NHS
Basildon and Brentwood
Clinical Commissioning Group

2014 – 2016

Operational Plan

Important Note:
This document is draft and subject to final review and consideration by the CCG Board.

Contents

Plan on a page	4
Executive summary	5
Strategy and direction	6
Quality and safety	7
Section A: Improving outcomes	**8**
Domain 1:	10
Domain 2:	15
Domain 3:	20
Domain 4:	23
Domain 5:	25
Improving health:	26
EDS2	29
Parity of Esteem:	30
Section B: NHS Constitution	**33**
7 day working:	35
Referral to Treatment Times	36
Diagnostics, A&E, Urgent Care	37
Cancer:	40
MSSA and CPA:	42
Section C: Finance, Activity, QIPP	**43**
Financial plan and assumptions:	44
Activity plan:	46
QIPP:	47
Risk:	50
Section D: Better Care Fund	**53**
Section E: Delivery	**58**
Section F: Engagement	**62**

Annex A: Quality and Safety
Annex B: QIPP Checklist
Annex C: Better Care Fund Template
Annex D: 7 Day standards mapping
Annex E: RTT Action Plan

This plan has been completed by the Executive and Governing Body of Basildon and Brentwood CCG in conjunction with member practices a number of partner organisations (relative to specific sections). Notably this includes joint working with Essex County Council and Castle Point and Rochford CCG in respect of proposals for implementation of the Better Care Fund and joint commissioning of services. The CCG also liaises closely with key provider organisations, e.g. Basildon and Thurrock University Hospital Trust (BTUH) and North East London Foundation Trust (NELFT) in respect of the system unplanned care programme, new pathways of care, etc.

Any enquiries about the plan should in the first instance be addressed to:
BBCCG, Phoenix Place, Christopher Martin Road, Basildon SS14 3HG

Tom Abell, Chief Officer Tom.Abell@nhs.net
Tonia Parsons, Chief Operating Officer tonia.parsons1@nhs.net
Tracey Easton, Chief Finance Officer teaston@nhs.net
Lisa Allen, Chief Nurse lisa.allen3@nhs.net

Document control	Reviewed by:/when	Comments:
Draft v1 and BCF proposals	• BBCCG Clinical Executive 16/1/14 • Patient and Community Reference Group 21/1/14	For information/comment
Draft v 2 and BCF proposals	• BBCCG Board (Governing Body) 6/2/14 • BCF system wide stakeholder event 28/1/14	Approval of draft; still subject to NHSE comment/approval
Draft v 3	• Submission to NHSE 31/1/14	
Draft v 3	• BBCCG Board 6/2/14	For information/further comment

Our plan on a page

Basildon and Brentwood health economy is a system of 264,000 patients across 44 GP practice members working with partner organisations to implement the following vision and objectives:

"A healthier population that is receiving the right care in the right place at the right time"

System Objective One

To achieve excellence in primary care service delivery

System Objective Two

Patients to have a named clinical lead as part of a wider integrated team

Teams will be built from geographic **GP Federations**, promoting clinical and professional leadership in communities and more holistic intermediate care offer. GPs to be lead professional working with multi-disciplinary team, centred around the patient and focused on early intervention and prevention. Support to include pump priming of **£5 per head of population** in 2014/15.

More people to pre-emptive receive care in primary care and community based settings. Resources to move from acute to community settings, with a range of joint budgets and commissioning with ECC.

System Objective Three

To develop specialist pathways of care, improving outcomes

The **integration** of existing community, acute and specialist services to provide comprehensive pathways for designated indications. Such pathways will be evidence based and time limited.

System Objective Four

To reduce reliance on urgent/unplanned use of hospital services by 15% by 2018

System wide **Urgent Care Working Group** and **Better Care Fund (BCF)**, both aimed at reducing unnecessary emergency admissions and developing fully integrated community alternatives across health and social care.

Proactive case finding, with reablement and rehabilitation as the default offer; more acute clinical and social care services moved to the community.

BCF to include community nursing services, community beds and reablement in year 1 expanding to include social care funds for elderly care in following years. Total value c£18.5m 2015/16.

Governance: System wide arrangements including:

- ECC, CPRCCG and BBCCG leadership group overseeing the **BCF** pooled budget
- **Business Management Group** of the H&WB Board.
- **Unplanned Care Working Group** and Access Group
- **BTUH** executive group with TCCG

Measured using the following success criteria

- All organisations within the health economy report a financial surplus in 2015/16 and beyond
- Delivery of the system objectives, inc those in BCF.
- No provider under enhanced regulatory scrutiny due to performance or quality concerns
- With the expected change in resource profile

System values and principles

- Services are always centred around the people we serve
- We will maximise value by seeking the best outcomes for every pound invested
- We work collaboratively with our population to design the services they need
- Work cohesively with colleagues to build tolerance, understanding and co-operation

Executive summary

This plan sets out the two year work programme for NHS Basildon and Brentwood CCG for the period 1st April 2014 to 31st March 2016.

Our first year of operation leading up to the publication of this plan has been a challenging one, yet one where we have taken significant steps forward to begin to put in place the foundations of an NHS locally which is safe, high performing and financially sustainable. But we recognise that we are very much at the start of this journey.

Our overarching priorities for the next two year is to see a step change in a number of key areas:

- Continued improvement in the safety and quality of local NHS services.

- The implementation of our transformation programme to deliver better outcomes for the people we serve.

- Consistently delivering the standards as set out in the NHS Constitution and strengthening our urgent care system further.

- A financially robust health and care economy which has the necessary resource to be able to deliver the priorities above.

This plan covers the following areas:

Firstly, how we intend to **improve outcomes** for our local communities where we have set ourselves the following ambitions:

- Where we are below national average against a particular measure, to achieve or better the average.

- Where we are above the national average, to achieve the next appropriate quartile of performance.

In this section, we also demonstrate the steps we will take **to reduce health inequalities** in our local communities through the implementation of 8 high impact pathways, and the work we intend to undertake **to achieve parity of esteem** for people with mental health conditions and to break the silos in our current services between physical and mental health services.

The plan then moves onto the action we intend to take to ensure delivery of the **NHS Constitution**, in particular focusing on our work to introduce 7 day working, strengthening our urgent care system and improving cancer waiting times.

We also cover our **Financial and QIPP** position within the plan and how we intend to deliver the national planning requirements in terms of both our surplus and non-recurrent funding headroom.

A key development during the lifetime of this plan is the introduction of the **Better Care Fund** and the pooling of significant amounts of money from the NHS to social care. We see this as an exciting driver to improve the effectiveness and efficiency of care in our area and describe the things we intend to do to make this new fund deliver for our local communities.

Finally within the plan we outline our **Delivery** mechanisms and the ways we will **engage and work with patients and our local communities** to ensure that what we do reflects their needs as well as this actually coming to fruition.

Strategy and direction

Our strategy and direction
The CCG is currently developing its' five year plan and strategy which will outline the detailed aspirations and direction for the local NHS for the future. This 5 year plan will be published in June 2014.

However, we have outlined three core aims which are currently being developed to deliver care which delivers better outcomes for people whilst meeting the resource constraints faced by the local NHS.

Aim 1: Excellent primary care
We believe that our success as a CCG will be fundamentally based on high quality, consistent primary care which delivers to people's expectations.

A key part of this development is through supporting general practice to strengthen and develop their core primary care service and to align the focus on primary care to the commissioning work of the CCG. During the two year period of this plan, we are aiming to secure the following changes:

- Introducing a new mechanism to support practices to undertake an extended range of care processes for patients, aligned to our commissioning work streams, particularly focusing on developing a modern model of integrated care to support the frail elderly and people living with long term conditions.

- Working with primary care to develop federations of practices, based around our local communities to deliver the extended range of care processes and to move general practice towards a 7 day service, operating for longer hours each day.

- Working with NHS England to support general practice to improve the standard of care they can provide to patients, through adopting the requirements of 'training practices' as the gold standard of service that all surgeries should offer in Basildon and Brentwood.

Aim 2: Accountable professional teams
Our second aim is to transform the way that people with long term need are cared for within their local communities and to simplify the currently complex and overlapping arrangements we have across primary, community, secondary and social care.

It is therefore our aim that everyone with an identified long term need has a named 'accountable professional' who works as part of a wider GP Federation team who is accountable for co-ordinating care and maximising outcomes for their patients through the introduction of the 'House of Care' model of care planning to secure greater independence, control and self-reliance for their patients. As an Accountable Professional they will have enhanced authority to make decisions and allocate resources to achieve their aims.

This will involve the restructuring of existing community and community mental health services to base them around GP Federations and provide seamless care within the community.

Aim 3: Specialist pathways
For people who have additional needs which cannot be managed within their accountable professional team we will roll out a set of specialist pathways with the aim of breaking down existing barriers between specialist community and secondary care services.

Integral to this approach is the adoption of evidence based practice, interventions and timescales within these pathways as well as putting patient control and shared decision making at the centre.

During this two year plan, we intend to implement the following specialist pathways:

- Frail / complex specialist pathway.
- Cancer pathways.
- Stroke pathway.
- MSK pathway.

In particular we expect this area of work to drive both the creation of specialist centres and the 20% productivity gain in elective care.

Quality and safety

Safe, high quality NHS care
BB CCG is committed to ensuring the delivery of safe, high quality NHS care that provides a good patient experience with good outcomes for the population we serve.

One of the fundamental changes for delivering the PS&Q Plan (see annex A of this plan) is to bring the function of PS&Q into the CCG from a hosted position. This will enable PS&Q to become interwoven with all commissioning activity within the CCG and our commissioning partners.

The PS&Q delivery plan describes the ambitions for PS&Q against each domain and outcome, the mechanisms for delivery and the action we will take.

The plan describes the underlying fundamental mechanisms of internal structures such as governance within the CCG, the use of contracts and the development of integrated working whilst striving to reduce harm at every opportunity.

All of the above is underpinned by the commitment to create a culture of **C**aring and **C**ompassion, which delivers good **C**ommunication from **C**ompetent and **C**ommitted staff who have the **C**ourage to ensure the delivery of safe, good quality care at every point of care

Armed Forces Covenant
The Armed Forces Covenant Commitment sets out the relationship between the national, the state and the armed forces. It recognised that the whole nation has a moral obligation to members of the armed forces and their families and it establishes how they should expect to be treated.

The CCG's identified lead to support the delivery of the Armed Forces Covenant is Tonia Parsons, Chief Operating Officer. Although the CCG does not have any military bases in the locality, it is recognised that the military and veteran community may well be registered with GP practices in south Essex and will be accessing services through providers. To that end, it is recognised that there is a need to build strong mechanisms within services commissioned to ensure access routes into mental health and other health services are available.

• Ensure NHS employers are supportive towards those staff who volunteer for reserve duties.
• Ensure primary care is provided with information and signposting for military and veterans who access services
• To ensure veterans‟ prosthetic needs are met.

We will continue to work with South Essex University Partnership NHS Foundation Trust to implement a plan for managing military and veterans cases referred by GPs or other agencies, this plan will include:

• Follow-up protocols for regulars and reserves leaving the forces.
• Access arrangements for crisis services
• Specification of outreach and early intervention services.

Section A

Improving outcomes

A. Improving outcomes

We are committed to improving the health and wellbeing of our local communities, we can measure the impact of our work through the NHS Outcomes Framework which sets out 5 domains for improvement:

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

Each of these domains have aligned 7 outcome measures by which we can identify where we need to improve and those areas where we are doing well and where we need to set ourselves stretching ambitions.

To set our ambitions against each of the 7 outcome measures we have set out our current performance against that of other CCGs in England and have set 2 year targets on the basis of:

- Where we are below national average, to achieve national average.
- Where we are above national average, the next appropriate quartile.

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

Local measure

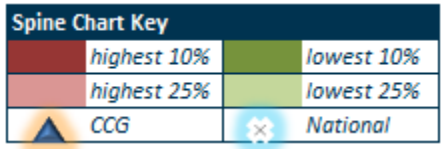
In addition to the national outcome ambitions the CCG has also selected the following measure as a local ambition for our population which we believe needs to improve.

C3.7 People who have had a stroke who are discharged from hospital with a joint health and social care plan

For details on stroke performance and actions, see page 13.

A1. Improving outcomes (Domain 1: Preventing people from dying prematurely) 1

The following indicators benchmark current CCG premature mortality from the major causes of death. The indicators consist of directly age and sex standardised mortality rate (DSR) per 100,000 population.



Period	National	Median	75th Percentile	CCG	% Var (Nat.)	Rank (of 211)	Spine Chart (Diff from Median) [Limited to +/-100%]
CCGOF 1.2 | Under 75 mortality from cardiovascular disease							
2012	65.47	66.35	77.46	61.71	▼6%	81	

Ambition: 56.71 or lower

CCG rate is 6% lower than national average. CCG is aiming to reduce the rate further to lowest 25% nationally by the cardiology review described below.

CCGOF 1.6 | Under 75 mortality from respiratory disease							
2012	27.44	27.01	33.62	21.8	▼21%	58	

Ambition: 21.21 or lower

CCG rate is 21% lower than national average. CCG is aiming to reduce the rate further to lowest 25% nationally by the respiratory review described below.

CCGOF 1.7 | Under 75 mortality from liver disease							
2012	15.4	14.8	18.8	10.18	▼34%	25	

Ambition: 10.18 or lower

CCG rate is 34% lower than national average. CCG is aiming to reduce the rate further to lowest 25% nationally by the alcohol pathway.

CCGOF 1.8 | Emergency admissions for alcohol related liver disease							
Jul12 - Jun13	24.7	22.6	32.9	10.5	▼57%	17	

Ambition: 10.5 or lower

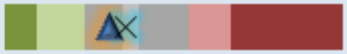
CCG rate is 57% lower than national average and currently in lowest 10% nationally. CCG is aiming to sustain this performance and implement with ECC the Alcohol treatment services.

CCGOF 1.9 | Under 75 mortality from cancer							
Directly age and sex standardised mortality rate (DSR) per 100,000							
2012	123.26	122.1	135.0	123.85	▲0%	114	

Ambition: 122.1 or lower

CCG rate is similar to national average. CCG is aiming to reduce to below national average.

A1. Improving outcomes (Domain 1: Preventing people from dying prematurely)

Period	National	Median	75th Percentile	CCG	% Var (Nat.)	Rank (of 211)	Spine Chart (Diff from Median) [Limited to +/-100%]
CCGOF 1.1 | Potential years of life lost (PYLL) from causes considered amenable to healthcare							
Directly age and sex standardised potential years of life lost (PYLL) per 100,000							
2012	2,060.8	2,083.4	2,390.1	1,966.4	▼5%	81	

Ambition:
1,842.6
or lower

Overall, the CCG performs well on this standard and has lower mortality rates than the national average the overarching indicator as well as the majority of disease specific areas. However, we aspire to achieve upper quartile performance consistently across the key disease areas and are therefore implementing a number of key work programmes to improve overall outcomes. These are outlined below. A key priority for the CCG is the improvement in Cancer outcomes. For this disease area, the CCG mortality is worse than the national average.

		2014/15				2015/16			
No	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A1.1	Hypertension • Continue the roll out of the programme to identify patients with hypertension and manage them through primary care registers/QOF	**P** →				**O**			
A1.2.1	Respiratory review • Review existing service against DH best practice model • Improve management closer to home • Develop prescribing formularies • Develop a specification for high quality, cost effective provision • Patient engagement via survey to shaping model and stakeholder group			**R**		**I** →			

R: Complete Review **I:** Implement **P**: Phased Implementation **O:** On-going

A1. Improving outcomes (Domain 1: Preventing people from dying prematurely)

		2014/15				2015/16			
No	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A1.2.2	Respiratory Review - COPD passport • Patient self management and empowerment plan • Includes model for annual review	**I** →							
A1.3	Cardiology service review • Review pathways • Reduce duplication • Improve management closer to home • Develop prescribing formularies		**R**		**I** →				
A1.4	Heart Failure review • Explore gaps in service against NICE recommendations • Review model • Develop case for change (if required)		**R**		**I** →				
A1.5	Haematology review (warfarin, pathways for management including AF, Blood and other transfusions) • Explore existing pathways • Review systems to ensure patient safety • Work with Medicines Management to develop formularies and guidance for clinicians			**I** →					
A1.6	Implement new integrated alcohol treatment pathways (lead by Essex County Council) • Develop new pathway • Procure new solution • Mobilise				**I** →				

R: Complete Review **I:** Implement **P**: Phased Implementation **O:** On-going

A1. Improving outcomes (Domain 1: Preventing people from dying prematurely)

		2014/15				2015/16			
No	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A1.7	Health check for people with MH needs - SMI registers, cross reference with SEPT - Target smoking, obesity, diet - General wellbeing education for patients		I →	I →	I →				
A1.8	Antenatal smoking and breastfeeding • Maintain UNICEF accreditation within BTUH	O →							
A1.9.1	Cancer Services - Inter provider transfer policy • A more effective protocol around the Cancer pathways between South Essex Acute providers incorporating transfer dates and breach allocations.	I →							
A1.9.2	Cancer Services - Patient tracking • Review of anonymous Patient Tracking List (PTL) on regular basis to identify themes and issues causing delays in patient pathways. • Regular meetings with BTUH cancer leads to ensure early identification and resolution of issues arising in Primary Care.	I →							
A1.9.3	Cancer Services - Review of services Wider review of the South West Essex Cancer service including: • Review of patients with 1st cancer diagnosis seen via A+E to identify any missed opportunities in earlier intervention. • Children survival rates. • Effect of increased referrals and comparison of positive diagnosis conversion. • Capacity at South West Essex Trusts.		R			I →			

R: Complete Review **I:** Implement **P**: Phased Implementation **O:** On-going

A1. Improving outcomes (Domain 1: Preventing people from dying prematurely)

Stroke Outcomes (SUBJECT TO ONGOING PROCESS – TO BE REVISED IN FINAL SUBMISSION)

Measure	Basildon Hospital 13/14
Standardised Hospital Mortality Rate	104.5 'As Expected'
Thrombolysis within 3 hours	16.2%
Admitted to a stroke unit within 4 hours	62.7%
90% of time spent on a stroke unit	83.3%
Early supported discharge	25.2%

The CCG has identified that whilst improvements have been made in the provision of stroke care, further development is required to consistently achieve key metrics and be top quartile nationally for overall stroke mortality and long term outcomes.

A number of initiatives have been identified that will support the transformation of the stroke pathway;

		2014/15				2015/16			
	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A1.10	Stroke reconfiguration • Undertake a consultation on the future provision of HASU/ASU and Rehabilitation Pathways • Commence implementation • Utilise BCF process to commission increased capacity in Early Supported Discharge • Improve the transition between acute and community stroke services through the local stroke network.	**R**			**I** →				
			I →						
		O →							

R: Complete Review **I:** Implement **P**: Phased Implementation **O:** On-going

A2. Improving outcomes (Domain 2: Enhancing the quality of life for people with long term conditions)

Period	National	Median	75th Percentile	CCG	% Var (Nat.)	Rank (of 211)	Spine Chart (Diff from Median) [Limited to +/-100%]
CCGOF 2.6 | Unplanned hospitalisation for chronic ambulatory care sensitive conditions							
Jul 12 - Jun 13	795.1	802.2	970.6	729.9	▼8%	78	

CCG rate is 8% lower than national average. CCG is aiming to reduce the rate further to lowest 25% nationally through the Ambulatory Care Pathway developed with Basildon Hospital.

Ambition: 658.8 or lower

CCGOF 2.7 | Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s							
Jul 12 - Jun 13	326.2	308.6	397.3	197.6	▼39%	19	

CCG rate is 39% lower than national average. CCG is aiming sustain low rate to remain in lowest 10% nationally.

Ambition: 197.6 or lower

CCGOF 2.2 | People feeling supported to manage their condition							
Weighted percentage of people who feel supported to manage their long-term condition							
Jul 11 - Mar 12	69.57	70.5	72.7	69.39	▼0%	82	

Percentage of people feeling supported is in line with national average. CCG is aiming to increase to above national average.

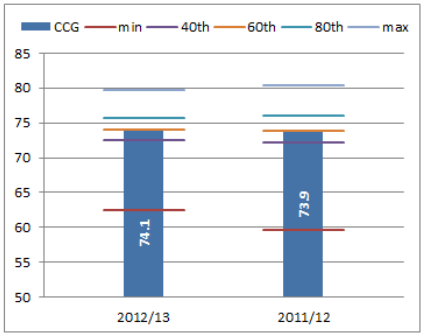
Ambition: 70.5 or above

NHSOF 2 | Health related quality of life for people with long-term conditions (Local Authority Borough Level)							
Average health status (EQ-5DTM) score for individuals aged 18 and over who identify themselves as having a long-term condition, weighted for design and non-response							
2012/13	0.73	0.74	0.77	0.73	-	130	Basildon
2012/13	0.73	0.74	0.77	0.78	▲7%	306	Brentwood

There is a variation in the quality of life measure between the two boroughs within the CCG boundaries. The average health status score is the same as national average for Basildon and 7% higher than national average for Brentwood which is in the top 10% nationally.

In terms of the total score for the CCG this is at the 60th percentile.

Total EQ-5D per 100 people:



Ambition:
Basildon 0.74 or above

Brentwood 0.78 or above

A2. Improving outcomes (Domain 2: Enhancing the quality of life for people with long term conditions)

		2014/15				2015/16			
No	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
N/A	Hypertension (see section A1.1)								
N/A	Respiratory (see section A1.2.1 and A1.2.2)								
N/A	Cardiology (see section A1.3)								
N/A	Heart Failure (see section A1.4)								
A2.1	Introduction of Ambulatory Emergency Care Pathways: • Initial 11 pathways (DVT, cellulitis, renal colic, chest pain, pleural effusion, UTI, falls, pulmonary embolism, TIA, seizure, pneumonia) fully implemented by April 2014 • Remaining 38 pathways implemented by April 2015	**P** →				**I**			
A2.2	Carers' strategy – • Education of relapse signs to carers		**I** →		**R**	→ **I**			→
A2.3	Dementia and anti-psychotic meds – • Educational programme for GPs, audit lowest/most appropriate dose	**R**	**I** →						→
A2.4	Continence programme – pan -Essex • Pathway review – adults • Pathway review – paediatrics • Procurement project – best value for products and standardisation across Essex					**I** **I** →			
A2.5	Diabetes service review (including renal) • Review existing service against NICE guidance • Improve management closer to home • Develop prescribing formularies • Develop a specification for high quality, cost effective provision			**R**		**I** →			

R: Complete Review **I:** Implement **P**: Phased Implementation **O:** On-going

A2. Improving outcomes (Domain 2: Enhancing the quality of life for people with long term conditions)

		2014/15				2015/16			
	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A2.6	Improving LTC management in patients with Mental Health conditions • Assigned MH well being practitioner to be supporting "Desmond" and "Dafne" courses (for diabetes) • Rollout RAID project – identification of MH symptoms for people on acute hospital wards • Shared care protocol to reduce gaps in service between primary and secondary care • South Essex Recovery College to enhance and promote healthy integrated living for people with MH • Increase medical cover on in patient psychiatric wards • Dementia screening (primary care QOF and acute)		I →						I →
		I →							
		I →							
									I
			I →						
		I →							
A2.7	Paediatric High Impact Pathways • Phased roll out of additional pathways	P →							I
A2.8	Roll out personal health budgets - CHC - Other health services - Mental health vol sector spend	I →							
				P →					
						P →			
A2.9	"Who Will Care?" recommendations – 5 proposals for improved integration and patient centred services; direct link to BCF delivery	P →							

R: Complete Review **I:** Implement **P**: Phased Implementation **O:** On-going

A2. Improving outcomes (Domain 2: Enhancing the quality of life for people with long term conditions)

Outcome Ambition 2: Improving the health related quality of life of people with long term conditions, including mental health

Outcome Measure 3: Roll out of Improving Access to Psychological Therapies service

Number of people with depression and/or anxiety:	32,743
Target (%):	12.6%
Target (number):	4,126

The number of people who have entered psychological therapies*

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Actual (Volume)	421	384	270	295	254	328	313	279	116				2,660
Actual (%)	1.3%	1.2%	0.8%	0.9%	0.8%	1.0%	1.0%	0.9%	0.4%				8.12%
Plan (Volume)	344	344	344	344	344	344	344	344	344	344	344	344	3,094
Pan (%)	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	9.45%

CCG is currently aiming for 12.6% of the 32,743 people with depression and/or anxiety (4,126). The CCG (as at December 2013) is currently at 8.12% compared to trajectory of 9.45%. The CCG is aiming to meet 12.6% by end of year and achieve 15% by March 2015.

	2014/15				2015/16			
Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
IAPT integrated into LTC - focus on clusters 1-3 and to include COPD, diabetes and stroke.	**P**		**R**		**I**	→	→	→
Access to IAPT – increase to 15% coverage	**P**	→	→	→	→	→	→	→
Collaboration with IAPT service provider to provide easier access to self referral	**I**	→	→	→	→	→	→	→

R: Complete Review **I:** Implement **P**: Phased Implementation **O:** On-going

A2. Improving outcomes (Domain 2: Enhancing the quality of life for people with long term conditions) – Increasing Dementia Diagnosis

Supporting Measure 1: Increasing dementia diagnosis rate to 67% by March 2015

The forecast year end position for the CCG at the end of 2013/14 for dementia is 62.3% or 2,054 people identified on dementia registers of an estimated 3,298 people living with Dementia.

Based on the current trajectory the CCG is aiming to have identified 2,500 people of an estimated 3,364 people living with Dementia in the CCG area, or 75%.

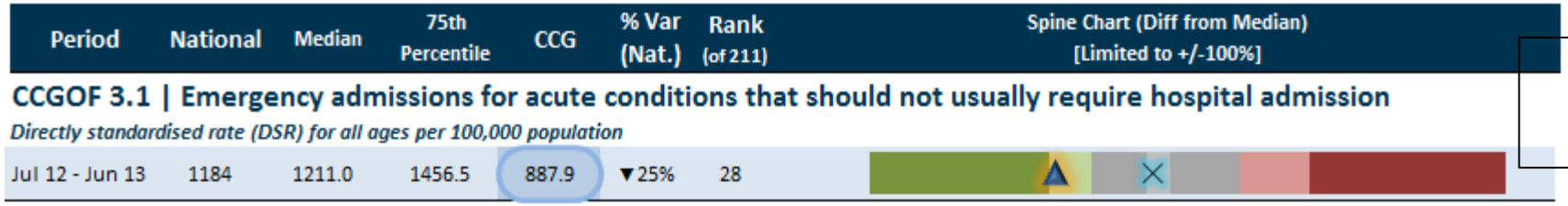
	2014/15				2015/16			
Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Practice level audit of dementia registers (subject to IG permissions)	**R** →							
Refresher training to practices to identify potential dementia and referral routes.		**I** →						
Maintain dementia awareness and training within secondary care.	**O** →							

R: Complete Review **I:** Implement **P**: Phased Implementation **O:** On-going

A3. Improving outcomes (Domain 3: Helping people to recover from episodes of ill health or injury)

Outcome Ambition 3: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.

Outcome Measure 4: Emergency admissions for acute conditions that should not usually require hospital admission



Ambition:
868.7
or lower

CCG rate is 25% lower than national average. CCG is aiming to reduce the rate further to lowest 25% nationally.

		2014/15				2015/16			
No.	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
N/A	Stroke (see section A1.10)								
N/A	Ambulatory Emergency Conditions (A2.1)								
N/A	Paediatric High Impact Pathways (see section 2.7)								
A3.1	Geriatrician Reduction in admission/re-admission of frail elderly via 'Interface Geriatrician' model including Consultant Geriatrician-led CGA and Medical Management Planning via DMOP discharge and ED 'Frailty Stream'; and Community Geriatric MDT/Practice-level MDT Case-management approach during 2014/15	**P**	**I** →			→			
A3.2	Frail Elderly Extension of Case Management approach to achieve full integration of health/social care provision for Frail Elderly individuals in line with BCF plan			**P**		**I** →			

R: Complete Review **I:** Full Implementation **P**: Phased Implementation **O:** On-going

A3. Improving outcomes (Domain 3: Helping people to recover from episodes of ill health or injury) **PROMS, LRTIs and REABLEMENT**

Period	National	Median	75th Percentile	CCG	% Var (Nat.)	Rank (of 211)	Spine Chart (Diff from Median) [Limited to +/-100%]
CCGOF 3.3a | Patient reported outcomes measures (PROMS) for elective procedures: Hip replacement							
2011/12	n/a	41.3%	42.9%	37.4%	n/a	23	

Ambition: 41.3% or higher

The PROMS percentage for Hip replacement is low in the bottom 10th percentile. CCG aims to increase this to national median.

CCGOF 3.3b | Patient reported outcomes measures (PROMS) for elective procedures: Knee replacement							
2011/12	n/a	30.1%	31.3%	30.0%	n/a	102	

Ambition: 30.1% or higher

The PROMS percentage for Knee replacement is in line with national median.

CCGOF 3.3c | Patient reported outcomes measures (PROMS) for elective procedures: Groin hernia							
2011/12	n/a	8.7%	10.0%	10.4%	n/a	166	

Ambition: 10.4% or higher

The PROMS percentage for Groin hernia is above the national median within highest 25%.

CCGOF 3.3d | Patient reported outcomes measures (PROMS) for elective procedures: Varicose veins							
2011/12	n/a	9.6%	11.0%	n/a	n/a	125	

Ambition: N/A

The CCG does not have a PROMS percentage for Varicose veins.

CCGOF 3.4 | Emergency admissions for children with lower respiratory tract infections							
Directly standardised rate (DSR) for all ages per 100,000 population							
Jul 12 - Jun 13	397.3	400.0	512.0	260.3	▼34%	31	

ASCOF 2B(1) | Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (effectiveness of the service) (Local Authority Council Level)							
Proportion of older people (aged 65 and over) discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an							
2012/13	81.40	83.60	88.40	82.00	▲1%	63	

Ambition: BCF

A3. Improving outcomes (Domain 3: Helping people to recover from episodes of ill health or injury)

		2014/15				2015/16			
No.	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A3.3	MSK pathway: • Developing an enhanced Hub/triage model for referrals • First pathways for development – spinal and rheumatology • Collaboration with medicines management to develop standardised formularies	**P** →				**I** →			
A3.4	South Essex SRP review: • Policy review • Standardising procedural and treatment restrictions in line with other Essex CCGs and best practice (e.g. NICE) • Patient engagement with process of review and development of patient information • Collaborative working with Public Health, Clinicians, PCRG and Medicines Management	**I** →							
A3.5	Review of SPOR/Reablement • Through the BCF, review the SPOR and provision of reablement services • Develop long term model • Commission new model • Implement	**R**				**I** →			
A3.6	Continuing Health Care • Review of Mountnessing Court • Review requirements for reablement/rehabilitation pathway pre CHC assessment • Commission new mode	**R**		**I** →					
A3.7	Community Intermediate Care Review • Through the BCF, review the provision and requirements for health/social intermediate care • Develop long term model	**R**		**P** →		**I** →			

R: Complete Review **I:** Full Implementation **P**: Phased Implementation **O:** On-going

A4. Improving outcomes (Domain 4: Ensuring that people have a positive experience of care)

Outcome Ambition 5: Increasing the number of people having a positive experience of care.

Outcome Measure 7: Inpatient Friends and Family Test

Basildon University Hospital - RDD

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Response Rate	8%	19%	13%	12%	10%	10%	12%	15%	16%
Net Promoter Score	39	35	44	49	51	45	53	59	61

Accident & Emergency (Types 1&2)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Response Rate	3%	11%	6%	6%	4%	4%	4%	5%	11%
Net Promoter Score	-42	-13	16	21	9	6	-11	31	49

Currently our main provider has a very low response rate. The provider has been asked to provide and implement solutions to rapidly increase the response rate to least national average by the end of Q2 2014/15. To encourage this we have used the CQUIN scheme within the contract.

Once the response rate has increased, further work will be done to interrogate the data to ensure any issues are identified and addressed, thus improving patient experience by responding to concerns. All of this will be achieved within an improved culture of care, compassion, communication, courage, competence and commitment as described within the Patient Safety and Quality section of this plan

		2014/15				2015/16			
No	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A4.1	Increase response rate for FFT: • Trust to provide and implement solutions • Include as part of CQUIN to Improve response rate	P		O	→	→	→	→	→
A4.2	Improve outcome of FFT: • continue to identify area of concern and • ensure provider develop actions to address.	O	→	→	→	→	→	→	→
A4.3	Roll out FFT programme to: • Maternity • Staff	I	→	→	→	→	→	→	→
A4.4	The above three actions will be underpinned by: • increased utilisation of patient engagement programmes • creation of a learning culture with all providers • the establishment of the culture of the 6 Cs as described in the quality section of this plan	P			I	O	→	→	→

A4. Improving outcomes (Domain 4: Ensuring that people have a positive experience of care)

Outcome Ambition 6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
Outcome Measure 8: Composite indicator of (i) GP services, (ii) GP out of hours services.

		2014/15				2015/16			
No	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A4.4	Primary Care Strategy Implementation of primary care strategy – named lead GP, services centric to patient care (see also BCF)	**P** →							
A4.5	Review of NHS 111 specification								**R**

R: Complete Review **I:** Full Implementation **P**: Phased Implementation **O:** On-going

A5. Improving outcomes (Domain 5: Treating and caring for people in a safe environment; and protecting them from avoidable harm)

Outcome Ambition 7: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

Outcome Measure 9: Hospital deaths attributable to problems in care (**under development**)

Supporting Measure 3: (i) MRSA zero tolerance (ii) Clostridium difficile reduction

Commentary on current position:

Historically our main provider has had a SHMI ratio above expected limits, and has moved to within expected limits in Q4 of 2013/14 (but still with a high ratio 1.11). Whilst this show movement in the right direction, the momentum must be continued. The Hospital Mortality Plan is closely monitored with key areas of performance monitored to drive down avoidable hospital deaths. Work has also commenced to influence factors external to the hospital to avoid inappropriate admissions that subsequently result in avoidable deaths e.g the End of Life pathway. This work will be further underpinned by the output from the Care Conversation.

C-Difficile (awaiting national trajectory)

		2014/15				2015/16			
	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A5.1	Reduce the number of avoidable deaths within the hospital • Care of deteriorating patient • Consultant review • 7 day working • Mechanisms used – contract and monitoring visits		**P**		**I**	**O** →			
A5.2	MRSA Maintain zero tolerance for MRSA bacteremia cases	**O** →							
A5.3	C-Diff Continue to drive down cases of Clostridium difficile	**O** →							
A5.4	Monitor Monitor on-going arrangements within the main provider to prevent and control infection: • Via the contract • Via the Clinical Quality Review Group • Quality visit programme	**O** →							

A6. Improving outcomes (Improving health and reducing health inequalities)

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

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

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

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

NHS England has published "Commissioning for Prevention" which outlines 5 steps which CCGs should take to improve health and reduce health inequalities. Within this section we outline the work undertaken so far within the CCG and that planned to put these 5 steps into action.

Steps 1 and 2: Analyse key health problems and Prioritise and set common goals.

The CCG's public health aligned staff have undertaken a 'deep dive' on health inequalities, lifestyles and prevention together with a wider clinical JSNA that analysed all of our areas of commissioning in terms of spend and outcome for our patients

This work has identified the following groups of people in our community who have worse outcomes and experience of care:

- The communities of:
  - Vange – Basildon town
  - Pitsea – Basildon town
  - St.Martins – Basildon town
  - Fryerns – Basildon town
  - Laindon Park – Basildon town
- People with mental health problems

It has also identified priority areas for action within these groups and more broadly across the entire CCG:

- Area 1: Respiratory Disease
- Area 2: Circulatory Disease
- Area 3: Diabetes
- Area 4: Cancer
- Area 5: Falls in Older People
- Area 6: Lifestyle issues, particularly smoking and alcohol misuse
- Area 7: Mental health

The CCG 's resource allocation framework, and business case template for new investment require that programmes demonstrate how they will positively impact on reducing health inequalities.

A6. Improving outcomes (Improving health and reducing health inequalities)

Steps 3 and 4: Identify high impact programmes and plan resources

The CCG has identified the following high impact work areas to implement over the next two years to improve health and reduce health inequalities:

High impact project 1: Prevention of Strokes through improving Hypertension QOF register completeness and improving clinical management of circulatory disease
Aimed at: Patients most at risk of hypertension and those with existing circulatory disease
Delivery start date: July 2013
Resourced through: ECC
Description: Use of the NHS Health Checks programme, Senior Health Checks programme, MIQUEST queries and Blood Pressure monitoring machines in GP surgery waiting areas to improve case finding of undiagnosed hypertension, and assist GP surgeries to improve the management of hypertension, CHD and stroke. If successful the programme will prevent 316 strokes in three years

High impact project 2: Preventing strokes through improved anti-coagulation in patients with Atrial Fibrillation
Aimed at: Patients on GP AF QOF registers
Delivery start date: November 2013
Resourced through: ECC
Description: AF is a significant cause of stroke which is preventable with identification and good management. The age-specific prevalence of AF is rising due to improved survival of patients with CHD. AF is associated with a five-fold risk of stroke, but this can be reduced by 66% through anti-coagulation. The programme incentivises GP practices to increase the percentage of AF patients who are anti-coagulated over and above what is required to achieve maximum QOF points.

High impact project 3: 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 continenc services.

High impact project 4: 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.

A6. Improving outcomes (Improving health and reducing health inequalities)

High impact project 5: Making Every Contact Count
Aimed at: Patients engaging in health damaging behaviour and poor lifestyle choices.
Delivery start date: On-going
Resourced through: CCG
Description: All contracts with our front line providers include a requirement to deliver MECC including performance metrics. The CCG will systematically monitor these to ensure that providers are delivering the programme.

High impact project 6: Respiratory Services Review
Aimed at: Reducing the health impact of respiratory disease amongst our patients.
Delivery start date: December 2013
Resourced through: CCG
Description: Patients with respiratory disease (particularly COPD) have poorer outcomes than expected, whilst local services cost considerably more than our ONS cluster CCG mean. The project is undertaking a deep dive review into the respiratory services pathway, with a view to whole pathway redesign to improve outcomes for patients. As respiratory disease impacts more significantly on our more deprived populations, the project should also reduce health inequalities.

High impact project 7: Diabetes and Endocrine Pathway re-design.
Aimed at: Reducing the health impact of diabetes on our patients
Delivery start date: February 2014
Resourced through: CCG
Description: Our JSNA identified that patients with diabetes have poorer outcomes than expected, whilst local services cost considerably more than our ONS cluster CCG mean. The project is undertaking a deep dive review into the diabetes and endocrine care pathway, with a view to whole pathway redesign to improve outcomes for patients. As diabetes disease impacts more significantly on our more deprived populations, the project should also reduce health inequalities

High impact project 8: 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.

A6. Improving outcomes (Improving health and reducing health inequalities)

EDS2

The CCG refreshed its Equality & Diversity Strategy recently and this was approved by the Board in November 2013. A further revision will be required in the coming months to reflect the new requirements of EDS2. However a number of steps have already been taken to ensure that the CCG fulfils its public sector equality duty :

- Information about the composition of the CCG's workforce has been published on the dedicated equality & diversity section of the CCG website;
- Within the Equality & Diversity Strategy, the CCG has published its interim EDS goals;
- Equality & diversity (including a refresh of the EDS goals) to be a topic for a meeting of the recently established Patient & Community Reference Group (PCRG) in the next few months. The PCRG will be a key vehicle for agreeing priorities with the community and assessing progress;
- Equality & Diversity Policy in place;
- Chief Nurse appointed as Board-level lead for equality & diversity;
- Equality impact assessments are undertaken on all CCG policies, QIPP plans and commissioning cases.

A5. Improving outcomes (Domain 5: Treating and caring for people in a safe environment; and protecting them from avoidable harm)

Outcome Ambition 7: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

Outcome Measure 9: Hospital deaths attributable to problems in care (**under development**)

Supporting Measure 3: (i) MRSA zero tolerance (ii) Clostridium difficile reduction

Commentary on current position:

Historically our main provider has had a SHMI ratio above expected limits, and has moved to within expected limits in Q4 of 2013/14 (but still with a high ratio 1.11). Whilst this show movement in the right direction, the momentum must be continued. The Hospital Mortality Plan is closely monitored with key areas of performance monitored to drive down avoidable hospital deaths. Work has also commenced to influence factors external to the hospital to avoid inappropriate admissions that subsequently result in avoidable deaths e.g the End of Life pathway. This work will be further underpinned by the output from the Care Conversation.

C-Difficile (awaiting national trajectory)

		2014/15				2015/16			
	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A5.1	Reduce the number of avoidable deaths within the hospital • Care of deteriorating patient • Consultant review • 7 day working • Mechanisms used – contract and monitoring visits		**P**		**I**	**O** →			
A5.2	MRSA Maintain zero tolerance for MRSA bacteremia cases	**O** →							
A5.3	C-Diff Continue to drive down cases of Clostridium difficile	**O** →							
A5.4	Monitor Monitor on-going arrangements within the main provider to prevent and control infection: • Via the contract • Via the Clinical Quality Review Group • Quality visit programme	**O** →							

A7. Improving outcomes (Parity of esteem)

Improving outcomes for people with mental health
We are committed to reducing the inequality in outcomes that we currently see for people living with a mental health problem, and intend to integrate mental and physical health services during the course of this plan in order to improve access to physical health services for people with mental health problems and equally improving access to mental health services for people with physical health problems. To this end we have appointed a Clinical Director for Mental Health to lead this work.

We intend to take the following steps over the next two years to achieve better parity of esteem:

	2014/15				2015/16			
Action	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Training NHS staff to better identify and respond to the needs of people with mental health needs								
All GPs to have had training to recognise signs of risk indicators for suicide and severe mental illness and correct referral paths.			I →					
All medical and nursing staff in Basildon Hospital to have received training to identify mental health problems and correct referral paths.	I →							
All mental health inpatient and community staff to have received appropriate training in physical health care and the identification of physical health needs.			I →					

A7. Improving outcomes (Parity of esteem)

	2014/15				2015/16			
Action	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Integrating physical and mental health care								
All people with low-level mental health need (clusters 1-3) to be principally cared for by their GP as their Named Accountable Professional.							I →	
Community mental health teams to form part of primary care multi-disciplinary teams	I →							
Community mental health teams to be integrated into primary care federation based health teams								I
IAPT services to be integrated into primary care federation based health teams, focusing on long-term conditions.								I
Psychogeriatricians and older people community mental health teams to be integrated into the new care of the elderly community 'step up' teams.							I →	
Introduce specified pathway of health prevention work with individuals who suffer from a mental health problem (e.g. obesity / alcohol).						I →		

A7. Improving outcomes (Parity of esteem)

	2014/15				2015/16			
Action	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Other areas								
Introduce audit programme of GP SMI registers and health checks for people with mental health needs.			I	→	→	→	→	→
Cross reference GP and secondary care SMI register to identify unidentified individuals.			I	→	→	→	→	→
Implement formulary for mental health services across primary and secondary care and supporting audit programme.			I	→	→	→	→	→
Implement the 'South Essex Recovery College'								I
Implement personal health budgets for people in recovery.								I
Specific actions to identify and support young people with mental health problems								
Extend IAPT to 14-18 year olds				I	→	→	→	→
Review of eating disorders service			I	→	→	→	→	→
Audit of A&E attendances to identify high risk young people.				I	→	→	→	→
Training of schools and health visitors in mental health identification and referral paths.				I	→	→	→	→

Section B

Delivering the NHS Constitution

B. Delivering the NHS Constitution

The CCG is committed to ensuring the delivery of the NHS Constitution for our local community.

This section of the report sets out the steps we are taking, or plan on taking in order to ensure the delivery of the Constitution through to 2016, including system wide plans for 7 day working.

B. 7 day working

The CCG has established a cross economy 7 day working group which is focusing on improving access to services across 7 days. We have used the levels of service provision as outlined by NHSIQ in *"NHS Services – Seven Days a week"* to establish our current position and to set ambitions regarding how this should be extended. For the period of this two year plan this will principally focus on emergency and urgent care services.

The full mapping is attached to this plan at Annex D which shows the current and proposed hours for service operational across our local health economy for urgent care services.

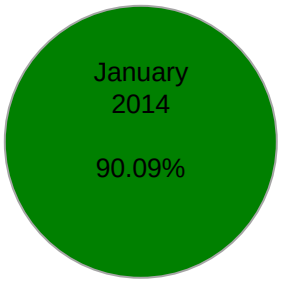
In addition it also outlines the current position in regard to the extent to which services meet the draft clinical standards published by NHS England.

> Seven day care is about having a service that gives me care, any day of the week, that meets my needs to maximise my recovery and well-being whilst keeping me safe.
>
> **Patient**

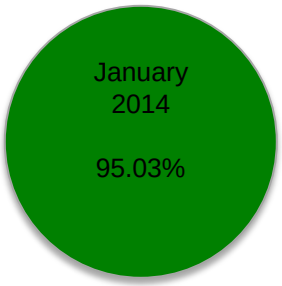
B. Delivering the NHS Constitution

Referral to treatment times for non-urgent consultant led treatment

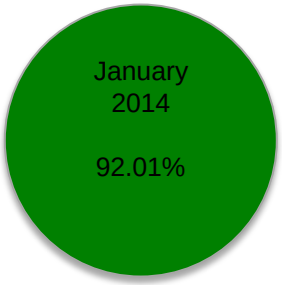
Percentage of admitted patients starting treatment within 18 weeks from referral.



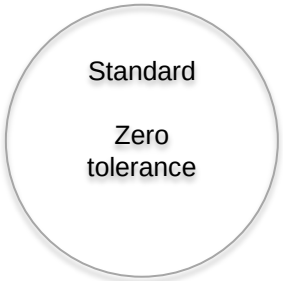
Percentage of non-admitted patients starting treatment within 18 weeks from referral.



Percentage of patients who are yet to start treatment who have been waiting less than 18 weeks



Number of people who have had to wait for 52 weeks or longer for treatment in the year / who are cancelled and are not offered an appointment within 28 day.



Commentary

Although the CCG is delivering the three core targets for non-urgent treatment, it recognises that work is required in two key areas during the period of this plan to reduce waiting times further and to ensure equity in service delivery for all patients. These are (i) the delivery of compliance with the standards across every specialty and (ii) the introduction of chronological booking.

Chronological booking implementation / specialty level compliance

The CCG has agreed a further action plan (available on request) to deliver chronological booking across all specialties in a phased manner over the next 5 (TBC) months.

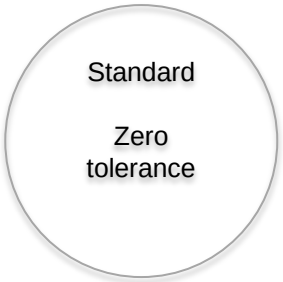
An outline of the RTT action plan is attached at Annex E for reference.

B. Delivering the NHS Constitution
Diagnostics and A&E

Percentage of patients who have waited less than 6 weeks for a diagnostic test

Percentage of people who have been admitted, transferred or discharged within 4 hours of their arrival at an A&E department

Number of people who have had to wait for longer than 12 hours following a decision to admit them in A&E.



A&E

During 2013/14 the CCG implemented an Urgent Care Recovery and Improvement Plan and significantly revised Winter Plan which resulted in significant changes across the local health economy in regard to the operation of unplanned care services.

This has resulted in a significant improvement in A&E performance with the delivery of the standard in Quarter 3. At the time of writing we forecast achievement of the 4 hour standard in Quarter 4 and overall for the year.

Our next steps in regard to further strengthening and improving our urgent care system is overleaf.

Establishing a safe and effective urgent care system

Urgent care working group
The CCG, with its partners will continue to use the Urgent Care Working Group (UCWG) as the principle driver of ensuring that we maintain and drive up the performance of our local urgent care system.

Overall urgent care performance this winter is significantly improved from the previous winter, although there remains too much variation and the need to improve the consistency of delivery across every day of every week.

We will also extend the representation at the UCWG from March 2014 to include the following agencies: GP Practices, Essex Cares and members of the voluntary and third sector.

Objectives of the UCWG
The objectives of the UCWG for the duration of this plan will remain as:

- Strengthening collaboration across health and social care in respect to the day to day operation of the urgent care system, proactively tackling and removing barriers when these are identified.

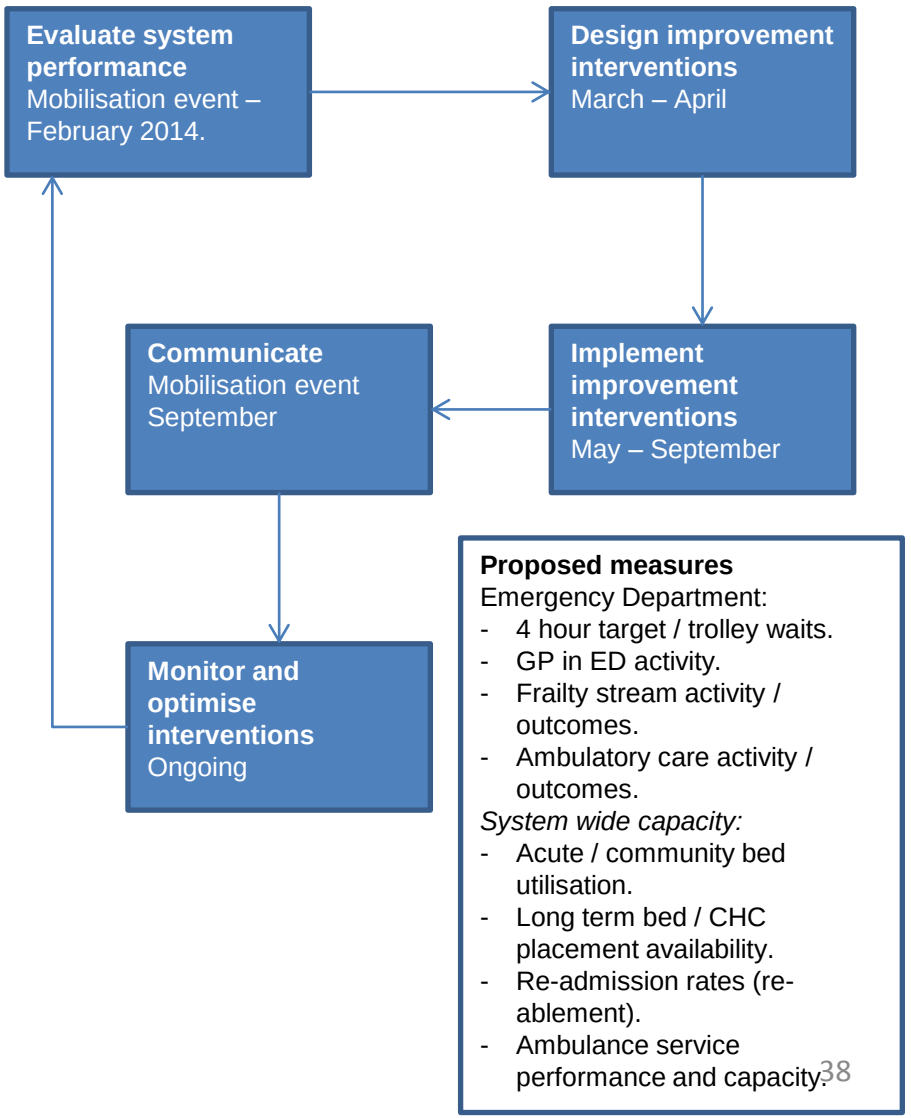
- Facilitating joint operational and tactical planning, including leading the work in respect to winter and other key challenges to urgent care performance as well as the allocation of any winter pressures funding.

- Evaluating the performance and resilience of the urgent care system and making decisions as to the action which should be taken to strengthen the system when this is required.

Key actions for the UCWG are identified on the diagram on this page.

Designation and unplanned care system structure
The CCG, alongside the CCGs and acute providers in greater Essex is fully engaged the in county wide scoping exercise on the future of acute services, anticipated to be published in Spring/Summer 2014.

Urgent care system: improvement approach



Learning from Winter 2013/14

The CCG is co-ordinating a cross system mobilisation event with the aim of agreeing the learning from our experiences during Winter 2013/14 to improve system resilience further in 2014/15 for all stakeholders within the local health and care system.

The agenda for the event has been agreed by the Urgent Care Working Group and will cover:

- **Reflections on Winter Period** (including a range of patient stories on their experiences where things went well / less well). - Supported by a breakout sessions on successes/failures, improvement areas for 14/15, engagement and communication with primary care.

- **System wide risk management** focusing on the definition of 'medically fit' and a focus on respiratory indications and management.

- **Pathways out of hospital** focusing on the findings/outcomes of a series of system workshops the CCG has led on reablement/rehabilitation/placement pathways.

Areas of focus for future winter pressures funding

Our expectation is that any winter pressures funding will be used to expand the capacity of existing service models, including those introduced and refined during the spring and summer 2014, rather than for commencing new or untested ideas immediately prior or during the winter period.

Key areas will include:

- supporting the expansion of community health & social care capacity to support vulnerable individuals and their carers, in line with the System-wide Urgent Care Plan
- enhancing primary care-led prevention targeting key patient groups (e.g. individuals with COPD, frailty, carers of vulnerable individuals)

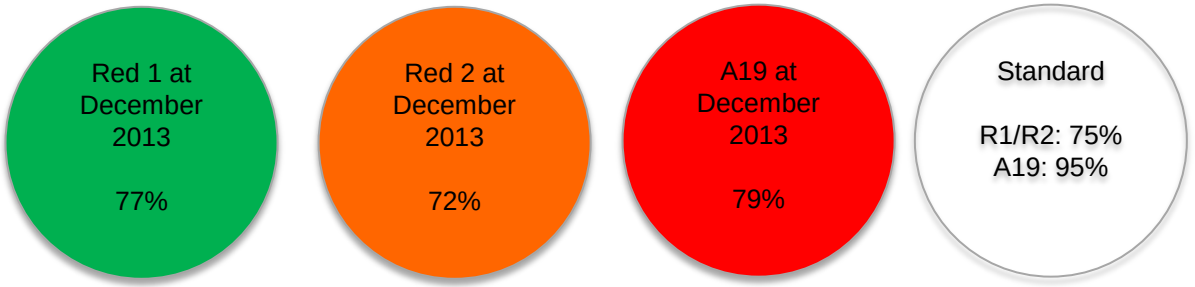
Key learning / improvement opportunities identified

The local health and social care system has made significant progress in taking a collaborative approach to both managing the general increased levels of demand associated with winter, and recovering rapidly from those periods where a surge in demand has represented a significant test to the system. In turn, this more integrated approach has allowed us to identify further opportunities for improvement to be developed in preparation for the winter of 2014/15:

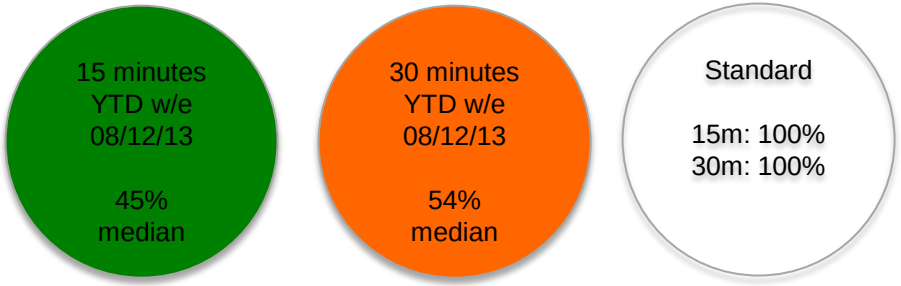
- **Improved involvement of key groups into the wider system planning and response -** in particular GP practices, East of England Ambulance Trust, and critically patients and carers.
- **Improved co-ordination through better information** – current process for collecting data to reflect demand and capacity within the system will be revised in order to incorporate information on key areas which are not currently included (e.g. capacity in primary care) and thereby both inform improved co-ordination in system-wide responsiveness, and support development of a predicative model.
- **Improvements in key organisational processes** – including
  - emphasis on increasing access to timely assessments by senior decision makers to ensure individuals receive the right care in the right place – e.g. key decision points for attention – prior to decision to admit to secondary care or into long term residential/nursing care ;
  - increase access to, and utilisation of, mechanisms to effectively navigate the health & social care system (e.g. SPOR/RRAS) by all stakeholder organisations;
- **Development of a 'convalescence' model** – offering short-term (i.e. up to 2 weeks) enhanced sub-acute care, providing clinical/social support to individuals with complex needs within a community environment. The intention being to reduce inappropriate hospital stays, and support individuals to maximise their recovery in order to ensure that any further packages of care to be provided are set at the appropriate level.
- **Multi-disciplinary training around early detection , intervention and on-going management of conditions affecting vulnerable individuals** – e.g. frail elderly

B. Delivering the NHS Constitution
Ambulance

Category A calls for an ambulance resulting in an emergency response within 8 minutes (R1 / R2) and ambulance arriving in 19 minutes



Percentage of ambulance handovers completed by 15 minutes of arrival and to be ready to accept a new call by 30 minutes of arrival

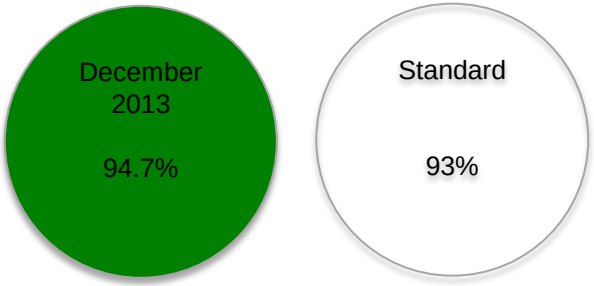


Commentary

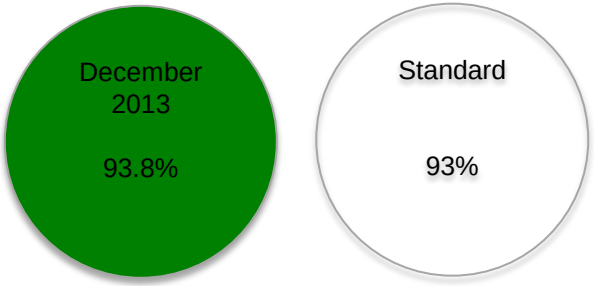
Performance issues with East of England Ambulance Service NHS Trust (EEAST) are well documented. We will continue to work with the CCG collaborative commissioning arrangement to support EEAST to move to a more sustainable position. The key issues of focus are capacity and recruitment, alongside the wider requirement for transformation of the ambulance service.

B. Delivering the NHS Constitution
Cancer

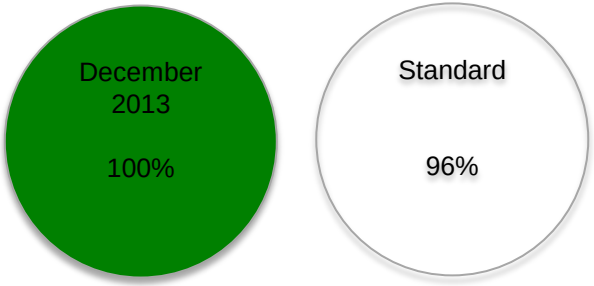
Percentage of people referred by their GP with suspected cancer seen within 2 weeks



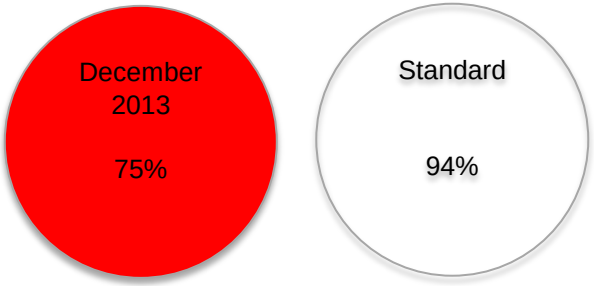
Percentage of people referred urgently with breast symptoms seen within 2 weeks



Percentage of people receiving first definitive treatment for cancer from diagnosis within 31 days



Percentage of people receiving subsequent treatment within 31 days where that treatment is surgery



Commentary:

<u>2 Week Waits & 32 Day Treatment Standards</u>

Although Performance on Operational Standards for 2 Week Wait and 31 day treatments are consistently above the relevant thresholds the CGG continues to proactively engage with Trusts to address any recurring delays and themes in site specific Cancer pathways.

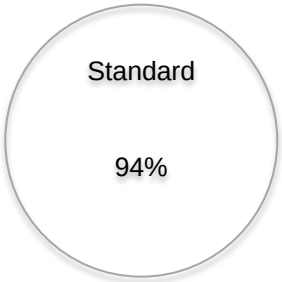
This includes (full list of actions is available on page 13 under action A1.9.3):

- Regular review of Patient Tracking Lists and early identification of issues arising at Trusts and in Primary Care for resolution.

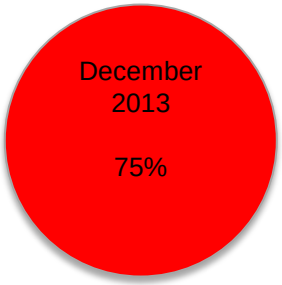
B. Delivering the NHS Constitution
Cancer

Percentage of people receiving subsequent treatment within 31 days where that treatment is an anti-cancer drug regime.

Percentage of people receiving subsequent treatment within 31 days where that treatment is radiotherapy.



Percentage of people receiving first definitive treatment for cancer from GP referral within 62 days.



Percentage of people receiving first definitive treatment within 62 days following a referral from an NHS screening service.

Commentary:

<u>62 Day Operational Standard</u>

The 62 day pathway continues to be an outlier. Breaches have been mainly due to clinical and patient delays overall.

BTUH are also receiving referrals into the CTC after target. The number of 2 week wait referrals continues to grow. (250 more in quarter 3 than in quarter 1), this is adding pressure in regards to capacity for 2 week wait patients being seen right on 14 days.

Patient cancellations for first outpatient appointments and diagnostics, putting pressure on the 62 day target.

The CCG is working in collaboration with the South Essex Trusts to address issues in Cancer pathways.

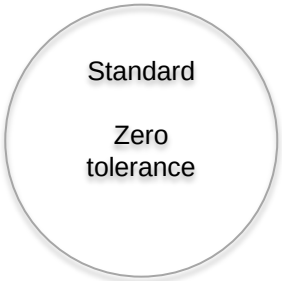
These include (full list of actions is available on page 13 under action A1.9.3):

- Implementation of an Inter-Provider Transfer Policy to ensure a smooth transfer of patient care across South Essex Tertiary Providers minimising delays in the pathway.
- Discussions around localisation of site specific “Timed pathways” implemented in Anglia.

B. Delivering the NHS Constitution

Mixed Sex Accommodation and Care Programme Approach

Number of people who breach mixed sex accommodation requirements



EMSA

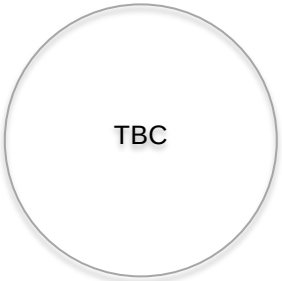
Breaches within main provider is not an issue.
However work around privacy and dignity related to EMSA has been undertaken to ensure the survey process is meaningful. Monthly collation of data has shown a response that patients are not always content with privacy and dignity, but current methodology does not enable interrogation to understand what the real issues are. Therefore a less frequent, but more in-depth, audit will take place to enable more narrative and therefore better understanding of issues, so that they can then be addressed.

There have been a number of breaches at some of the Specialist hospitals – mechanisms to better engage with the relevant commissioners is underway.

We will continue to monitor for breaches within our other main providers (NHS and private). Currently there have been no reported breaches (23.01.14)

Governance process in via the monthly Provider update for Patient Safety and Quality Report which goes to the CCG Quality and Governance Committee to the Board

The proportion of people under adult mental illness services on CPA who were followed up within 7 days of discharge from inpatient care.



Section C

Finance, Activity and QIPP

C. Finance and Activity - 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 planning assumption (see later slide) and a number of local assumptions reflecting the expected changes in population, technology and drug changes and the impact of the CCG's QIPP programme.

In 2014-15 the CCG is planning a QIPP programme of £10.009m in order to achieve the required level of surplus. The plan has been developed over a number of months and subject to robust challenge and risk assessment. The CCG used a number of benchmarking tools to identify potential QIPP including the commissioning for value tool and information. The majority of the plan is being negotiated into the contracts . The QIPP plan for 2015-6 is £7.1m and includes the 10% reduction in running costs.

In 2014-15 and 2015-16 the CCG will have 2.5% and 1% non recurrent monies available for transformation projects to start the delivery of the 5 year strategy. This non recurrent resource will also be used to support provider organisations as they make the necessary structural changes to enable them to support the revised ways of working required to deliver a strong integrated service. The 70% marginal rate investment is being discussed with the Trust and UCWG as part of the 14/15 SLA negotiations and will form part of this agreement. This is also the case with the readmissions funding.

The CCG has also provide a 0.5% contingency in each year. This will be used to address any potential financial risks as they arise in year.

The CCG has made significant progress in 2013-4 to improve financial stability and planning. The plan developed reflects this and the confidence of the CCG in future delivery.

Financial Position

Revenue Resource Limit

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Recurrent	306,129	312,540	321,955	327,559	332,947	338,427
Non-Recurrent	2,919	286	3,129	3,500	4,047	4,442
Total	309,048	312,826	325,084	331,059	336,994	342,869

Income and Expenditure

Acute	173,701	173,721	171,671	168,772	173,666	178,702
Mental Health	30,592	30,163	27,445	27,444	27,691	27,939
Community	38,538	36,397	36,106	36,106	36,432	36,760
Continuing Care	12,629	13,891	15,280	16,808	17,396	18,005
Primary Care	38,572	40,353	39,391	41,361	43,635	45,259
Other Programme	8,337	7,211	24,322	29,118	26,303	23,501
Total Programme Costs	**302,369**	**301,736**	**314,215**	**319,609**	**325,123**	**330,166**
Running Costs	6,390	6,387	5,743	5,743	5,743	5,743
Contingency	-	1,574	1,626	1,660	1,686	1,722
Total Costs	**308,759**	**309,697**	**321,584**	**327,012**	**332,552**	**337,631**

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Surplus/(Deficit) In-Year Movement	(15)	2,840	371	547	395	796
Surplus/(Deficit) Cumulative	289	3,129	3,500	4,047	4,442	5,238
Surplus/(Deficit) %	0.09%	1.00%	1.08%	1.22%	1.32%	1.53%
Surplus (RAG)	AMBER	GREEN	GREEN	GREEN	GREEN	GREEN
Net Risk/Headroom		863	626	160	186	222
Risk Adjusted Surplus/(Deficit) Cumulative		3,992	4,126	4,207	4,628	5,460
Risk Adjusted Surplus/(Deficit) %		1.28%	1.27%	1.27%	1.37%	1.59%
Risk Adjusted Surplus/(Deficit) (RAG)		GREEN	GREEN	GREEN	GREEN	GREEN
Underlying position - Surplus/ (Deficit) Cumulative	4,851	15,955	10,519	11,156	11,631	12,518
Underlying position - Surplus/ (Deficit) %	1.58%	5.10%	3.27%	3.41%	3.49%	3.70%
Contingency	-	1,574	1,626	1,660	1,686	1,722
Contingency %	0.0%	0.5%	0.5%	0.5%	0.5%	0.5%
Contingency (RAG)		GREEN	GREEN	GREEN	GREEN	GREEN
Notified Running Cost Allocation	6,390	6,387	5,743	5,743	5,743	5,743
Running Cost	6,390	6,387	5,743	5,743	5,743	5,743
Under / (Overspend)	-	-	-	-	-	-
Running Costs (RAG)	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN
Population Size (000)	255,603	255,603	255,603	255,603	255,603	255,603
Spend per head (£)	0.02	0.02	0.02	0.02	0.02	0.02

C. Finance and Activity - Planning Assumptions

The table below details the planning assumptions that have been used by the CCG in developing the financial plan. In addition to this the CCG is planning to achieve the 1% surplus requirement.

For running costs the CCG has assumed that for 2014-15 the overall envelope will remain the same but that from 2015-16 there will be a 10% reduction. In 2014-15 the CCG has set aside 2.5% of the funding for non recurrent expenditure. In 2014-15 the majority of this will be used for the transformation agenda, both for the £5 per head allocation to practices and for the local health economy to move towards the introduction of the Better Care Fund.

The £5 per head will be developed for use by practices to support two key things:

- Activities within primary care related to the improvement actions and schemes as outlined within this document.
- Support the formation of Named Accountable Professional Teams.

Planning Assumptions

		2014/15	2015/16	2016/17	2017/18	2018/19
Allocation Growth (+%)	Programme	2.14%	1.70%	1.80%	1.70%	1.70%
	Running Costs	-0.05%	-10.08%	0.00%	0.00%	0.00%
	Weighted Average	2.09%	1.46%	1.77%	1.67%	1.67%
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	2.50%	2.50%	3.00%	3.40%	3.40%
	Non Acute	2.30%	2.20%	3.00%	3.40%	3.40%
Demographic Growth (+/- %)		1.00%	1.00%	1.00%	1.50%	1.50%
Non-Demographic Growth (+/- %)	Acute	1.50%	1.50%	1.50%	2.00%	2.00%
	CHC	9.00%	9.00%	9.00%	2.00%	2.00%
	Prescribing	4.00%	4.00%	4.00%	4.00%	4.00%
	Other Non Acute	0.00%	0.00%	0.00%	0.00%	0.00%
Contingency (%)		0.50%	0.50%	0.50%	0.50%	0.50%
Non-Recurrent Headroom (%)		2.50%	1.02%	1.02%	1.02%	1.01%
Running Cost (spend per head (£)		0.02	0.02	0.02	0.02	0.02

C. Finance and Activity - Activity Plan

The activity plan is based on the forecast outturn activity for 2013-4 and is then adjusted across the five years for :

- Predicated growth levels – this includes both demographic change and changes in disease profile.
- Activity reductions associated with QIPP schemes

The QIPP schemes over the next 5 years assume a reduction in non elective activity of 15%

Activity Plan	Baseline	2014-15	2015-16	2016-17	2017-18	2018-19
Elective	**(13/14 FCOT)**	**Plan**	**Plan**	**Plan**	**Plan**	**Plan**
Ordinary	5783	5851	5910	5969	6029	6089
Daycase	26349	25921	26180	26442	26706	26973
Non-Elective						
Non-elective	22868	22118	21726	21330	20930	20527
Outpatients						
All Firsts	72474	72381	72805	73233	73665	74102
All Subsequents	151588	153393	154927	156476	158041	159621
A&E						
Type 1	71619	72472	73196	73928	74668	75414
All Attendances	78197	79127	79919	80718	81525	82340
Referrals						
GP Referrals	43362	43878	44317	44760	45208	45660
Other Referrals	37940	38391	38775	39163	39554	39950
First OP following GP Referral	37601	38048	38429	38813	39201	39593

C. Finance and Activity- QIPP

QIPP is the day to day business of the CCG and the basis of all decisions made by the CCG. The aim of the CCG is to develop integrated commissioning and locality teams in partnership with the Local Authority and community health care. This will be achieved by:

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

The QIPP plans for 2014-15 are still work in progress as part of the 2014-15 planning round. To support this the CCG has employed a QIPP lead to work with the groups to develop robust , deliverable plans. The CCG has developed a comprehensive business case and financial analysis process for the QIPP.

Delivery of the CCG QIPP plans is subject to a strong Programme Management Office process. All schemes have a detailed project plan with achievement milestones. The QIPP schemes are reviewed fortnightly with each of the programme leads and then jointly by exception at a monthly QIPP meeting. The GP leads and their commissioning managers are held to account by the CCG Finance and Performance Committee if scheme slippage occurs. This is also reviewed by the Governing Body as part of the monthly finance report. QIPP is visible and owned by all areas of the CCG and is subject to both high level and operational scrutiny in the CCG. The attached QIPP checklist evidences how well the PMO processes for QIPP are embedded within the CCG.

C. Finance and Activity- QIPP

The table below details the QIPP schemes for 2014-15. These have been developed since September via a robust process of challenge and scrutiny. The activity implications of the QIPP schemes have been reflected in the activity plan.

Scheme	Value £000s	Confidence of Delivery	Key Milestones
C2C Referrals	759		Secured in contract baseline- Audits quarterly, agreed protocols
Service Restriction Policy	453		Secured in contract baseline- Audits quarterly, agreed protocols
Unplanned Care (secured in contract)	956		Secured in contract- part of service design chnages- low figure for start position
Mental Health	990		£600K secured in contract, remainder NCA etc changes to provision
Paediatric Services	715		Changes to service provision, high impact pathways secured in contract
MSK	250		Secured in contract baseline
Prescribing	1600		Extension of exisiting schemes and new, history of achievement
Pathology	70		Secured in contract baseline
Contract issues e.g. CQUIN removed from pass through etc	900		Secured in contract baseline
Blood Transfusion	43		Decommissioned service
Community	509		Secured in contract baseline
Smaller schemes	964		Secured via budget reduction, contracts
Unplanned Care not secured in contract	1800		Expected additional savings, part of risk share- also no plan in
			contract for fines, challenges etc to BTUH
TOTAL	**10009**		

C. Finance and Activity- Contracts

The CCG is the lead Commissioner for one major contract:

- Basildon and Thurrock University Hospital Foundation Trust

The CCG also leads for Essex on other contracts including Barking, Havering and Redbridge NHS Trust and the Nuffield Hospitals.

There is a strong process for enabling the contracts to be signed by 28th February. This involves regular meetings and teleconferences around all the areas of the contract e.g. finance, activity, KPI's, CQUIN, Information etc. Progress has been good and are on line to deliver the contract in the required timescale.

There is also a bi-weekly Executive to Executive meeting for the Basildon contract to ensure timely resolution of issues.

Timeline

4th February BTUH/CCG Contract Meeting
6th February Contract update to Board
11th February BTUH/CCG Contract Meeting
13th February Executive to Executive Meeting
18th February BTUH/CCG Contract Meeting
24th February Executive to Executive Meeting
25th February BTUH/CCG Contract Meeting
28th February Contract sign off

C. Finance and Activity- Risk

The key risks to the delivery of the financial plan are outlined below along with the potential mitigating actions. All financial risk will be carefully monitored and discussed at both the Finance and Performance Committee and the CCG Board.

Risk	**Mitigation**
Delivery of financial savings through QIPP	• All schemes currently being worked up for review • PMO in place to support development of robust project plans with milestones, financial information and monitoring data • Engagement with providers to ensure realistic plans, actions and trajectories are agreed by all parties • Clinical leads own the plans and are fully engaged in delivery • Further schemes will be developed in year as part of normal CCG workplans
In year unplanned cost pressures	• Regular monitoring o the overall budget and contractual positions which will alert early notice of potential cost pressures • Finance and Performance committee requires action plans for areas of concern • A 1% contingency reserve (£1.5m) has been built into the financial plan. This can be prioritised for use when required in year
Impact of changes to PbR (Payment by results)	• Implications are being reviewed as part of the contract negotiations • CCG will be undertaking modelling of impact once data is made available centrally

C. Finance and Activity- Risk

Mental health activity changes – move to PbR	• Engagement with providers to ensure joint management of the impact • Establishment of risk share arrangements
CSU delivery	• Strong performance management of CSU with intervention where necessary • Relationships built with service leads • Robust KPIs • Review of CSU and development of strategy for service lines underway
Allocations from changes to NHS- especially impact of specialist services changes	• Work with LAT to resolve current allocation issues • Potential for risk shares across Essex
Impact of changes to the national allocations process	• CCG fully engaged in process for allocations change • Input to process for management of changes • Regular updating of MTFM to model potential impacts
Impact of retrospective continuing healthcare claims	• Additional resources in place from September • Engagement with CSU for early sight of impact on CCG resources

C. Finance and Activity- Risk

Governance of financial risk

During the production of the monthly financial position, the finance team updates the CCG risk register if any risk regarding the financial position is identified or an existing risk changes. The Finance and Performance Committee receives monthly finance and performance reports which detail the financial position and flag any existing or emerging risks to achievement of the financial position. In the event of significant budget variances the Committee requests an action plan from the relevant clinical lead and the commissioning manager to be presented.

Financial risks are escalated to the CCG Board via the Finance and Performance committee.

Financial risks are also monitored by the rest of the CCG as part of the regular QIPP monitoring process.

Strong financial governance is in place across the whole of the CCG and the finance team work with staff to ensure that high standards are maintained. There is also in place a strong internal and external audit process to ensure the CCG Board that risks to finance are being managed and mitigated where possible.

Section D

Better Care Fund

D. Better care fund

The Better Care Fund is a sum of money that will transfer funds for a range of community health and social care funds into an integrated pooled budget arrangement with Essex County Council (ECC). The fund comes into being in 2015/16 with 2014/15 seeing a modest increase in the Social Care Protection monies currently transferred to Local Authorities. The key objectives for the use of the BCF in Basildon and Brentwood are:

- To commission services that target frail and older people (>75yrs) who are vulnerable or at risk of losing their independence. The newly developed integrated community services teams will ensure a multidisciplinary approach that is targeted and risk based.
- To work with primary care to develop and commission integrated health and social care services that will reduce the need for people with a long term condition to utilise health and social care services;
- To move care closer to home so that our hospitals have manageable demand, one of the enablers for this will be the newly commissioned integrated health and social care rehabilitation and reablement service;
- To work together to ensure people are supported to look after their health and wellbeing, reducing unnecessary stays in hospital;
- To support providers to join up, share information, and make services easier to navigate;
- To create an Integrated Commissioning Board or similar with ECC and other local authorities as appropriate, to align our work and have a single commissioning process, services and work.

Patient and Public Engagement

Our vision is to design and implement an integrated care system based on what our resident population needs, that need will be articulated by the residents themselves via the various patient and service user engagement forums that we have already established. We already have established mechanisms to engage with our population to steer this work (see section E).

Provider Engagement

We have initiated a structured provider engagement strategy to ensure that we keep our providers alongside us as we bring about the changes required. The aim is not only to deliver the benefits that the BCF pooled funding arrangements but also the wider system changes that will be necessary if we are to deliver an efficient and accessible health and social care provision for Basildon and Brentwood.

Partnership Arrangements

Working with Essex County Council in an open and transparent partnership we are focusing our energies on:

- Ensuring that there are very clear synergies with ECC
- There are opportunities to prevent admissions to secondary care
- Maximising health deterioration prevention opportunities, ensuring people can manage their own conditions at home
- Developing a mechanism to deliver a reduction in Health Inequalities
- Realising financial economies of scale and benefits from Joint commissioning is driven by the needs identified in the JSNA and the HWBS.

Elements included for 2015/16

In 2015/16 the minimum investment into the BCF for BBCCG is £16,041k (as determined by the national formula). However, initial proposals for year 1 investment exceed this amount with the intention of achieving maximum benefit of the scheme rather than to simply meet minimum funding levels. In future years it is intended that social care funding for elderly care services will be added to the fund, including those for Telehealth and Telecare, home support, day care, etc.

Year 1 proposals are set out in the following slide – full details of the BCF fund and supporting metrics are appended.

Key changes expected as a result of the BCF:

- We will have GP Federations working effectively and efficiently across the borough;
- GPs will be at the centre of organising and coordinating people's care;
- Systems will enable and not hinder the provision of integrated care;
- Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system;
- Integrated health and social care teams will operate seamlessly across the system which links to the joint accountability with all our providers, in order to improve peoples outcomes across the health economy;
- Clinical pathways will be designed around the needs of patients, carers and their families.

How will we know if it is working?

We will use the NHS and Social Care Outcome Frameworks as our guides, we intend to measure specific nationally mandated and local metrics, the specific details of which are included in the full BCF plan (appended).

The success factors include elements such as reductions in hospital attendance and admissions. The advances in IT capability will help us to drill down deeper into the data held which in turn will lead to more information on specific reasons for admissions and by doing so will present opportunities to develop additional preventative measures.

In order to manage and track outcomes, we will be developing business cases to enhance developments in data warehousing, that will help us to work with all available care data, information and intelligence, getting as close to “real time analysis” as we can to allow us to make rapid and accurate decisions - including total activity and cost data across health and social care for individuals and whole segments of our local populations. Our vision is to develop interoperability between all systems to provide this “real time” information and managerial analytics capability. This ambition is in line with the recommendations of the “Who Will Care” report on the Essex system.

Min / Max Funding Amounts (subject to Board Decision)

Minimum requirement Function:	Min - 2015/6 £
Protection of Social Care (PSC)	£3,790,000
Uplift in PSC	£1,063,000
Reablement	£1,400,000
Community Beds	£4,600,000
Mountnessing	£
Continence	£
COPD	£
LTC's	£
Community Geriatrician	£
Community Nursing	£7,509,000
Discharge Support	£
Mental Health/dementia	£
Carers	£82,000
Total - Minimum	**£18,444,000**

Proposed maximum for 2015/16 Function:	Max - 2015/6 £
Protection of Social Care (PSC)	£3,790,000
Uplift in PSC	£1,063,000
Reablement	£1,400,000
Community Beds	£4,600,000
Mountnessing	£450,000
Continence	£400,000
COPD	£593,000
LTC's and Community Matrons	£691,000
Community Geriatrician	£250,000
Community Nursing	£7,509,000
Early Stroke Discharge Support	£507,000
Mental Health/dementia	£71,000
Carers	£82,000
Emergency threshold fund (70% tariff)	£1,800,000
Total - Maximum	**£24,006,500**

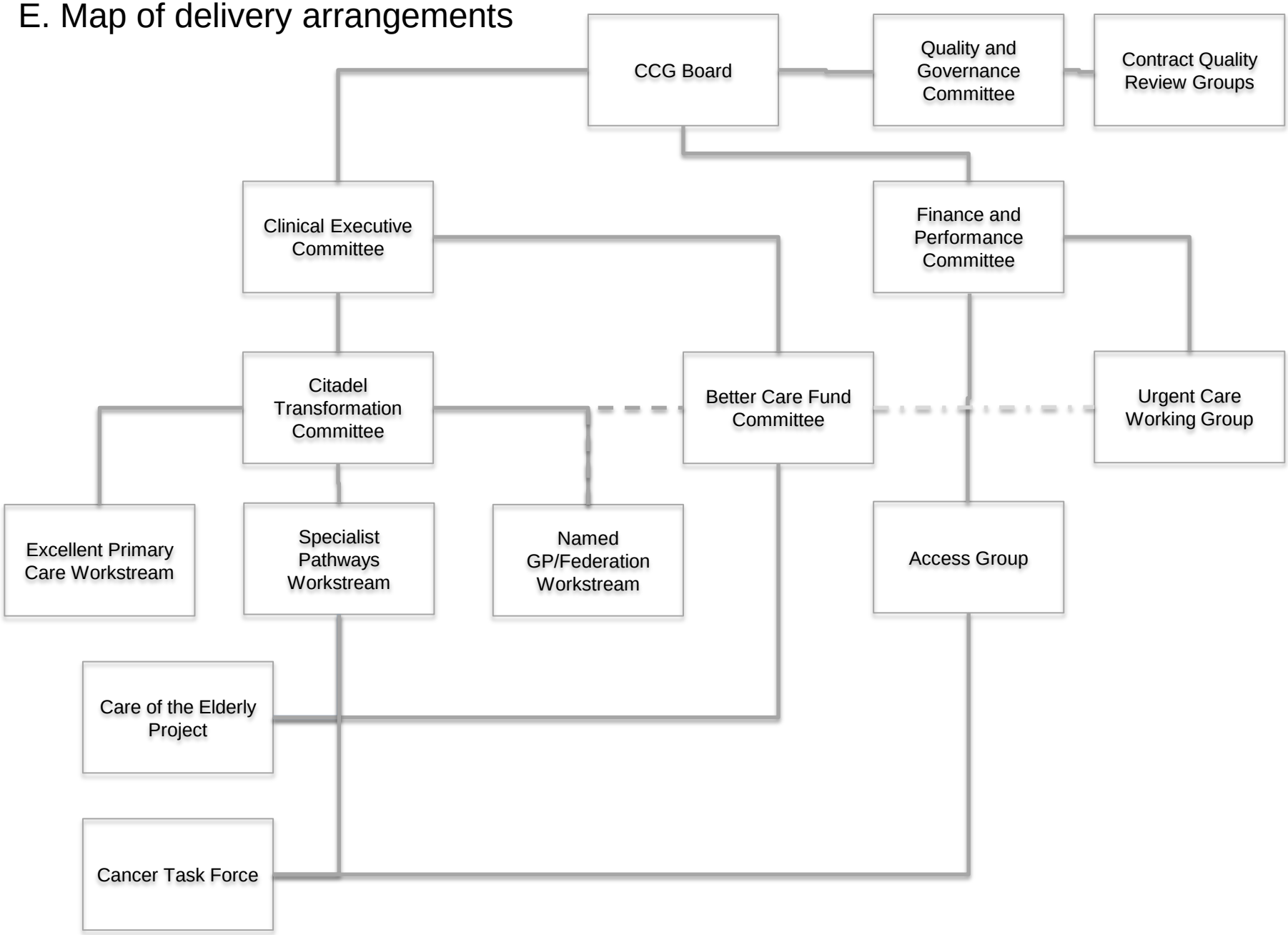
South Essex BCF metrics

Metrics		Current Baseline		
		Essex(Total of 5 x CCG & ECC)	B&B CCG	CP&R CCG
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	583.0	576.7	565.0
	Numerator	1575	254	215
	Denominator	270160	44041	38055
		(April 2012 - March 2013)	(April 2012 - March 2013)	(April 2012 - March 2013)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	82%	82%	82%
	Numerator	692	130	133
	Denominator	844	158	163
		(April 2012 - March 2013)	(April 2012 - March 2013)	(April 2012 - March 2013)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	199.3	202.8	23.2
	Numerator	2212	395	32
	Denominator	1109834	194784	138052
		2012-13 outturn		
Avoidable emergency admissions (composite measure)	*Metric Value*	1674	1621	1636
	Numerator	5296.4	987.7	603.1
	Denominator	316466	60923	36864
		(TBC)		
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]		*(insert time period)*		
Additional Local Measure - Coverage of reablement	*Metric Value*	1451.0	1934.6	1842.1
	Numerator	3920	852	701
	Denominator	270160	44041	38055
		2012-13 data		

Section E

Delivery

E. Map of delivery arrangements



E. Governance, Delivery and Engagement

In order to deliver this plan, the CCG is currently reviewing the governance and working arrangements which it has in place. This slide summarises our current thinking on the structural arrangements which are required to ensure successful delivery.

Segment	Measure	Primary delivery mechanism	Supporting delivery mechanism
Outcomes	Domain 1/Ambition 1/Measure 1 Securing additional years of life	Citadel Transformation Committee	Named GP Teams Workstream
	Domain 2/Ambition 2/Measure 2 Health related quality of life	Citadel Transformation Committee	Named GP Teams Workstream
	Domain 2/Ambition 2/Measure 3 Roll out of IAPT	Citadel Transformation Committee	Named GP Teams Workstream
	Domain 2/Ambition 2/Supp' M 1 Dementia Diagnosis	Citadel Transformation Committee	Care of the Elderly Workstream
	Domain 3/Ambition 3/Measures 4-7 Emergency admissions for acute conditions Unplanned hospitalisation for ACSC Under 19 hospitalisation Emergency admissions for children with lower resp. tract inf.	Citadel Transformation Committee	Named GP Teams Workstream
	Domain 3/Ambition 4/ Supp' M 2 65+ at home 91 days after discharge	Better Care Fund Committee	Care of the Elderly Workstream
	Domain 4/Ambition 5/Measure 8 Inpatient Friends and Family	Basildon Hospital Contract Quality Review Group	N/A
	Domain 4/Ambition 6/Measure 9 GP and OOH experience	Citadel Transformation Committee	Excellent Primary Care Workstream

E. Delivery

Segment	Measure	Primary delivery mechanism	Supporting delivery mechanism
Outcomes	Domain 5/Ambition 7/Measure 10 and S.Measure 3 Hospital deaths attributable to problems in care MRSA and C-Diff	Basildon Hospital Contract Quality Review Group	
Improving Health and Reducing Health Inequalities	Project 1		
	Project 2		
	Project 3		
NHS Constitution	Elective waiting times and diagnostics	Access Board	N/A
	A&E and Ambulance	Urgent Care Working Group	N/A
	Cancer	Access Board	Cancer Task Force
	Mixed Sex Accommodation	Basildon Hospital Contract Quality Review Group	N/A
	CPA 7 day follow-up	SEPT Contract Quality Review Group.	
Better Care Fund	Delayed Transfers of Care	Urgent Care Working Group	Better Care Fund Committee
	Avoidable emergency admissions	See Domain 3/Ambition 3	
	Residential and nursing home admissions	Better Care Fund Committee	Care of the Elderly Workstream
	Effectiveness of Reablement	Better Care Fund Committee	Care of the Elderly Workstream
	Patient/Service User Experience	Better Care Fund Committee	
	Local Measure 1		

Establishing **Excellent Primary Care** across Basildon and Brentwood

We will support the development of 'Excellent Primary Care' by practices across Basildon and Brentwood by outlining the core expectations of any practice. This is being done by:

- Asking our patients – consultation from January 2014 and through our Patient and Community Reference Group
- Working with our localities to draw out the added value of good existing working relationships
- Using known markers of good quality practice, such as those set out by the Royal College of GPs, the East of England Deanery, etc.
- Promoting the spread of training practices, both to raise the quality standard but also to attract registrars and improve recruitment and retention. The environmental standards required to achieve training status will also be used to help define the ambition for non-training practices.

Once this has been defined this will be applied to all practices within Basildon and Brentwood to be used as the basis of developing practice specific development plans and support from the CCG and/or their localities.

We will promote the 'federation' model of general practice be developed within the local area (as outlined by the Royal College of General Practitioners) in order for the necessary partnerships to be built in order to:

- Allow for peer-support between GPs to achieve the standards set out in the definition of 'Excellent Primary Care'.

- To provide the mechanism through which practices could use to tackle financial sustainability issues, such as shared back-office and front office functions.

- To provide the basis upon which consistent appointments, across both extended hours and 7 days a week could be facilitated.

- To allow for interested GPs to specialise in particular care areas, such as leading named GP teams (see below) or focusing on the provision of episodic, sophisticated diagnosis care.

Establishing **Excellent Primary Care** across Basildon and Brentwood, contd

The formation of the federated teams will take place within the four CCG localities, although it is likely that some arrangements will span different locality groups where this makes community or geographic sense. The four localities will continue to work jointly under the auspices of the single CCG Governing Body so any local arrangements will not affect the boundary of the CCG as a statutory body.

We have a total of 44 practices, clustered into 4 localities:

	Total patients (actual)	Average practice list size (actual)
Arterial	67128	4972
Brentwood	76077	9510
Partnership/BIC	66020	5502
SEMC	56194	5352
BBCCG	**265419**	**6032**

Based on locality profiles, the expectation is that there would be 4 or 5 federations each serving a population of between 50,000 and 75,000 patients.

We will continue working with Essex NHSE AT to address the workforce issues and encourage the spread of training practices. The expected level of growth in the area suggests a further 12-13 GPs may be necessary to keep pace with current delivery, in addition to the requirement for new infrastructure and estate.

The creation of **Named GP Teams**

The aim is that geographic, federation configured, 'Named GP Teams' would be the sole deliverer of front line care to people with complex needs and long term conditions, this would include existing generic community, social care and mental health resources. This clearly aligns with the requirements of the new GP contract.

In practice, this would mean that every patient who is covered within these teams has a named GP who is responsible and accountable for their care and outcomes.

In order to deliver this responsibility, the named GPs would directly instruct (either through virtual or structural integration) a range of health and social care professionals as identified below:

- General Practitioners
- Practice Nurses
- Generalist community nursing:
  - District Nurses
  - Community Matrons
- Social workers
- Therapies
- Pharmacists
- Psychological therapy staff
- CPNs and SWs

An integral part of the effectiveness of these teams would be the ability to access specialist advice and support to inform the care plan of an individual and to reduce the reliance on specialist pathways of care.
It is proposed that these teams would initially operate as shadow integrated care organisations with access to a combined health and social care budget. Initially this will be for specific related service areas, moving to include all relevant budgets over time. Over the medium term funding for these services could be on a capitation basis with risk share between the CCG and team.

Section F

-Engaging and working with the people we serve

-Criminal Justice

- Digital / data

F. Engaging with our community and the people we serve

The CCG has implemented a wide range of activities to help ensure that our patients and community experience service improvements and are fully engaged with the planning and quality monitoring of local services :

- All 4 locality groups have Patient Engagement Groups (PEGs) which meet monthly to hear patient views and act as an information exchange about service development, enabling patients to make informed decisions about their care.

- The CCG and Basildon hospital are working collaboratively to recruit Patient Leaders who will participate in visits and quality assurance of provider services (first visits due March 2014). These are paid representatives, recruited and trained jointly by the CCG and Basildon hospital. They report to the PCRG and CCG Board, ensuring that the patient voice is at the heart of quality monitoring.

- In 2013 the CCG established a Patient and Community Reference Group (PCRG) to act as a formal reference source for the Governing Body, receiving proposals for service developments, commissioning plans, etc. Members include 9 lay reps, 2 x CVS, 3 local authorities, Healthwatch Essex and GP chair of the CCG. Lay reps were recruited on the basis on their existing links to the wider community, e.g. one is the chair of the Disability Equality forum, another of the Cancer Survivor's Group.

  Key roles of the PCRG include receiving reports from the Patient Leaders for monitoring quality of service delivery, participating in planning services with the CCG, receiving reports on specific service areas throughout the year such as feedback from the Friends and Family test (especially where BTUH was an early adopter for the maternity F&F test), complaint and comments, etc. The PCRG then has direct access to the CCG Board to ensure that emerging issues are acted upon. The PCRG links to the locality PEGs through lay members and CCG locality managers to ensure local views and connections are maintained. The workplan of the PCRG is aligned to the national and local planning process to ensure that the group has the opportunity to influence commissioning and integrated plans prior to Board approval. http://www.basildonandbrentwoodccg.nhs.uk/patient-and-community-reference-group.

- The PCRG received a presentation and was asked to comment on both the CCG's Operational Plan and BCF submissions/proposals at its January 14 meeting.

F. Engaging with our community and the people we serve

- The GP Chair of the CCG is the CCGs representative on the Essex Health and Wellbeing Board and a member of the Basildon Health Forum. A Brentwood GP is a member of the Brentwood Council health forum.
- CCG officers regularly attend patient and other stakeholder groups and meetings, presenting information and receiving feedback from patients,.
- Board meetings are held in public, with questions invited, and some GP locality groups have patient representatives as members.
- The CCG Chair and executive officers routine liaise with local MPs, local authority elected councillors and other community groups.
- We publish periodic information leaflets (e.g. for our winter campaign) and website links to help people manage their own conditions. We have a wide range of information available for patients with specific conditions, such as the bespoke "patient passport" we had published for every patient known to have respiratory disease, allowing them to manage their own care plans in conjunction with the clinical teams.
- The CCG runs an annual winter information campaign, helping patients make the best choice of where to seek help. The south Essex 111 service was successfully implemented in 2013.
- The CCG has its own website where all plans (including the more detailed Engagement Strategy, Commissioning Plans, etc), policies and documents are published and accessible to the public www.basildonandbrentwoodccg.nhs.uk. A prospectus for patients is published in printed hard copy and on the website each year.
- Contact details for the CCG and a general enquiry email account has been set up to receive comments and messages from the public.. Bbccg.contacts@nhs.net

F. Criminal justice

The Chief Officer of the CCG is both a member of Safer Essex as well and the Basildon Community Safety Partnership (CSP).

The final priorities of joint NHS / CSP working will be discussed at a joint workshop on 13th February – the draft findings from the 2014/15 Strategic Assessment are:

- Night Time Economy
- Domestic Abuse
- Hate Crime

Particular areas of joint work that the CCG would like to explore during the workshop are:

- Learning from the CCG led work on the Night Time Economy during Christmas and New Year 2013.

- Improving responsiveness and joint working of mental health services with the Police and Probation services.

- Reviewing the effectiveness of NHS input into Family Solutions locally and opportunities to improve NHS input into this.

F. Digital / data

Integrating and providing better access to electronic records
The CCG is committed to improving both the quality of care through integrating healthcare records for its patients, as well as providing better electronic access to the NHS for patients.

The CCG already has a good foundation for the integration of healthcare records with a common system (SystmOne) being in place across general practice and community services, allowing for a single health record and shared care plans for people accessing both general practice and community services.

The next stage of our work is to improve the integration, or integrated use of primary and community care data within an acute hospital setting. The technical work has already been completed, including the necessary data sharing protocols to allow hospital staff to access SystmOne records within hospital, with pilots having taken place within the A&E department at Basildon Hospital.

Within our contract for services with Basildon Hospital, we have agreed a CQUIN to support the roll out and more systematic use of SystmOne within a hospital setting. This is in addition to our standard contractual requirements for all our providers to comply with NHS data standards, be this the use of the NHS number or other requirements such as IAPT reporting.

In addition, through our **Excellent Primary Care work stream** we will specifically consider better use of technology for people to access general practice such as:

- Online appointment booking and telephone/video consultations.
- Implementation of e-prescribing and improving e-referrals to secondary care.

A clear ambition through our **Accountable Professional Teams** is the implementation of the House of Care model for care planning, an integral element to the implementation of this model is improving health literacy as a means of supporting an individuals own self-management and independence, as well as the use of telehealth and telecare as a tool to support this further.

Finally, during 2014/15 the CCG intends to develop and re-launch its website, aligned and integrated (where possible) with NHS Choices or its' successor website.

Annex A

Quality and safety

See separate attachment

Annex B

QIPP Checklist

See separate attachment

Annex C

Better Care Fund Template – BBCCG section

See separate attachment

Annex D

Seven day working mapping

See separate attachment

Annex E

RTT Action Plan

Reducing elective waiting times for patients

Vision and values for RTT pathway management
There are two key principles by which the CCG and Basildon Hospital operate in regard to pathway management for patients:

- Patients with the greatest clinical need / risk are dated first.
- Patients who have experienced the longest waits will be booked chronologically, whilst ensuring that newly referred patients do not wait longer than 18 weeks.

Current performance
The Trust is meeting month on month RTT performance indicators for admitted, non-admitted and incomplete pathways. However the backlog of patients waiting over 18 weeks remains static. To address this a series of modelling has been undertaken in establish the correct approach which should be taken to reduce this backlog and begin the process of booking patients chronologically and, in turn, to consistently deliver 18 week performance across all specialities at the Trust.

As with any model, it is based on a number of assumptions all of which are available in the detailed plan.

Action plan to reduce waiting times for patients
The action plan agreed between the Trust and CCG establishes the following actions which will be undertaken to tackle waiting times:

- We will maintain the focus on ensuring that patients with the greatest clinical need/risk are dated first.
- With immediate effect, the following specialities which have no patients waiting over 18 weeks will be booked in chronological order:
    - Cardiology
    - Fertility
- With immediate effect, the following specialities which have a low number of patients waiting over 18 weeks will be booked in chronological order:
    - Gynaecology
    - Rheumatology
- A phased approach will then be implemented across all remaining specialities, in the following order:
    1. Cardiothoracic Surgery
    2. Pain Management
    3. ENT
    4. CTC Cardiology
    5. Urology
    6. General Surgery
    7. Oral Surgery
    8. Trauma and Orthopaedics

This order has been established to minimise the overall total waiting of patients who have waited both over and under 18 weeks.

- A central booking mechanism will be implemented.

The modelling suggests that this work can be completed over a [20 TBC] week period and will deliver Trust level RTT performance over this period. This assumes that c.[200 TBC] patients take up an offer of choice.

Patient choice and rights under the NHS Constitution
Alongside this process the CCG has also agreed with the Trust to implement a mechanism during this period that should a patient be referred to a speciality where we know there is a potential they may have to wait longer than 18 weeks then they will be proactively offered the choice of attending another provider at the point of a decision to admit being made. In addition, where patients are already listed and either have waited longer than 18 weeks, or are anticipated to have to wait longer than 18 weeks choice will also be offered.