards of care 24/7 going forward.

The CCG has recognised the need to provide acute care (HASU) at scale, but also recognises the need to improve all components of stroke care. We are therefore about to conduct a local review of all stroke services across the pathway

Stroke Pathway Review	14/15				15/16			
	Qtr 1	Qtr2	Qtr3	Qtr4	Qtr 1	Qtr2	Qtr3	Qtr4
Conclude review for HASU inc consultation/engagement								
Conclude review of ASU capacity and performance and rehabilitation services								
HASU mobilisation and implementation								
New ASU/rehabilitation model mobilisation and implementation								

NHS
West Essex
Clinical Commissioning Group

5.0 Improvement Interventions – Transformation Programme

5.10 Concentrated Centres of Excellence

5.10 Concentrated Care in Centres of Excellence

Our Vision, *" My Health, My Future, My Say"* 2014-2024 outlines how we plan to work with our acute sector and what we expect from them.

For patients with rare and complex health needs we want them to be able access the right clinical expertise from specialist centres of excellence such as cases for major trauma, severe stroke, rare cancers or complex child health care

Improving quality

Stroke	• The CCG is undertaking a review of all stroke services having acknowledged the need for immediate acute care to be provided from Hyper Acute Stroke Stroke Units (HASU)
Children	• The CCG commissions complex acute care for children from specialist centres of excellence at Cambridge and London hospitals
Trauma	• The CCG commissions major trauma care from specialist centres of excellence at Cambridge and London hospitals
Cancer	• The CCG commissions specialist cancer services in the main from London Hospital. Cancer services are under review in London and the CCG is contributing to this. Princess Alexandra Hospital is a specialist centre for cancer services.
Cardiac	• The CCG commissions specialist cardiac care from specialist centres of excellence at Basildon and London Hospitals

5.0 Improvement Interventions – Transformation Programme

5.9 Enablers

5.9 Enablers

To transform the local health and social care system we have acknowledged that we will have to work differently. Integrated commissioning and provision of services is key and our plans for this are described earlier in this plan. We also recognise certain enablers that are key to support our transformation. These are described below:

Supporting Transformation

Contracting	• Better sharing of risk within our provider supply chain to incentivise behaviours that are conducive to seamless integrated care • Aligning our CQUINs to improving patient outcomes • New methods og contracting including Accountable Lead Provider model • Longer contract to give time and commitment to transform • Contracting with primary care for a wider range of services	On-going
Contestability	• Supporting primary care to develop as a competitive provider in the market place • Encouraging acute, community and primary care providers to integrate as providers at scale • Growing the proportion of services that we commission from the voluntary sector • Use competition where it demonstratively helps us improve quality and outcomes for patients	June 2014
estate	• During 14/15 we will review the capability of the estate within each locality covering both community and primary care estate to support the demands that will be placed on it to deliver transformation. We will also work with Princess Alexandra Hospital to consider any impacts that our developments in our communities might have on the hospital estate.	Sept 2014
Workforce	• System workforce development strategy to support staff development and workforce planning to ensure that staff are available and trained to work in new ways and potentially at new points of care.	Sept 2015
IT	• Macro-System information strategy	Sept 2014
Organisational Development	• System leadership • Embracing CCG values • Staff development	On-going

5.9 Enablers - Digital/Data Assurance

The CCG is about to embark on a range of enabler programmes to support transformation (slide 5.11 outlines) On of these is the development of a system information strategy to be developed by September 2014. In the meantime key lines of enquiry are responded to as follows:

Line of Enquiry	Response
Patient reported outcome measurement – giving patients and carers the ability to manage and share data on their own care (what does this look like)	We will be reviewing this as part of the digital strategy that will be concluded in September 2014
care plans for patients with LTC are electronically linked to the GP health record	Patients will have an electronic coordinated care plan within GP records with a platform for other providers to access and input information. This is a key component of the ACS and Primary Care transformation programmes.
patients 'digital front door', NHS choices and information for empowerment of patients (who provides this?)	Provided via website and all public literature. Website refresh planned for 2014 to improve navigation for patients.
provision of Telehealth and telecare	This will be a key enabler to support expansion of primary care and the scope of services that they can offer.
implementation of health literacy (with Tinder Foundation) training people to use the internet and Care Connect.	We are working with NHSE with a view to becoming a pilot site for Care Connect
Has assurance been provided for data sharing protocols being implemented successfully or are planned to for sharing patient data.	This is a key component to our programme of work for provision of integrated care. Across our provider organisations. Our providers routinely implement data sharing protocols in line with PID governance to support delivery
Has assurance been provided for providers to comply with data standards for provision (care.data)	The CCG expects its providers to have Patient Data Governance Policies and will assure itself that these are in place through contract management processes
Has assurance been provided for 100% of GP practices to be linked to hospital data	Believe this programme has been put on hold
providers to be NHS number compliant through the Clinical Digital Maturity Index (CDMI) showing the scale of digitisation for each provider. Improvement must be shown for providers in the bottom quartile.	Data quality meetings take place routinely with providers to ensure that they are meeting the 90% target.

West Essex Clinical Commissioning Group

6.0 Financial Sustainability

In this section we give assurance that our plans are sustainable and affordable.

1. Financial Governance
2. Finance – the 5 year plan
3. Planning Assumptions
4. Running Costs
5. Transformation & Efficiencies
6. Contracts – Activity Plan
7. Contracts Summary
8. Contracts – Key points
9. Key Financial Risks

6.1 Financial Governance

The Director of Finance, Contracting and Performance has overall fiscal responsibility in the CCG and is responsible for ensuring that the organisation carries out its business within sound financial governance and that risk management arrangements are controlled and monitored through robust accounting mechanisms that are open to public scrutiny on an annual basis.

Assurance and scrutiny for financial performance and strategy, commissioning and contracting activities is within the remit of the Finance and Performance Committee, where monthly meetings provide the forum for highlighting existing and emerging risks to achievement of the financial position. Financial risks are escalated to the CCG Board via the Finance and Performance Committee.

The CCG's prime financial policies (Standing Financial Instructions) describe financial management arrangements for all areas of CCG expenditure, creditors, debtors, cash and capital assets. Financial performance reports are produced for internal and external stakeholders over the course of the financial year; these aim to ensure that the CCG is working within the resources available and to demonstrate the appropriate use of resources.

Financial risks of an operational nature are entered onto the CCG's risk register and reviewed monthly. Financial risks to the CCG's strategic objectives are managed through the assurance framework, these are reviewed bi-monthly. The most significant (red) risks and the assurance framework are reported to the CCG Board.

6.2 Financial Plan

The table on the right shows the summary of the CCGs' Financial Plan which demonstrates that the CCG is planning to achieve a 1% surplus in all financial years of the planning cycle.

The plan has been developed using the agreed national and local planning assumptions reflecting the expected changes in population, provider efficiencies and the impact of the Transformation and Efficiencies (T&E) programme assumptions as set out in the next slide.

In 2014/15 the CCG T&E target is set at £12.9m in order to achieve the required surplus. The plans are transformational and are limited to just 8 schemes (reduced from the 20+ schemes in place for 2013/14) under the 4 transformation work streams. Additionally there are benchmarked efficiencies which are to be delivered via contract management.

The CCG is planning to hold a 1% contingency (minimum national requirement is 0.5%) in each of the 5 years of the planning cycle. This will be used to address any potential financial risks as they arise in year. In addition, the CCG is planning to hold a 1% Transformation Fund in all financial years of the planning cycle.

The CCG has set aside 2.5% of the RRL in 2014/15 for non-recurring investments. In the CCG Plan The 2.5% investment fund is made up of the 1% transformation fund, the new investments reserve and the T&E headroom reserve.

NHS West Essex CCG	07H					
Financial Position						
Revenue Resource Limit						
£ 000	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Recurrent	318,299	329,814	342,959	351,887	361,010	370,366
Non-Recurrent	9,923	(1)	3,339	3,464	3,566	3,648
Total	328,222	329,813	346,298	355,351	364,575	374,014
Income and Expenditure						
Acute	186,345	177,401	165,995	158,198	151,017	143,882
Mental Health	31,653	30,238	30,168	30,062	29,984	29,910
Community	34,168	34,454	44,137	53,147	62,555	71,755
Continuing Care	16,061	17,915	24,437	25,521	26,673	27,723
Primary Care	43,237	43,915	45,712	47,206	48,794	50,437
Other Programme	9,517	11,305	20,841	25,845	29,848	34,223
Total Programme Costs	**320,981**	**315,228**	**331,290**	**339,979**	**348,871**	**357,929**
Running Costs	7,241	7,912	8,078	8,240	8,408	8,603
Contingency	-	3,334	3,465	3,566	3,648	3,739
Total Costs	**328,222**	**326,474**	**342,834**	**351,785**	**360,927**	**370,272**

£ 000	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Surplus/(Deficit) In-Year Movement	(719)	3,339	125	101	82	94
Surplus/(Deficit) Cumulative	-	3,339	3,464	3,566	3,648	3,742
Surplus/(Deficit) %	0.00%	1.01%	1.00%	1.00%	1.00%	1.00%
Surplus (RAG)	AMBER	GREEN	GREEN	GREEN	GREEN	GREEN
Net Risk/Headroom		6,429	2,674	531	1,090	1,763
Risk Adjusted Surplus/(Deficit) Cumulative		9,768	6,139	4,096	4,738	5,505
Risk Adjusted Surplus/(Deficit) %		2.96%	1.77%	1.15%	1.30%	1.47%
Risk Adjusted Surplus/(Deficit) (RAG)		GREEN	GREEN	GREEN	GREEN	GREEN
Contingency	-	3,334	3,465	3,566	3,648	3,739
Contingency %	0.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Contingency (RAG)		GREEN	GREEN	GREEN	GREEN	GREEN

6.3 Planning Assumptions

The table on the right details the planning assumptions that have been made by the CCG in developing the financial plan.

The plan has been developed using the agreed national and local planning assumptions reflecting the expected changes in population, provider efficiencies and the impact of the Transformation and Efficiencies (T&E) programme assumptions as set out within the plan.

The CCG is planning to achieve a 1% surplus in all financial years of the planning cycle.

The CCG has taken a prudent view on population growth and has planned for a rise of 1.54%, in contrast to the ONS forecasts which predicts a rise of just over 1% per year.

For Running Costs, the Target Cost per Head (excluding costs of NHS Property Services) for 2014/15 has reduced to £24.73 (from £25.00 in 2013/14) and from 2015/16 there will be a 10% reduction to decrease the indicative target to £22.07 per head.

Planning Assumptions

		2014/15	2015/16	2016/17	2017/18	2018/19
Allocation Growth (+%)	Programme	3.43%	2.57%	2.65%	2.63%	2.63%
	Running Costs	13.05%	-9.75%	0.28%	0.31%	0.33%
	Weighted Average	3.62%	2.31%	2.60%	2.59%	2.59%
Gross Provider Efficiency (-%)	Acute	-4.00%	-4.00%	-4.00%	-4.00%	-4.00%
	Non Acute	-4.00%	-4.00%	-4.00%	-4.00%	-4.00%
Provider Inflation (+%)	Acute	2.80%	2.50%	3.30%	3.70%	3.70%
	Non Acute	2.20%	2.30%	2.20%	2.20%	2.20%
Demographic Growth (+/- %)		1.54%	1.47%	1.45%	1.54%	1.55%
Non-Demographic Growth (+/- %)	Acute	0.00%	0.00%	0.00%	0.00%	0.00%
	CHC	0.00%	0.00%	0.00%	0.00%	0.00%
	Prescribing	0.00%	0.00%	0.00%	0.00%	0.00%
	Other Non Acute	0.00%	0.00%	0.00%	0.00%	0.00%
Contingency (%)		1.01%	1.00%	1.00%	1.00%	1.00%
Non-Recurrent Headroom (%)		2.50%	1.02%	1.02%	1.02%	1.02%
Running Cost (spend per head (£)		26.29	26.54	26.77	27.01	27.33

6.4 Running Costs

For Running Costs, the CCG has been notified that the Target Cost per Head for 2014/15 has reduced to £24.73 (from £25.00 in 2013/14)

From 2015/16 there will be a 10% reduction to reduce the indicative target to £22.07 per head.

On current spending plans the CCG will be exceeding its running cost allowance from 2015/16.

The table below outlines the CCG running costs position over the planning cycle.

Running Cost Allowance	2013/14 £'000	2014/15 £'000	2015/16 £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000
Notified Running Cost Allocation	7,000	7,016	6,332	6,350	6,370	6,391
Target Cost per Head (£/h)	25.00	24.73	22.07	22.07	22.07	22.07
Plan Estimated Running Cost	7,241	7,912	8,078	8,240	8,408	8,603
less: NHS Property Services	(1,060)	(1,080)	(1,099)	(1,119)	(1,137)	(1,160)
Revised Running Cost Expenditure	6,181	6,832	6,979	7,121	7,271	7,443
Under / (Overspend)	(819)	(184)	647	771	901	1,052
Population Size (000)	298	301	304	308	311	315
Spend per head (£)	20.74	22.70	22.93	23.13	23.36	23.64
Running Costs (RAG)		GREEN	RED	RED	RED	RED

6.5 Transformation & Efficiencies

The 2014/15 funding settlement has improved the plan position such that the T&E targets have reduced to 4.00% of the 2014/15 resource limit, from the 6.44% target in 2013/14.

Based on initial planning assumptions and subject to the outcome of the detailed contracting discussions, the T&E target for 2014\15 is set at £12.9m of which £0.95m is unidentified.

In 2014/15, the plans are transformational and are limited to just 8 schemes (reduced from the 20+ schemes in place for 2013/14) under the 4 transformation work streams. Additionally there are benchmarked efficiencies which are to be delivered via contract management. All schemes are subject to a business case review mechanism.

Delivery of the T&E is taken forward by Programme Boards and subject to scrutiny via the Finance & Performance Committee which holds the GP leads and commissioning managers to account if slippage occurs.

The T&E plan for 2015/16 is £12.37m and will be closely linked with the introduction of the Better Care Fund.

				2014/15 Activity	2014/15 Financial Gross Savings £	2014/15 Investment / reprovision £	2014/15 Financial Net Savings £
Frailty (Older People)	Frailty - PAH Savings	13/14 start	1	1,222	1,834,002	(1,223,555)	610,447
	Frailty - Other Acute	13/14 start	1	386	555,941	0	555,941
	Hospice at Home	13/14 start	1	180	432,000	(278,407)	153,594
Childrens and Mat	High Impact Pathways	13/14 start	1	39	13,628	0	13,628
	Other childrens pathways	14/15 start	2	2,041	520,405	(8,500)	511,905
MH & Vulnerable Adults	Clusters 1-4		2		1,696,919	(443,317)	1,253,602
	SPoA		2		99,000	(22,000)	77,000
Working Age Adults	ACS priorities (Under 75 only)excludes OP procedures. (Gross scope includes estimate of OP procs.)	Staggered implement ation	2	585	401,330	(200,665)	200,665
Primary Care	Referral Management (Gross scope assumes 20% greater activity reduction	13/14 start	1	2,792	411,984	(24,000)	387,984
Medicines Management		13/14 start	1	na	300,000	0	300,000
Contract Management	Invoice Validation		3	na	1,594,664	0	1,594,664
	Elective IP conversions from 1st outpatient led attendances		3		1,174,902	0	1,174,902
	Follow Up to First OP		3	18,303	1,435,431	0	1,435,431
Productivity			4				
Unidentified			4		2,441,793		2,441,793
					12,912,000	**(2,200,443)**	**10,711,556**

6.6 Contracts – Activity Plan

Activity Plan - taken from CCG ProvComm First Submission (14th Feb 2014)

The activity plan is based on the forecast outturn activity for 2013-14 and then adjusted across the five years for:

- Predicted growth levels based on demographic change
- Activity reductions associated with transformation schemes not yet included

Activity Plan	2013/14 Baseline	2014/15 Plan	2014/15 Plan	2014/15 Plan	2014/15 Plan	2014/15 Plan
Elective						
Ordinary	7,516	7,632	7,744	7,856	7,977	8,101
Day Case	29,215	29,665	30,101	30,538	31,008	31,489
Non Elective	26,585	26,995	27,392	27,789	28,217	28,654
Outpatients						
Firsts	82,905	84,182	85,419	86,658	87,992	89,356
Follow Ups	239,538	243,227	246,802	250,381	254,237	258,177
A&E (All Attendances)	93,667	95,109	96,508	97,907	99,415	100,956
Referrals						
GP Referrals	58,784	59,690	60,567	61,445	62,392	63,359
Other Referrals	34,330	34,859	35,371	35,884	36,437	37,002
First OP following GP Referral	53,840	54,669	55,473	56,277	57,144	58,030

6.7 Contracts - summary

The CCG is the lead commissioner for the Princess Alexandra NHS Trust contract and also leads for Essex on the Barts Health NHS Trust contract.

The CCG is working towards 2014/15 contracts to be signed within the agreed timetable. This involves regular meetings on all aspects of the contract and strict timetables are in place.

The tariff for acute services has been adjusted to deliver a 4% efficiency requirement .

Pay and price inflation is assessed at 2.8% giving a net decrease adjustment of 1.2%.

The overview of contract values is detailed in the table on the right.

Contract value 2014/15		Total
		£000
Code	Trust	
RQW	The Princess Alexandra Hospital NHS Trust	97,705
R1H	Barts Health NHS Trust	20,446
RGT	Cambridge University Hospitals NHS Foundation Trust	20,471
RQ8	Mid Essex Hospital Services NHS Trust	10,521
RYC	East Of England Ambulance Service NHS Trust	9,530
RRD	North Essex Partnership University NHS Foundation Trust	24,019
RWN	South Essex Partnership University NHS Foundation Trust	30,450
		-
XXX	Other Contracts (less than £5m)	11,630
	Total	224,772
	Non NHS Contracts	11,311
	Total NHS & Non NHS Contracts	236,083

6.8 Contracts – Key Points

For **Elective Inpatients and Outpatients**, there are currently no planning expectations that an 18 week backlog clearance will be required in 2014/15.

Growth in **planned care** activity in non NHS providers is broadly flat against prior year. Essex CCGs have commissioned the services of a consultant in order to negotiate 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 average

Current trends in **A&E** show an overall increase of A&E attendances through 2013/14, the CCG has factored in changes in counting due to changes in the redirection of patients at the front door of the PAH A&E department.

The current trends in **emergency inpatients** show a circa 8% year over year overall growth against prior year activity. The current expectation is that this growth in activity will be factored into activity plans plus an additional 1.54% before adjusting out for transformation programmes.

In setting out the **national tariff for 2014/15** NHSE have gone for a position of stability and consolidation, as a result there are very few amendments to tariff structures or risk shares. It is anticipated that there will be some significant amendments to national tariff for 2015/16, including the increased use of pathway payments as well as material changes to current rules on emergency thresholds and readmissions. At the time of writing, the details of these changes have not been notified to commissioners

6.9 Key Financial Risks

The principle financial risks facing the CCG in 2014\15 are:

1. **Allocations**

   There are a series of programme allocations for the CCG that are yet to be actioned recurrently by the Local Area Team, although the LAT CFO has confirmed that the Barts transfer will be recurring. These allocations total £3.57m and are incorporated within the financial plan and therefore provide a material risk if not forthcoming.

2. **Transformation & Efficiency Targets**

   The CCG's efficiency target in 2014/15 is set at £12.9 million of which £2.4m is unidentified.

   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.

3. **Prescribing**

   There exists price inflation risk in 2014/15 because the national guidance for prescribing price inflation was set considerably lower at 1.9% due to the PPRS agreement with the pharmaceutical industry on medicines prices. This figure has been used within the plan however, historically prescribing price inflation has been higher. In mitigation, the Medicines Management Programme Board will monitor the prescribing patterns throughout the year to oversee achievement of efficiency targets.

4. **Continuing Healthcare**

   The Continuing Care run rate associated with new care packages has grown very significantly over the past few years. It is anticipated that this will continue during 2014/15 and there is still a high risk that this area will overspend despite the substantial level of new funding that has been targeted in this area.

   The CCG has been recently notified by the NHS England Director of Financial Control that it will be required to contribute £1.254m to a risk share pool held centrally by NHS England to fund payments against historical CHC claims. This has been done on the premise that the CCG allocations for 2014/15 include the costs of settling legacy CHC provisions.

   The CGG has been notified that this contribution can counted against the 2.5% non-recurrent investment requirement.

8.0 Governance Overview

In this section we show the governance arrangements that we are proposing to ensure corporate decision making and assurance is given

8.0 Governance Overview (under review)